The Role of Regulation in the Care of Older People with Depression Living in Long-Term Care in Ontario

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Thesis submitted to the Faculty of Graduate and Postdoctoral Studies in partial fulfilment of the requirements for the Doctorate in Philosophy degree in Nursing

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ABSTRACT

In this thesis, the overall purpose was to investigate the role of regulation in the care of older people with depression living in long-term care (LTC).

The first manuscript in this thesis is a systematic scoping review protocol which was published in BMJ open, using Arksey and O'Malley's scoping review methodology as a guide. In the second manuscript which was submitted to BMC Geriatrics, a systematic scoping review was conducted, exploring the concepts of regulation, older people, depression, and long-term care. The search yielded 778 unique articles, of which 21 were included in the final analysis. The scoping review revealed that the highly regulated environment of LTC poses significant challenges which can influence the quality of care of residents with depression. Despite evidence of high prevalence and improved treatment, regulation appears to have failed to capture best practice and contemporary knowledge. The scoping review demonstrated a need for further empirical research to explore these issues.

Findings from this study, which explored the role of regulation on the quality of care of older people living with depression in LTC are presented, and which were the basis of the third manuscript, to the Canadian Journal of Aging. Using instrumental case study methodology, I interviewed managers, staff, informal carers and residents, and reviewed documents and clinical charts. I found that Ministry of Health and Long-Term Care regulations influenced strategic planning, educational priorities, resourcing decisions and direct care. The findings from the study suggest an alternative approach to regulation is needed in this sector, which places accountability for standards of care at a provincial level and which has a more supportive and collaborative approach to regulations. The research findings showed that the staff working in the LTC home are committed to the care of residents with depression, but they had little time to implement

additional quality initiatives outside of the identified mandated areas. The study concludes by suggesting that in its current state, the care of residents with depression in LTC homes is not reflected in Ministry of Health and Long-Term Care regulations and inspections, which make little difference to the care of older people living with depression living in LTC.

In contributing to the existing knowledge and practice the study along with the findings from the scoping review, finds an alternative model of inspection could be implemented in partnership with the province. An alternative approach to inspection might adopt an extended approach to quality, along with an individualized approach to inspections to meet the requirements set out in regulation, but at the same time offering flexibility and a more collaborative approach to improving quality in the LTC sector.

ACKNOWLEDGEMENTS

I would like to begin by thanking my supervisor Dr. Chantal Backman for her invaluable insights and constant support during my PhD studies. I did not know anyone before moving to Ottawa, and although I had been able to access her profile online, I had no idea just how excellent a supervisor she would be. She has been encouraging, patient and kind but has also taught me a great deal about research and writing. I would also like to thank my committee members Dr. Wendy Sword and Emeritus Professor Doug Angus, who have spent time sharing their insights with me. I have felt privileged to feel the benefit of their academic wisdom and guidance along the way. On too many occasions to mention during my PhD journey, I have given thanks to whoever sent me this talented, warm and outstanding team.

My gratitude also goes to the professors who taught me in my first year of the PhD program, and whose contribution has influenced this final piece of work more than they will know. Those early classes which seemed so intense, helped me to shape my thinking and the final thesis.

I would also like to recognize the commitment from the staff, managers, families and especially residents in the long-term care home, who welcomed me into their home so that I could carry out my study. I appreciated the honesty with which you shared your stories and experiences, and without whom this research would not have been possible.

On a personal level, there are so many people who I would like to acknowledge for their contribution to this work, which began much earlier than the first semester of the program, in many cases. Of course, there are specific individuals to thank who have also been on their own academic path. Three individual friends are Danielle MacDonald, Jette Lange and Robin Devey-Burry whose support has been valuable beyond measure.

I would also like to acknowledge my other close friends from further afield who have given me encouragement, validation and been interested my work, my gratitude goes to Dr. Jayne Krisjanous, Jane Perry, Leanne Pool, Dr. Shiv Chaudhry, Geet Chaudhry, and of course Nicky Poole. These people have understood when I have needed to work and not play, to grumble about workload, and when I have cancelled events, Skype chats or phone calls because deadlines have got in the way. I should also like to thank countless other people who checked-in and asked about the study along the way, which includes Kim, the wonderful lady at Panera Bread who brought me coffee, cookies, and a smile when I sat and worked in there all day.

Special thanks go to my family. I would like to thank my sister, Martina McGrath, who during very challenging times in the past couple of years, released me from some tough family responsibilities so that I could work on the thesis, whilst she took on more. My son, James, who has completed his own PhD during this time, but has supported me, listened to me and been there for me. James, I know there have been times that I have put this work before spending time with you and I would like to thank you for understanding. I should also like to thank my furry family member, Kiki the dog, who has taken me for walks and warmed my feet under my desk, as required.

Extra special thanks belong to my husband, Professor David Crick, my other half, my partner and my soul mate. I am certain that I would not have even started this endeavour without your support, and I am positive that I would not have been able to complete it without you. I am blessed that you have been able to guide, counsel and support me throughout this process. I have always had you to turn to, as my advocate, my champion and my rock.

Sadly, during my PhD journey, both my parents, Raymond and Mildred Green passed away, within less than 2 years of each other. I am heart-broken they are not here to share the

journey as it comes to a close. My parents have taught me so much, which I draw on every day. My mum schooled me in communication and learning to get along with people, which has helped me as a practising nurse, but also in other aspects of my life. Even though she was very ill during the latter stages of my writing, she continued to encourage me and support me. My dad was the driving force in my education. He rightly taught us that an education was a gift that is yours to keep forever and is a key to freedom for people from working class backgrounds. He never stopped encouraging me to learn. Whether this was arguing about math homework, my nurse training, completing my master's degree or enrolling for the PhD. To say he would have been proud that this work is complete, is an understatement.

Accordingly, I dedicate my completed PhD thesis to my dad, Raymond Green. I know that you are in heaven and will be filled with joy. I am thankful to you for all that you have done to support me. Love always and forever.

Raymond Green 1942 - 2016

CONTENTS

CHAPTER 1: INTRODUCTION

This research explored the role of regulation on the care of older people with depression, living in a long-term care home (LTCH) in Ottawa, Ontario.

Depression is a serious mental health condition which affects an estimated 350 million people worldwide (www.who.int). The risk of depression increases with age (Wu, Schimmele, & Chappell, 2012). The literature indicates that the prevalence of depression is higher still in LTC settings (Ellard, Thorogood, Underwood, Seale & Taylor. 2014; Knight, Davison, McCabe & Mellor, 2011; Smallbrugge, Jongenelis, Pot, Beekman & Eefsting, 2008; Teresi, Abrams, Holmes, Raimez & Eimicke, 2001). Studies have described the prevalence of depression in LTC between 10-15% (McDougall, Kvaal, Matthews, Paykel, Jones, Dewey, & Brayne, 2007; Smallbrugge, et al., 2008), with other studies, describing the prevalence higher still, suggesting around half of the residents in LTC are affected by depression (Teresi, et al., 2001; Zuidema, de Jonghe, Verhey, & Koopmans, 2007).

Several studies have shown links between depression and physical ill health (Bruce et al., 2002; Cummings, 2002; Dennis, 2005; Dow, Lin, Tinney, Haralambous & Ames, 2011; Teper & Thomas, 2006). In a study of over 2500 older people living both independently and in LTC, McDougall et al. (2007) found that people living in LTC, who also had functional disabilities were at higher risk of depression.

In addition to older people in LTC being at increased risk of becoming depressed, the literature suggests that older often people fail to report depression (Barg, Mavandadi, Givens, Knott, Zubritsky & Oslin, 2010), believing it is not worthy of a professional's time (Burroughs, Lovell, Morley, Baldwin, Burns, & Chew-Graham, 2006) and because of the stigma around mental health (Chapman & Perry, 2008). Recognition and treatment of depression in older people in LTC is crucial. Older people experience chronic health problems, which can impede the recognition of depression in this population (Areán &

Reynolds, 2005; Cummings, 2002; Dow et al., 2011; McDougall et al., 2007; Phillips, Rantz & Petroski, 2011; Stek, Vinkers, Gussekloo, Beekman, van der Mast & Westendorp, 2005; Zuidema et al., 2007). Many professionals see low mood as a normal part of the ageing process and may accept symptoms, fail to assess the older person further, or decide against prescribing appropriate treatment (Burroughs, et al., 2006; Dow et al., 2011; Pachana, Helmes, Byrne, Edelstein, Konnert & Pot, 2010; RANZCP, 2009; Teresi et al., 2001).

Treatment of depression in older people is complex. Bruce et al. (2002) surveyed almost 540 older people living in LTC. Of the 73-people found to be depressed, only nine were prescribed appropriate anti-depressant medication and none received psychotherapeutic intervention despite the success of these approaches (Barg et al., 2010; Harris, Caswell, Woods, Gibbs, Mackay, Maloney-Moni & Pye, 2011). Anderson, Lyons and West (2001) found that over half of the 200 participants in their USA study did not receive any mental health support other than medication.

In this study, Residential long-term care for older people, is defined as "24-hour professional nursing care and supervision in a protected, supportive environment to seniors with complex care needs… for people who have the highest level of care needs and can no longer safely live on their own (www.nursinghomeratings.ca). Kane (1995) suggests that quality, as a concept in long-term care, has been focused on reducing harm rather than on promoting well-being. She argues that whilst the aims of quality care in an acute care setting are more likely to be curative, the goals of quality in long-term care are linked to the functioning and autonomy of residents. In LTC, quality has been linked to regulatory processes (Acquaviva & Johnson, 2014; Ferrino, 2013). Regulation in LTC takes place in many jurisdictions via regulatory frameworks (Department of Health [DOH], 2000a; Ministry of Health [MOH], 2008a; Ministry of Health and Long-term Care [MOHLTC], 2007). Despite the focus on regulation in LTC, serious issues around the quality of care continue to

remain in this setting (Institute of Medicine [IOM], 2010; Lloyd, Banerjee, Harrington, Jacobsen, & Szebehely, 2014).

In Canada, there are different approaches to quality in healthcare including licensure, registration with professional bodies, and controlled regulation (Marchildon, 2013). Quality improvement in Canadian LTC facilities is driven by legislation (Daly, Struthers, Müller, Taylor, Goldmann, Doupe & Jacobsen, 2016), by health organizations, by regulation, and in some provinces by accreditation with independent agencies (Marchildon, 2013). In Ontario, LTC facilities adhere to the Long-Term Care Quality Inspection Process (MOHLTC, 2007), where compliance teams inspect LTC facilities.

There have been 4 key stages in the history of regulation in Ontario since the 1940s (Daly, 2015). The first involved the expansion in the number of private providers between 1940 and the mid-sixties. The second phase from 1966 to 1993 was defined by the expansion of public funding for LTCHs and emphasis on regulation. The third phase in the history of regulation in LTCHs in Ontario continued until 2007 and involved the introduction of funding equity between for-profit, non-profit and public homes. It also involved the growth of public capital funding, which further cemented the hegemony of for-profit providers. Finally, following several media exposés, complex regulatory and reporting requirements were introduced.

Walshe (2001) argues that quality is achieved by a mix of both responsive and adaptive approaches. Ferrino (2013) compared approaches to regulation in LTC in New Zealand and the USA and found that approaches were generally deterrence based but suggested that responsive approaches are more effective. Other approaches have been described in the literature, such as ‘New Governance’, which is a collaborative approach to quality (Lobel, 2012), where organizations are more adaptive in responding to changes in the context of LTC. This might include global competition; privatisation; fiscal demands and

changes in technology (Lai, 2015). 'New Governance' offers a way to involve stakeholders in achieving quality in this sector, extends the oversight of quality improvement, and can improve the effectiveness of compliance in LTC (Lai, 2015; Lobel, 2012). Involving residents in LTC in the quality agenda is arguably aligned to the widely recognised characteristics of quality in LTC, such as: person centeredness (Brooker, 2004; Dewar & Nolan, 2013; Wilson, Davies, & Nolan, 2009); well-being of residents (Government of New Brunswick, 2008; Kane, 1995); outcome measurement (Acquaviva & Johnson, 2014; Ferrino, 2013); and working in partnership with other providers to share best practice (Government of New Brunswick, 2008).

Appendix 1 provides a glossary of terms and Appendix 2 outlines the definitions of concepts which are used in this thesis. In this study the term older people refers to people aged 65 years and over. (www.WHO.org; www.servicecanada.gc.ca).

Suzman and Beard (2011) predict the global population of older people is set to triple to 1.5 billion by 2050. In 2011, 14.8% of the Canadian population were aged 65 and older (Statistics Canada, 2011), which in 2016 increased to 16.8% (Statistics Canada, 2016). Global spending on older peoples' healthcare is high (Gray, 2005; Suzman & Beard, 2011). In Organisation for Economic Co-operation and Development (OECD) countries, which includes Canada, people aged 65 and over account for 40 to 50 percent of healthcare spending (Safiliou-Rothschild, 2009). It is estimated that the health care cost of people aged 90 and over is six times that of young people (Maisonneuve & Martins, 2013). In Ontario, 60% of the total annual expenditure on healthcare is spent on only 10% of older Ontarians (Sinha, 2012).

As well as an increasing population of older people, there is an increasing demand for LTC in Canada. It is estimated that Canada will need an additional 199000 LTCH beds in the next 2 decades (The Conference Board of Canada, 2017). In 2015 over 26000 older people in

Ontario were waiting for a LTC bed (Ontario Long Term Care Association, 2016). The LTCH population is increasingly complex (Canadian Institute for Health Information, 2011), with LTCHs having expanded roles, such as palliative and end of life care (Ibrahim & Davis, 2014). The trends in growing numbers of older people, rising healthcare costs and increasing acuity in the LTC sector, suggest an increased demand for high quality LTC provision (OECD, 2013).

1.1 RESEARCH OBJECTIVES AND 'ISSUES'

This research used an instrumental case study methodology (Stake, 1995). In instrumental case study 'issues' are presented to outline the aims and objectives of the research (Baxter & Jack, 2008; Stake, 1995). 'Issues' in our study were developed from a range of sources (Baxter & Jack, 2008; Stake, 1995) to provide an overview of the key aspects being explored in the research. In this research, the 'issues' were developed based on the experiences of the research team working with older people with mental health needs, our epistemological position, and gaps in the body of knowledge in the academic literature. The 'issues' which were explored in this case study were:-

1. What regulation is in place to care for older residents with depression living in LTCHs?

2. How does regulation support or hinder improvements in the care of older residents with depression living in LTCHs?

1.2 RESEARCH QUESTION

The 'issues' in our research have led to the development of the research question: "What is the role of regulation in the care of older people with depression living in a Long-Term Care Home in Ottawa?".

1.3 FORMAT OF THESIS

This thesis first acknowledges those who have been part of my PhD journey. This chapter, Chapter 1, and the introduction to the thesis, describes the relevance and importance of our research, the research objectives, which have been presented as 'issues' (Stake, 1995), and the research question in this study.

Chapter 2 of this thesis presents the Systematic Scoping Review Protocol, which was published in BMJ open in 2018. Chapter 3 presents a systematic scoping review of the literature, which was based on the Arskey and O'Malley's Methodological Framework for Scoping Studies (2015). I chose to conduct a scoping review instead of another type of literature review, because unlike systematic reviews which answer specific research questions, scoping reviews tend to address broader questions to identify research gaps (Daudt, van Mossel, & Scott, 2013). The final version of this manuscript is under review in BMC geriatrics. The paper examines the concepts of regulation, LTC and depression in order to explore the role of regulation on the care of older people with depression who are living in LTCHs. The findings from the scoping review highlighted a gap in the current body of knowledge in this area and supported a need for further investigation around the role of regulation on the care of older people with depression living in LTCHs.

Chapter 4 describes the study design and methods and concludes with how the data in the research were analyzed. Chapter 5 presents the findings of this research, which has been submitted to the Canadian Journal of Ageing. The paper describes how using instrumental case study methodology, we explored the role of the Ministry of Health and Long-Term Care (MOHLTC) regulations in the care of residents in LTCHs with depression. The paper highlights how operational decisions and clinical priorities are influenced by MOHLTC regulations. The study concludes by suggesting that an alternative approach to regulation is needed in LTCHs which places accountability for standards of care at a provincial level and

adopts a supportive and collaborative approach to MOHLTC regulations and inspections for LTCHs.

Chapter 6 of this thesis is an integrated discussion which links the articles presented in Chapters 2, 3 and 4 with a modified version of the Extended Quality Framework (Crick, Backman & Angus, 2017), which was adapted as a result of this study. The chapter also outlines the contributions this research makes to nursing and healthcare knowledge and policy. The integrated discussion concludes that the current approach to MOHLTC inspection and regulation may not be aligned to the needs of residents in LTCHs with depression, and indeed does not appear to make a difference to the care of people with depression living in the LTCH in this research. Finally, the limitations of the study and ideas for future research are summarized.

CHAPTER 2: THE ROLE OF REGULATION IN THE CARE OF OLDER PEOPLE WITH DEPRESSION LIVING IN LONG-TERM CARE: A SYSTEMATIC SCOPING REVIEW PROTOCOL ***(Crick M, Angus DE, Backman C. Exploring the role of regulation and the care of older people with depression living in long-term care? A systematic scoping review protocol. BMJ Open 2018;8:e021985. doi: 10.1136/bmjopen-2018-021985)***

Title: Exploring the role of regulation and the care of older people with depression living in long-term care? A Systematic Scoping Review Protocol

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Key Words:

Depression & mood disorders; Regulation; Long-term care; Older people

Word count: 1831

2.1 ABSTRACT:

Introduction

This systematic scoping review will explore the role of regulation on the care of older people living with depression in long-term care. Depression presents a significant burden to older people living in long-term care. Regulation in the long-term care sector has increased, but there are still concerns about quality of care in the sector.

Methods and analysis

Using Arksey and O'Malley's scoping review methodology as a guide, our scoping review will search several databases: Embase; MEDLINE [using the OVID platform]; Psych info; Ageline; and CINAHL, alongside the grey literature. An expert librarian has assisted the research team, using the Peer Review of Electronic Search Strategies' (PRESS) to assess the search strategy. The research team has formulated search strategies and two reviewers will independently screen studies for final study selection. We will summarise extracted data in tabular format; use a narrative format to describe their relevance; and finally identify knowledge gaps and topics for future research.

Ethics and dissemination

This scoping review will outline the scope of the existing literature related to the influence of regulation on the care of older people living with depression in long-term care. The scoping review findings will be disseminated through publication in a peer-reviewed journal. The findings will be useful to policy makers; and managers and clinicians working in the long-term care sector.

Key Words:

Depression & mood disorders; Regulation; Long-term care; Older people.

2.2 INTRODUCTION

The global population of older people (65 years of age and older) is set to triple to 1.5 billion by 2050[1]. Canada saw a 14.1% increase in the number of older people between 2006 and 2011, with over 7% of them living in specialist care facilities, such as nursing homes, chronic care, long-term care hospitals and residences for seniors[2].

The prevalence of depression among older people living in long-term care (LTC) settings is higher than in the general population[3-6], with some studies suggesting it could be as high as 44%[6,7]. Recognizing depression in older people is problematic. Older people are less likely to report depression[8], with many professionals seeing it as a normal part of the ageing process[9,10].

This scoping review will focus on depression in long-term care (LTC) as it presents a serious risk to physical and psychosocial well-being to older people. For example, depression presents a significant cost to health services[11] and impacts on the well-being of older people residing in LTC[12]. Depression in older people in LTC is associated with loneliness[13,14], health related problems[15-17], failure to thrive[18,19], as well as suicidality[20,21].

Regulation and accreditation can be linked to quality, especially in LTC settings, where there is an expectation that compliance with standards will achieve higher quality[22,23]. Prior to 2007, the quality of long-term residential care in Ontario was inconsistent between profit and non-profit providers as both compliance with standards and funding was applied differently across both types of providers[24]. The Long-Term Care Homes Act[23] led to parity in funding and parity in the application of quality standards for all long-term care facilities, including the current approaches for inspection of LTC facilities[23]. Although LTC regulation has increased[24] and regulation has been linked with quality [22,23], there is a

paucity of literature examining the relationships that exist between regulation and the care of older people with depression who are living in LTC.

Definitions of the concepts in this scoping review are outlined in the Additional File 1.

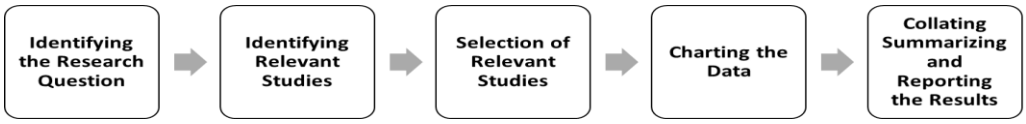
2.3 PURPOSE AND OBJECTIVES

This scoping review will explore the role of regulation on the care of older people with depression living in LTC. Understanding previous studies relating to the role of regulation on the care of older people with depression is an important stage in this work. It is a means to broadly identify gaps in this area, with findings being used to identify areas for future research development.

2.4 METHODS

This scoping review protocol will be based on the Arskey & O'Malley's Methodological Framework for Scoping Studies[25], which includes the following 5 stages for conducting a scoping review: (1) Identifying the research question; (2) Identifying relevant studies; (3) Study selection; (4) Charting the data; and (5) Summarizing and reporting the results. Unlike systematic reviews which answer specific research questions, scoping reviews tend to address broader questions to identify research gaps[25,26]. We have not registered this study with PROSPERO, because only systematic reviews are registered with this database. The search strategy is illustrated in figure 1.

Figure 1 – Search Strategy



STAGE 1: IDENTIFYING THE RESEARCH QUESTION

As discussed earlier, this scoping review will explore the role of regulation on the care of older people with depression living in LTC. Understanding previous studies relating to the role of regulation on the care of older people with depression is a means to broadly identify gaps in this area. The research question in this scoping review has been developed by the research team, based on the factors outlined in the previous section.

STAGE 2: IDENTIFYING RELEVANT STUDIES

The search strategy will be developed in consultation with the research team and a librarian. The specific eligibility criterion may evolve as the review progresses, which is commonly seen in a scoping review. To enhance quality, the search strategy will be peer-reviewed by a second librarian using the 'Peer Review of Electronic Search Strategies' (PRESS) evidence-based guidelines[27]. Search terms will be developed to capture a broad notion of the different concepts. A PRISMA diagram[28] will be completed to show the numbers of articles identified, screened, eligible and included for full text review. Using the subject headings and keywords, our comprehensive and systematic search strategy will include the following electronic databases: Embase; MEDLINE (using the OVID platform); Psych info; Ageline; and CINAHL, using search terms which are listed in the Additional File 2. A search of the grey literature will also be incorporated from various websites including health

ministries; Health Canada; Manitoba Centre for Health Policy and Evaluation; and the Canadian Institute for Health Information. All retrieved titles and abstracts will be uploaded into Covidence (an on-line application service developed in partnership with Cochrane), which will be used to facilitate this process.

STAGE 3: SELECTION OF RELEVANT STUDIES

Two researchers (MC and RD) will independently review and screen all titles and abstracts of retrieved publications based on a predetermined inclusion and exclusion criteria which has been developed in consultation with the research team (see Additional File 3).

Inclusion criteria: This scoping review will include primary research studies only, which will include qualitative, quantitative, and mixed method studies at the intersection of regulation; LTC and depression in older people. In this scoping review, age will not be used as a concept in the title and abstract screening of articles, as it may be limiting, instead the concept of age will be applied during the screening of full text articles. All articles will be written in French or English.

Exclusion Criteria: Although systematic reviews; scoping reviews; meta-analysis; editorials, commentaries which provide a description of policies or initiatives; and study protocols will be exclude from this scoping review, they have helped to inform the research strategy. Articles which are related to quality of life measurement; pain; palliative care; and cancer services will be excluded, unless they are specifically related to depression in LTC settings. There will be no limitations placed on the dates of publications. This scoping review will be conducted to explore the landscape of research available in this area and will provide a basis for ongoing research. The authors are not aiming to make specific recommendations or decisions, based on the results, and as such, quality will not be an exclusion criterion used in this scoping review.

Following the title and abstract screening, two reviewers (MC and RD) will independently review the publications as full text items, against all the same criteria, with the additional criteria of studies relating to people aged 65 years and above. Full text items which meet the predetermined inclusion and exclusion criteria will be selected for charting the data (data extraction). Conflicts and disagreements will be resolved by consultation between the two reviewers (MC and RD) and a third party, who in this case will the academic supervisor and co-author (CB).

STAGE 4: CHARTING THE DATA

Charting the data consists of the data extraction process[25]. Once agreement is reached on eligibility, each article will be read in full by the lead reviewer (MC). A data charting form, adapted from Booth, Sutton & Papaionannou's templates for qualitative studies and quantitative studies[29] will be used (see Additional File 4). The use of this form will be trialled on a randomly selected article by MC to determine feasibility and to determine whether any unforeseen issues exist. During the charting process approximately 10% of the final full text articles will also reviewed independently by a second reviewer (RD) to ensure consistency and quality in the charting process. Conflicts and disagreements during charting will be resolved by consultation between the two reviewers (MC and RB) and a third party, who in this case will the academic supervisor and co-author (CB).

Narrative synthesis will be conducted to summarize the findings of the different studies; to explore the depth of information; and to determine the integrity of the literature. The analysis will be focused on extracting key themes from the scoping review studies as well as exploring the relationships between the themes.

Stage 5: Collating Summarizing and Reporting the Results

The findings from this scoping review will be presented in a tabular format which will capture the details of each study (author; intervention type; study population; aims of the

study; methodology; outcomes; key results); as well as a descriptive narrative which will be used to organize the key issues thematically.

PATIENT AND PUBLIC INVOLVEMENT

There was no specific patient and public involvement in the development of this scoping review.

ETHICS AND DISSEMINATION

This scoping review will outline the existing literature related to the role of regulation in the care of older people living with depression in LTC. The scoping review findings will be disseminated through publication in a peer-reviewed journal, where the findings will be used by policy makers, managers, and clinicians working in the long-term care sector to make improvements in the care of older people in LTC with depression.

2.5 DISCUSSION

This scoping review is a first step in contributing to advancing the theoretical and applied knowledge of care of older people living with depression in LTC facilities. This will enable nurses and other members of the healthcare team, working in LTC, to be better equipped to improve the quality of services offered to this population. Understanding the influence of regulation in LTC on the care of older people with depression, has the potential to contribute to future quality improvement efforts at local, provincial, federal and global levels by exploring evidence of depression as a priority in regulation, in a highly regulated context[24], which adopts a deterrence-based approach to this process [30].

The findings of this scoping review will be of interest to the management teams of LTC facilities, directors of care, managers, policy makers, informal caregivers, and older people living in LTC.

Strengths and Limitations

This scoping review will explore the relationship between regulation and the care of older people with depression living in LTC. Using a scoping review will enable the authors to address broader areas to map concepts which underpin the research area and evidence available, arguably because this issue has not been extensively reviewed before[25] and given the issues involved are complex [29]. In terms of limitations, there is the possibility that the search terms which have been developed, do not capture all aspects of each of the concepts. However, to mitigate against this several strategies were adopted including developing the search strategy with a subject expert librarian; using the PRESS framework to assess the quality of the search strategy; and by extensive reading of the literature around the individual concepts. As a result, this scoping review protocol describes a rigorous and transparent approach to understanding what literature exists around the concepts.

Contributors

All authors have made substantive contributions to the development of this scoping review protocol. MC, CB and DA conceived the idea for the review. MC, CB and DA contributed to the development of the design of the research questions. MC and CB conceptualized the review approach, and MC wrote the protocol. RD is a 2nd reviewer. All authors provided comments on earlier drafts and have approved this manuscript.

Funding

This project is unfunded

Competing Interests

None declared.

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2.7 SUPPORTING DOCUMENTS

Additional file 1 – Definitions of Concepts

Concept 1: Long-term care - Residential long-term care for older people, and is defined as "24-hour professional nursing care and supervision in a protected, supportive environment to seniors with complex care needs… for people who have the highest level of care needs and can no longer safely live on their own"[31]

Concept 2: Regulation - A "rule or directive made and maintained by an authority, in accordance with regulations". (Oxford English Dictionary). In many cases, regulations originate with governmental agencies at a federal, state, and local level, and carry the weight of the law (National Association for Healthcare Quality [NAHQ] 2016).

Concept 3: Depression - A serious mood disorder, causing severe symptoms that affect how the individual feels, thinks, as well as daily activities, such as sleeping, eating, or working. (https://www.nimh.nih.gov).

Additional File 2 -Search Terms (based on Medline Search on OVID Platform).

1. assisted living facility/
2. (assist* adj3 living facilit*).tw.
3. Long-Term Care/
4. (long term adj3 care).tw.
5. (home adj3 age*).tw.
6. Nursing Homes/
7. nursing home*.tw.
8. Residential Facilities/
9. (resident* adj3 facilit*).tw.
10. residential aged care facilities/
11. geriatric.tw.
12. residential care.tw.
13. skilled nursing facilities/
14. (extended adj4 facilit*).tw.
15. or/1-14
16. Depression/
17. depression*.tw.
18. (depress* adj3 symptom*).tw.
19. Depressive Disorder/
20. (depressive adj3 disorder*).tw.
21. (depressive adj3 neuroses).tw.
22. (depressive adj3 neurosis).tw.
23. (depressive adj3 syndrome*).tw.
24. melancholia*.tw.
25. (neurotic adj3 depression).tw.
26. low mood.ti,ab.
27. or/16-26
28. Government regulation.tw.
29. social control, informal/ or social control, formal/
30. social control*.tw.
31. Government Regulation/
32. Health Care Reform/ or Health Policy/ or Health Planning/ or Health Plan Implementation/ or Health Facility Planning/
33. government publication*.tw.
34. Government Regulation/ or "Delivery of Health Care"/
35. management audit/
36. management audit*.tw.
37. mandatory reporting/
38. mandatory report*.tw.
39. quality control/
40. quality control*.tw.
41. guideline adherence/ or Health Care Evaluation Methods/
42. guideline* adherence.tw.
43. (practi* adj2 guideline*).tw.
44. standards of care/

45. legislation, nursing/
46. legislation, hospital/
47. legislation/
48. legislation.tw.
49. quality of care/
50. quality of health care/
51. health services for the aged/
52. certification/
53. (institutional adj3 compliance).tw.
54. (polic* adj3 complian*).tw.
55. or/28-54
56. 15 and 27 and 55

Additional File 3 - Inclusion Criteria for Abstract Review.

Criterion	Inclusion	Exclusion
Type of Study.	Qualitative studies; quantitative studies; mixed method studies.	Systematic reviews; scoping reviews; meta- analysis; or literature reviews. Commentaries; editorials or descriptions of policy. Study protocols.
Concepts:	Regulation.	
	Depression.	Exclude pain; palliative care; quality of life studies UNLESS there is a direct link to depression.
	Long-term care.	Long-term care which is not 24-hour residential care; community-based studies. Assisted living facilities; community-based care; where care is provided at home by family or informal carers.
Dates	All dates	
Location.	All locations.	
Language.	English / French.	

CHAPTER 3: THE ROLE OF REGULATION IN THE CARE OF OLDER PEOPLE WITH DEPRESSION LIVING IN LONG-TERM CARE: A SYSTEMATIC SCOPING REVIEW *(FORMATTED AND SUBMITTED TO BMC GERIATRICS 22 OCTOBER 2018)*

The Role of Regulation in the Care of Older People with Depression Living in Long-Term Care: A Systematic Scoping Review.

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Word count: 5049

3.1 ABSTRACT

Purpose: Older people living in long-term care (LTC) are affected by an increased prevalence of depression, poor symptom recognition, and inadequate treatment. Although regulation has increased in LTC, there is minimal literature examining the relationship between increased regulation and quality of care of older people with depression who are living in LTC. This aim of this study was to explore the impact of regulation on the quality of care of older people living with depression in LTC.

Methods: A peer reviewed search strategy was developed in consultation with a specialist librarian. Several databases were searched to identify relevant studies including: Embase (using the OVID platform); MEDLINE (using the OVID platform); Psych info (using the OVID platform); Ageline (using the EBSCO platform); and CINHAL (using the EBSCO platform). Articles were screened by three reviewers with conflicts resolved in consultation with a fourth reviewer. Data charting was completed by one reviewer, with a quality check performed by a second reviewer. Key themes were then derived from the included studies.
Results: The search yielded 778 unique articles, of which 21 were included. Articles were grouped by themes: regulatory requirements, funding issues, and organizational issues.

Conclusion: The highly regulated environment of LTC poses significant challenges which can influence the quality of care of residents with depression. Despite existing evidence around prevalence and improved treatment regimens, regulation appears to have failed to capture the best practice and contemporary knowledge available. This scoping review has demonstrated a need for further empirical research to explore these issues.

Keywords: Depression, Older people, Long-term care, Regulation

3.2 BACKGROUND

The prevalence of depression in older people living in long-term care (LTC) is high[1-4]. Recognition of depression in older people living in LTC is problematic. First, it has been suggested that older people are less willing to report feeling depressed[5], and second, there is a risk that professionals believe it to be a normal part of the aging process[6,7]. Depression has a significant impact on the well-being of older people living in LTC[8]. Depression in LTC is associated with loneliness[5,9,10], physical morbidity[11-13], failure to thrive[14,15], and suicidality[16].

Regulation in LTC has been linked to quality[18-20], although there are contradicting views. Regulation can have a negative impact on quality in health care, in that it can distract LTC care workers from providing quality care to residents[19]. Lobel[21] suggests that control and command approaches to regulation, which focus on identifying what organizations fail to achieve, are ineffective, whereas Ferrino[18] reports responsive approaches, characterized by support and collaboration are more effective. Although regulation in LTC has increased[22], there remains significant issues in the provision of quality services in LTC settings. Concerns of poor quality in LTC are evidenced by reports and studies from the past 30 years related to the quality of care in the sector[23-25], which might suggest that attempts to improve quality by increased regulation is proving to be unsuccessful in many jurisdictions. This presents an urgent need for more reliable methods of addressing quality in LTC[26].

Many frameworks, models of care and evidence-based practices have been described in the literature to improve the quality of care for older people living with depression in LTC. Furthermore, multi-disciplinary approaches to care[27] which involve specialist teams have been suggested as good practice[28,29].

Recognition of depression in LTC residents is a crucial aspect of quality[30], with assessment

being the cornerstone of effective treatment[31]. Despite what is already known about the prevalence, recognition and treatment of depression in LTC, implementing these best practices into regulation is challenging. In research exploring the alignment of quality improvement in care of depression in home care services, Bao et al.[31] found funding incentives for reimbursement were misaligned with best practices in the care of people with depression, specifically, a lack of explicit recognition of the amount of nursing time that is needed when supporting a person with depression. Nurses in this study were aware that they were unable to implement best practice but felt inhibited by policy that incentivized productivity. They also found the electronic health record system they were working with was a barrier to completing ongoing assessments, as the electronic system only allowed a brief window of time for uploading supplementary assessments. This resulted in nurses being unable to supplement any initial screening with a more detailed mental health assessment. Boyle et al.[33] concluded, that whilst it was used inconsistently in their study, participants using the Geriatric Depression Scale [34] felt it would improve quality. Similarly, 90% of experts endorsed the use of the GDS when developing guidelines for treating depression in nursing homes[35].

There are risks from failing to recognize depression in LTC. Podgorski et al.[36] studied suicide risks in LTC facilities and found there were opportunities for suicide prevention through local risk management strategies as well using a population-based approach. The research team found that there were opportunities for LTC facilities to assess their own local populations and set local goals and priorities, according to their needs, thus being able to develop policies and goals which balance safety and risk, with the freedom and individual preferences of residents.

Although a deterrence approach to regulation dominates the LTC sector[18] other studies

have described alternative approaches to achieving quality. These are characterised by participation, flexibility and responsiveness, collaboration and partnerships, dynamic learning, and self-enforced regulation[19,21]. A study which explored the integration of best practice guidelines into system-based protocols for quality monitoring in LTC, found a collaborative approach between educators and licensing agencies was a way to improve quality, whilst at the same time continuing to utilize the Minimum Data Set (MDS)[27]. However, some experts have found the MDS to be limiting in the field of depression[37], in part because its implementation in relation to psycho-social care had several barriers, including variation across jurisdictions and lack of federal guidance for its use[38].

An expert panel, which included leaders and stakeholders in the field of LTC, systematically reviewed the literature and made recommendations that families, residents, and 'substitute decision makers' (where capacity is an issue) should be actively involved in decision making in the LTC environment, as stakeholders[39]. LTC is a unique environment, given it is the residents' home, and arguably regulations should reflect the preferences and individualities of the residents themselves[40,41]. Lenhoff[37] led an expert review of quality in LTC and suggested that regulation should reflect the need to promote autonomy in residents.

In summary, the treatment of older people with depression living in LTC is hindered by several factors including, a lack of recognition of depression, an increased prevalence of depression and a reduced access to treatment for depression. The literature also shows that whilst LTC quality is driven by regulation across the sector, there remains concerns about quality. It appears there is strong evidence that collaboration and partnership is an effective way to deliver care in this setting. The concepts of regulation, long-term care and depression, have been extensively addressed in the literature in isolation, however, there is a paucity of literature examining the relationship between the role of regulation and the care of older people with depression who are living in LTC. The aim of this systematic scoping review was

to describe and analyze published studies and relevant grey literature, to explore the impact of regulation on the quality of care of older people with depression living in LTC.

3.3 METHODS

This systematic scoping review is based on the Arskey & O'Malley's Methodological Framework for Scoping Studies[42]. The complete detailed protocol is published elsewhere[43].

3.3.1 Search strategy

A search strategy was developed in consultation with experts in both scoping reviews, and in the topic area, along with consultations with a specialist librarian who had knowledge of the health literature. Search terms were developed by capturing a broad notion of the different concepts of regulation, older people, depression, and LTC. LTC and nursing homes are terms often used interchangeably in the literature but for this scoping review only LTC facilities or nursing homes that provided "24-hour professional nursing care and supervision in a protected, supportive environment to seniors with complex care needs… for people who have the highest level of care needs and can no longer safely live on their own"[44] were included. Depression was defined as a mood disorder, which causes severe symptoms that affect the individual emotionally and cognitively, which has an impact on daily activities, such as sleeping, eating, or working[45]. Regulation was characterised as standards set by governments or public agencies relating to activities valued by the community, they serve[18].

Concepts were further developed by exploring background reading and looking at keywords in other relevant systematic reviews to develop the search terms, described later in this paper. To enhance the quality of this review, the search strategy was peer-reviewed by the specialist librarian using the 'Peer Review of Electronic Search Strategies' evidence-based guidelines[46], with subsequent changes incorporated into the search strategy terms.

Although quality assessment can be conducted in scoping reviews, this is normally dependent on the aim of the scoping review[47]. The aim of this scoping review was to explore the landscape of research available in this area to provide a basis for ongoing research, and as such, quality was not used as an exclusion criterion used in this scoping review.

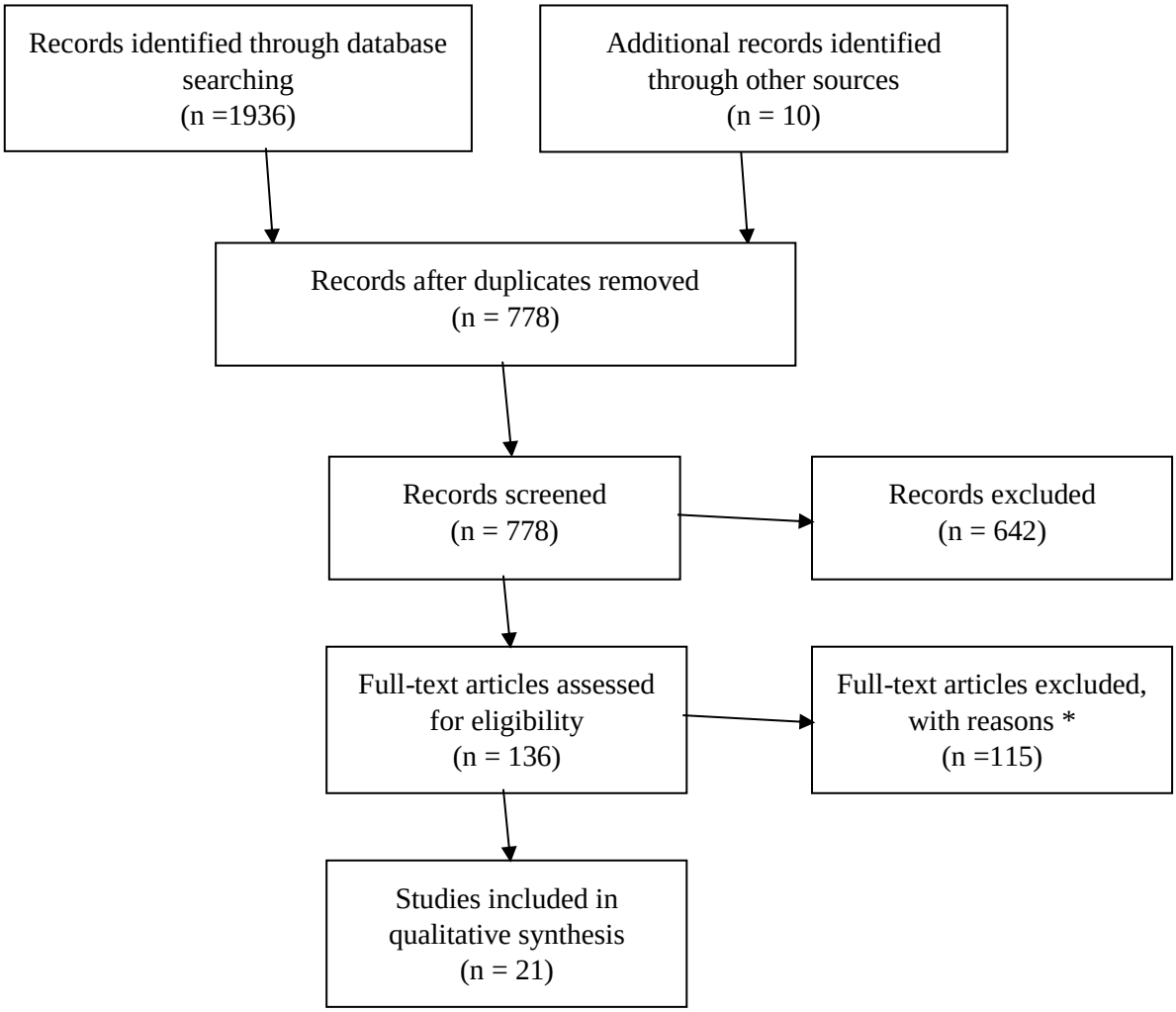
Several databases were searched to identify relevant studies (Embase [using the OVID platform]; MEDLINE [using the OVID platform]; Psych info [using the OVID platform]; Ageline [using the EBSCO platform; and CINHAL [using the EBSCO platform]), using search terms which are listed in supplementary document 1. A search of the grey literature was also undertaken from various sources, using the concepts already described. The websites that were searched included Health Canada, Care Quality Commission, National Institute of Clinical Excellence, Manitoba Centre for Health Policy and Evaluation, health ministries, and the Canadian Institute for Health Information.

Using the broad concepts in the search strategy to identify items which were relevant, handsearching of relevant key journals, relevant reference lists and relevant grey literature identified from the systematic searches were also conducted. The Preferred Reporting System for Systematic Reviews and Meta-Analysis [48]was utilized to show the numbers of articles identified, screened, eligible and included in the study, see Figure 1.

3.3.2 Screening

A two-stage screening process was conducted using the pre-defined inclusion criteria. Any qualitative, quantitative, or mixed method studies focused on regulation, LTC, and depression were included. The inclusion criteria at the screening of title and abstract stage did not include age as a concept. This decision was reached in consultation with a specialist librarian, who agreed that adding age, as a concept, in the initial phase of the scoping review might limit results. Therefore, the concept of age was applied during the screening of full text articles only.

Figure 1 -PRISMA Flow Diagram (Moher, Liberati, Tetzlaff &Altman. (2009)



***Full Text Articles Excluded (reasons):**

51- Not related to regulation
26 - Primary focus not depression
26 - Editorial; commentary type piece or wrong study design
5 -Full text not available
5- Not Long-term Residential care
1- Duplicate
1 -Under 65 Years old

Articles written in English and French were included in the study.

We excluded editorials, study protocols, and commentaries which only described policy or initiatives. Articles related to quality of life measurement, pain, palliative care, and cancer services were also excluded unless they were specifically linked to depression in LTC settings. There were no limitations placed on the dates of publications or the location of the studies in the search strategy. Covidence, an online systematic review software application, was used for this process.

A total of 1,946 articles were retrieved from the search, with 778 remaining following removal of duplicates. In the first phase, three researchers (MC, RDB and JH) independently examined the 778 titles and abstracts produced from the systematic search. 642 articles were excluded in this initial screening based on information within the title and abstract of the article. Where this was unclear, or if the title and abstract did not provide enough information to decide, these articles were included in the full text arties which were assessed for eligibility in the second stage of the screening process.

Where conflicts were noted in the outcome of this initial screening, they were resolved by consultation between the three reviewers (MC, RDB and JH) and a fourth party (CB).

During the second stage of the process, the same group of researchers examined 134 full-text articles, adding the concept of 'older people' (in this study described as 65 years or older). An article was included if it was related to regulation, older people, depression, and LTC.

3.3.3 Data charting and analysis

Data was charted using a tool based on Booth, Sutton & Papaionannou[49], which can be found in supplementary document 2. Approximately 10% (n=3) of the articles were randomly selected and reviewed by a second reviewer (RDB) and checked for consistency and quality. Results were charted using an excel spreadsheet. A narrative synthesis was conducted which

consisted on extracting key themes from the scoping review studies as well as exploring the relationships between the themes.

3.4 RESULTS

Of the final 21 articles included in this scoping reviews, the majority were based in the USA. Chart 1 outlines the distribution of articles by country of origin.

Chart 1 – Full Text Articles (by Country)

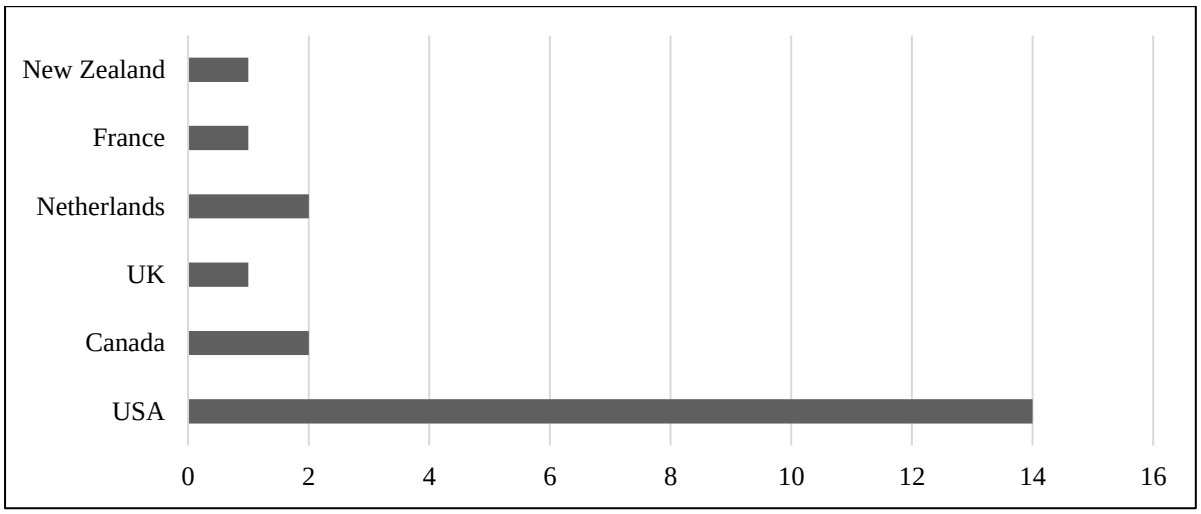
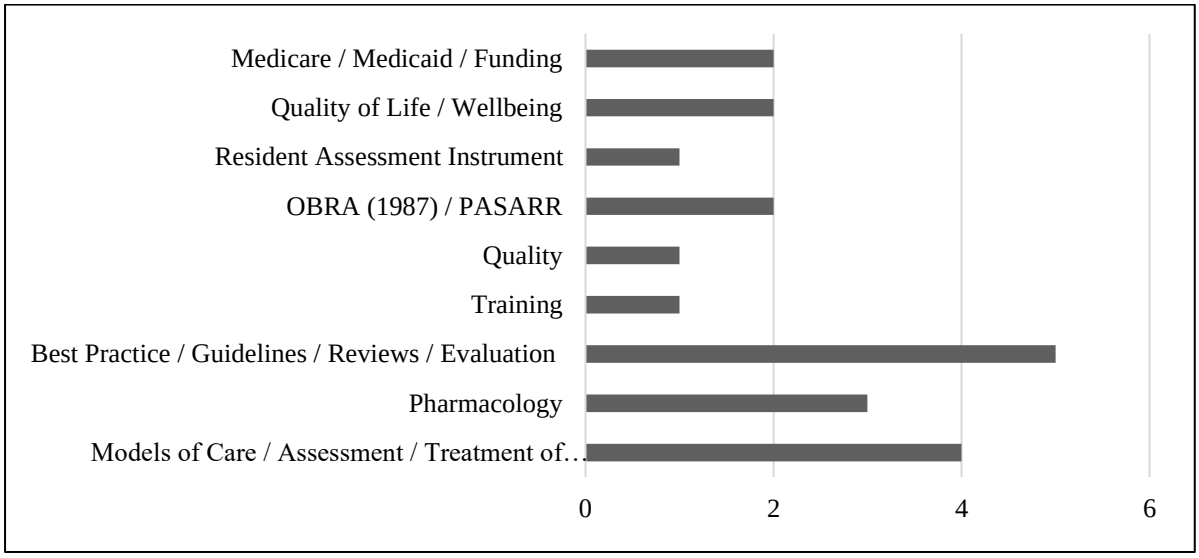


Chart 2 outlines the full text articles by their primary topic area. Of the final 21 articles, many were focused on models of care and the assessment and treatment of depression. Evaluation studies and pharmacology also featured strongly. Several articles were related to OBRA (1987) legislation introduced in the USA which instituted screening for individuals placed in nursing facilities. OBRA (1987) legislation also influenced the development of the Resident Assessment Instrument (RAI) and MDS tool, which was linked to Medicare and Medicaid reimbursement[50], and which was also represented in several retrieved articles. Researchers focused on the impact of such legislation, may explain the presence of a selection of older articles retrieved in this scoping review.

Most of the studies had a quantitative design (n=11); 4 studies were qualitative; and 6 had a

mixed methodology approach. Supplementary document 3 provides an overview of the included studies. Regulatory requirements; funding and organizational issues were identified as key themes in this scoping review.

Chart 2- – Full Text Articles (by Topic)



Theme #1: Regulatory requirements

There are several different approaches to quality described in the literature, which suggest accreditation and regulation are linked to quality outcomes in care[18]. In many cases, the funding streams in LTC are linked to meeting predetermined performance measures, using tools such as the MDS or RAI to establish levels of need; measuring whether those needs are met; developing a case mix index; and apportioning funding according to the level of need of the LTC facility[51]. How well residents perceived needs are met was studied by Holtkamp et al.[52], who assert that there is a lack of research conducted which explores the difference between the residents' perceptions of needs with those of the nurse. They investigated the effect of the RAI on the perceived level of need between residents and nurses, suggesting there were gaps. However, they did note that using the RAI was associated with improvements in meeting resident's needs. Chodosh et al.[53] argue that the MDS improved opportunities for assessment and examination of nonpharmacological care but

conclude in their study that a lack of technical knowledge and awareness of this tool could be a barrier to its effectiveness in LTC.

The extent to which systems which are governed by regulation in the LTC sector make a difference to the quality of care that is delivered has been studied. In the USA, the Omnibus Budget Reconciliation Act (OBRA) of 1987 was enacted with the goal of helping improve LTC residents' quality of life by mandating standardized assessments; by prescribing a policy of psychotropic drugs; and by enacting care planning requirements[54]. This act led to the use of the Pre-Admission Screening and Annual Resident Review Program (PASARR), which was designed to improve access to appropriate mental health care for long-term care residents[55]. This scoping review found that the program had mixed reviews. Taylor et al.[54] explored prescribing patterns of psychotropic drug use before and after the implementation of the OBRA (1987) legislation in a not for profit LTC facility, using data retrieved from medical records. They found that before the enactment of the OBRA (1987) regulations, the use of anti-depressant medication was higher than after the introduction of OBRA (1987) legislation. However, they also noted that other concurrent legislation also impacted on the success seen in psychotropic prescribing patterns, making it harder to credit success to OBRA (1987) which was introduced in the changing context of the healthcare landscape. For instance, in January 1994, Medicaid in Georgia, USA stopped reimbursing LTC facilities for prescribing anxiolytics (usually benzodiazepines) except where they were prescribed for the treatment of seizures. The Medicare and Medicaid system in the USA is an example of a federally regulated system which may present barriers for LTC residents in accessing specialised treatment. Linkins et al.[55] found reimbursement from Medicare and Medicaid was often too low to incentivise LTC facilities to organize appropriate mental health input from specialised teams, despite the provision of mental health care being mandated in OBRA (1987)[55,56].

In Hanlon et al.[57] they noted that the Centre for Medicare and Medicaid Services included antidepressants in a list of potentially 'unnecessary medications', which may have had an impact on the reduction in antidepressant prescriptions noted in their study of psychotropic drug use in the USA between 1996 and 2006. This study further demonstrates that concurrent regulations can impact on decisions made at the local level. However, given what is known about prevalence of depression in LTC it was not clear why these drugs are included in this list, especially since best practice indicates Selective Serotonin Reuptake Inhibitors are a first line treatment of depression[58]. Other studies have seen less success in using the PASARR process to identify depression. Borson et al.[56] studied over 7000 residents in 54 facilities and found that whilst the PASARR process in LTC identified residents with schizophrenia, it was less successful in identifying those residents with depression. The seriousness of depression in LTC[58], is highlighted by the OBRA (1987) legislations' requirement for potential residents to complete the Pre-Admission Screening Annual Resident Review (PASARR) prior to admission to LTC. PASARR was seen to be a feasible approach to determine whether nursing home applicants and residents required specialized services to meet their mental health needs[31]. It has been argued that these regulations have contributed to reducing inappropriate placements in USA nursing homes, by ensuring that nursing homes admitting residents with mental health issues are equipped with the necessary skills and the experience to provide care[31]. However, research indicates that OBRA (1987) has not enhanced the capacity of nursing homes to deliver appropriate mental health services, beyond standard case consultation and medication, suggesting some nursing homes cannot access appropriate mental health services for their residents[55]. Although the PASARR directives are mandated federally, Linkins et al.[55] noted significant variation in the implementation between different states and considerable latitude in defining 'serious mental illness', which is a key factor in the legislation.

Incorporating assessment in mental health care has been shown to have a positive impact on care[27,31]. Molinari et al.[31]compared residents in not for profit facilities who had a mental health assessment conducted versus those who did not receive this assessment. They found that incorporating mental health assessment assisted with care planning, promoted non-pharmacological approaches to care and was quick and feasible. Murphy et al.[27] evaluated a program to manage depression in LTC and found that utilizing the MDS assessment in a more structured approach was helpful to staff when planning and implementing care, to improve residents' depression. Although there is emphasis on the role of the MDS as a tool for assessment in many jurisdictions, there was no evidence seen in the literature retrieved in this scoping review regarding the importance of completing ongoing assessment of depression of residents in LTC, within regulatory frameworks. Datto et al.[59] found that MDS measures are sensitive to changes in depressive symptoms and as such would provide the means for ongoing monitoring; and evaluation of adherence to treatment in depression, in their study of pharmacological treatment of nursing home residents. Various studies retrieved in this scoping review suggest there is variability in how such mandated tools are implemented across different areas. For instance, in a national study in the USA, Linkins et al.[55] noted that federal regulations allow for flexibility regarding how specialised mental health services are defined. Huang & Carpenter [60] researched use of the RAI tool in almost 500 residents in UK nursing homes. They found that government initiatives have not resulted in standardized assessment tools, resulting in an inconsistency of their application. A star quality rating system in the USA, which is based on health inspections, staffing, and quality measures, showed that a higher star rating scale was not associated with improving quality of life scores[61]. Similarly, in a UK study which explored the impact of using the Depression Rating Scale in LTC, found there was no association between a higher Care Quality Commission scores and lower rates of depression[60].

Holtkamp et al.[52] concluded from their study of 300 residents in Dutch nursing homes, that whilst using RAI leads to improvements in meeting of the residents' perceived needs, they found that the implementation of RAI was varied, often due to staff absenteeism and turnover; and lack of computerization in the case of one area.

Theme #2: Funding issues

In this scoping review, almost one fifth of the articles were related to Medicare and Medicaid funding, the RAI, and legislation, which was not surprising since in many jurisdictions, performance,

quality and funding are inter-related. In a study of over 88000 residents in over 2000 facilities across 6 states in the USA, Lapane & Hughes[62] explored nursing home characteristics and their impact on the management of depression. They found that when placement was funded from sources other than Medicaid or Medicare, a resident was more likely to be prescribed anti-depressant medication. To appreciate possible explanations for these findings, the characteristics of Medicare and Medicaid users' needs further exploration. Kang-Yi et al.[63] studied the results of a Medicaid census and nursing home characteristics on quality of psychosocial care and found that higher Medicaid use in a LTC facility was associated with reduced recognition of psychosocial symptoms. Kang-Yi et al.[63] also noted that where staffing levels were improved, the prescribing of antidepressant medication was also more common, resulting in increased prescribing of anti-depressant medication. A study of almost 50 residents in Florida concluded that further understanding of funding was needed around mental health, with the authors asserting that Medicare and Medicaid are reluctant to reimburse for the costs of follow up mental health assessments[31]. Linkins et al.[55] concur, noting in their study of the impact of the OBRA (1987) legislation, the number of re-assessments conducted in LTC facilities were between 0 and 10%.

Wagenaar et al.[35] suggest formal guidelines and knowledge are available to guide practice,

but that there are challenges to their implementation, including financial constraints, attitudes, and psychosocial barriers. They suggest feasibility is a significant issue when treating LTC residents who have depression. Some barriers, such as funding, exist because of complex reimbursement schemes[31], where follow up assessment for depression may not be funded by the state, or where the funding of anxiolytics has been curtailed except for specific medical conditions[54]. Linkins et al.[55] also suggest that regulation should be supported by the appropriate policies and financing to enhance the availability and integration of appropriate mental health services in nursing homes.

Most researchers argue that improved quality of care is linked to improvements in staffing levels[64], in the ratio of registered staff to residents[57,62]. Recognition of depression has also been associated with having enough numbers of registered nurses in LTC homes that are able to identify the symptoms of depression in their residents. Lapane & Hughes[62] studied organizational characteristics of nursing homes and their influence on care of depression. They found that there was increased use of anti-depressants in facilities where there were more professional nurses. Trinkoff[65] studied data from over 15000 nursing homes across 50 states, exploring the impact of Certified Nurse Aides (CNA) training on the quality of care provided, concluding that higher training hours were linked to better care outcomes; and that facilities offering CNA training above federally mandated hours resulted in fewer adverse events in the facility.

Linkins et al.[55] assessed the implementation of the PASARR program (was which part of the OBRA 1987 legislation), specifically exploring whether this had impacted on the identification of Serious Mental Illness in nursing homes in the USA and found that funding was not always aligned to the new policy. As an example, federal statutes mandate that facilities are required to provide mental health services to residents with serious mental illness, however, in this study, 38 states reported that Medicaid only reimbursed LTC

facilities for basic services for mental health. Linkins et al.[55] argue there is significant latitude at the state level, in the interpretation of this legislation, specifically with what is regarded as 'basic' services. Holtkamp et al.[52] researched the implementation of the RAI in Dutch nursing homes, and found differences in how this tool was used, which would give cause for concern when the outcomes from using this tool are used to determine funding streams and case mix indices in LTC.

Theme 3: Organizational issues

Taylor et al.[54] suggests that nursing homes are subject to institutional and structural forces which can be challenging to staff, administrators, and policy makers, as they are faced with competing demands and priorities from funding constraints, inadequate staffing levels, care expectations and regulation. In a cross-sectional study of Medicare and Medicaid use in over 2000 nursing homes in 6 states in the USA, Lapane & Hughes[62] used MDS data from almost 88000 residents to explore the relationship between nursing home characteristics and the management of depression. Findings from this study included how larger facilities were less likely to treat depression with anti-depressant medication, and how the structure and resources of the home influenced the choice of anti-depressant drug, with older tricyclic anti-depressant drugs used less in for profit facilities, in franchised facilities, and in homes with a higher percentage of Medicaid patients. The characteristics of LTC facilities also influenced the way in which care was organized. The articles retrieved in this scoping review showed that in LTC organizations with collaborative care models, there was a positive impact on the care of people with depression. Murphy et al.[27] describe, in positive terms, an intervention in which the Department of Health works alongside nursing homes to develop and implement best practices. Rolland et al.[66] examined the effects of an intervention which comprised professional support and education for nursing home staff linked to a range of quality indicators, including functional decline and emergency department transfers of residents. In

their study they noted that improved communication and collaboration from the work between geriatricians and nursing home staff, improved problem solving when sharing psychiatric expertise, which ultimately had a positive influence on the care of depression in this population. However, in examining organizational issues in the relationship between regulation in LTC and depression, it is arguably harder to monitor quality when there is inconsistent application of tools and an inconsistent interpretation of the legislation[52,55,60]. Verkaik et al.[67] described the results of a small study of Dutch nursing homes, which explored the effect of introducing a nursing guideline for depression and dementia. They noted that its introduction had short term effects on how the CNA perceived their levels of autonomy, professionalism, workload and confidence levels. However, there were barrier to successful implementation to successfully implementing guidelines which included: time pressures, reorganization or other staff change, guidelines introduced in a 'top-down approach', the level of training of the CNA, lack of leadership, and unrealistic expectations that the guidelines would have an instant impact. Verkaik et al.[67] indicated that a multi-level, collaborative approach in translating guidelines to clinical practice was effective, and although leadership was identified by the team as enabling, the team working collaboratively was also perceived as a key to success. Trinkoff[65] found that nursing homes providing professional development time for CNAs which exceeded the minimum mandated requirement were linked to improved outcomes for residents. In terms of external support for LTC facilities, research has suggested that mental health services delivered to residents living LTC are inadequate[33,52,56). Linkins et al.[55] found that over half the staff in their study had difficulty in accessing specialist mental health workers, who they found were unwilling to provide services to their residents in the nursing home. Even when this had been identified as a need.

3.5 DISCUSSION

This systematic scoping review explored the role of regulation, and the care of older people with depression living in LTC. There is evidence that regulation in LTC does not necessarily have a positive role in the care of older people with depression. It could be argued that inspection processes result in LTC facilities being so concerned with what they need to demonstrate in relation to meeting standards, it results in a preoccupation with inspections leaving no time to think about quality[60,61]. Such studies unavoidably lead to the question as to the value of such quality metrics, and whether residents and families can rely on them as a measure of what constitutes quality.

Many of the studies retrieved have presented issues relating to Medicare and Medicaid, which was not surprising since many articles in this scoping review were based in the USA. Although the articles explore the links between certain mandated requirements in different jurisdictions and depression in LTC, they did not explore the direct role of regulation on the care of people with depression living in LTC facilities.

Many of the articles in this scoping review have shown LTC to be a complex and highly regulated environment has significant challenges due to funding constraints and has many structures and processes in place which can influence the care of residents with depression. Despite existing evidence around prevalence and improved ways to manage depression in this population, generally regulation continues to adopt a deterrence-based approach[18], but which fails to incorporate into practice available contemporary knowledge[35,67]. This scoping review also showed that there are many inconsistencies, in regulatory approaches in LTC[52,55,60,61]. However, perhaps these inconsistencies in regulatory approaches in the sector enable organizations to meet regulatory standards in the context of funding being misaligned with what is required of the sector.

The widely used deterrence approach to regulation[18], may also fail to make the best use of learning opportunities, which arise from critical incidents in LTC, such as suicide, where in one study, organizational risk factors were rarely mention[68], which is a curious finding given that such a serious adverse event would almost certainly have organizational implications and learnings beyond the individual case.

3.6 CONCLUSION

This systematic scoping review showed that in many cases decisions regarding regulation and legislative requirements in the LTC sector, have a direct influence on the structures and processes of care delivered to residents, but which staff, who are accountable for the provision of care, have little influence over. We have found a paucity of literature exploring the role of regulation on the care of older people living with depression in long term care. This review indicates a need for further research in this area, which explores this important issue, and which could contribute to the policy direction of regulation.

3.7 FUNDING

The authors received no specific funding for this work.

3.8 CONTRIBUTION OF AUTHORS AND ACKNOWLEDGMENTS

MC drafted the manuscript, led the development of the search strategy, reviewed the articles and conducted the narrative synthesis. CB assisted in the development of the search strategy, reviewed the screening conflicts and edited the manuscript. RDB & JH contributed to this paper by screening titles/abstracts and full-text articles. RDB was also involved in the quality assessment of the final full-text data extraction. All co-authors (MC, RDB, JH, DA, CB) critically reviewed and approved the final manuscript. Special thanks are expressed to Lindsey Sikora, Specialist Librarian, Health Sciences Library, University of Ottawa for her support in developing and reviewing the search strategy. None of the authors have any competing interests.

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3.10 SUPPLEMENTARY DOCUMENTS

Supplementary Document 1— Search Terms (based on Medline Search on OVID Platform).

1. assisted living facility/
2. (assist* adj3 living facilit*).tw.
3. Long-Term Care/
4. (long term adj3 care).tw.
5. (home adj3 age*).tw.
6. Nursing Homes/
7. nursing home*.tw.
8. Residential Facilities/
9. (resident* adj3 facilit*).tw.
10. residential aged care facilities/
11. geriatric.tw.
12. residential care.tw.
13. skilled nursing facilities/
14. (extended adj4 facilit*).tw.
15. or/1-14
16. Depression/
17. depression*.tw.
18. (depress* adj3 symptom*).tw.
19. Depressive Disorder/
20. (depressive adj3 disorder*).tw.
21. (depressive adj3 neuroses).tw.
22. (depressive adj3 neurosis).tw.
23. (depressive adj3 syndrome*).tw.
24. melancholia*.tw.
25. (neurotic adj3 depression).tw.
26. low mood.ti,ab.
27. or/16-26
28. Government regulation.tw.
29. social control, informal/ or social control, formal/
30. social control*.tw.
31. Government Regulation/
32. Health Care Reform/ or Health Policy/ or Health Planning/ or Health Plan Implementation/ or Health Facility Planning/
33. government publication*.tw.
34. Government Regulation/ or "Delivery of Health Care"/
35. management audit/
36. management audit*.tw.
37. mandatory reporting/
38. mandatory report*.tw.
39. quality control/
40. quality control*.tw.
41. guideline adherence/ or Health Care Evaluation Methods/

42. guideline* adherence.tw.
43. (practi* adj2 guideline*).tw.
44. standards of care/
45. legislation, nursing/
46. legislation, hospital/
47. legislation/
48. legislation.tw.
49. quality of care/
50. quality of health care/
51. health services for the aged/
52. certification/
53. (institutional adj3 compliance).tw.
54. (polic* adj3 complian*).tw.
55. or/28-54
56. 15 and 27 and 55

Supplementary Document 2 –Charting Review Headings

Title of article
First author
Study type
Study design
Study aims
Country
Language
User /carer / stakeholder involvements in conduct / design of study
Setting
Target population(s)
Sampling / recruitment
Theoretical / conceptual models
Study date & duration
Data collected by?
Research tools used
Analysis used
Results
Results
Results
Strengths of study
Limitations of study
Conclusion

Supplementary Document 3- Overview of Included Studies

Title of article	**Psychiatric assessments of nursing home residents under OBRA-87: should PASARR be reformed? Pre-Admission Screening and Annual Review.**	**Recognition and management of depression in skilled-nursing and long-term care settings: evolving targets for quality improvement.**
First author	Borson	Boyle
Year	1997	2004
Country	USA	USA
Study type	Quantitative	Quantitative
Focus of Article	Implementation of PASARR	Assessment of Depression
Conclusions	The role of cognitive deficits in dependency and the need for nursing home care for patients with psychiatric illnesses plays a role in clinical assessment of nursing home patients. It contributes to difficulties encountered in setting treatment goals and implementing management plans.	Depression is a serious issue in newly admitted nursing home residents; It should be a focus of quality improvement efforts in nursing homes; GDS is inconsistently used in nursing homes. Supplementing the MDS with GDS would be helpful.

Title of article	**Recognition and management of depression in skilled-nursing and long-term care settings: evolving targets for quality improvement.**	**A Practice Improvement Education Program Using a Mentored Approach to Improve Nursing Facility Depression Care--Preliminary Data.**	**Pharmacologic treatment of depression in nursing home residents: a mental health services perspective.**
First author	Boyle	Chodosh	Datto
Year	2004	2015	2002
Country	USA	USA	USA
Study type	Quantitative	Quantitative	Quantitative
Focus of Article	Assessment of Depression	Quality Improvement in Depression	Pharmacology
Conclusions	Depression is a serious issue in newly admitted nursing home residents; It should be a focus of quality improvement efforts in nursing homes; GDS is inconsistently used in nursing homes. Supplementing the MDS with GDS would be helpful.	Assisting nursing homes with analysis of PHQ-9 data allowed strategic targeting of at-risk residents, when interventions could make a significant difference; structured and monitored tools helped standardization across nursing homes	Issues to address to improve quality of care in nursing home residents with depression: monitoring outcomes; modifying interventions; changing medication. Nursing home structures / care processes which have supported the increases in recognition of depression and initiation of treatment may not be insufficient to enable on-going treatment and monitoring over the course of the illness. Treatment for depression should include non-pharmacological strategies. Re-designed environments, to improve autonomy, could improve depression.

Title of article	**Improving the quality of age-related residential care through the regulatory process.**	**Antidepressant prescribing in US nursing homes between 1996 and 2006 and its relationship to staffing patterns and use of other psychotropic medications.**	**Effects of the implementation of the Resident Assessment Instrument on gaps between perceived needs and nursing care supply for nursing home residents in the Netherlands.**
First author	Ferrino	Hanlon	Holtkamp
Year	2013	2010	2001
Country	NZ	USA	Netherlands
Study type	Review	Quantitative	Mixed methods
Focus of Article	Comparative Review	Pharmacology	Resident Assessment Instrument
Conclusions	Recommendations in this report to support quality improvement make use of ideas or practices can be readily adopted in New Zealand. There is good evidence and research for New Zealand stakeholders to use when considering their implementation.	Prescribing anti-depressant medication has increased in the past decade, these increases are associated with staffing characteristics and with co- prescribing of certain drugs	Use of the Resident Assessment Instrument leads to improvement in meeting NH residents needs

Title of article	**Identifying elderly depression using the Depression Rating Scale as part of comprehensive standardised care assessment in nursing homes.**	**Interaction effect of Medicaid census and nursing home characteristics on quality of psychosocial care for residents.**	**The Association Between Quality of Care and Quality of Life in Long-Stay Nursing Home Residents with Preserved Cognition.**
First author	Huang	Kang-Yi	Kim
Year	2011	2011	2014
Country	UK	USA	USA
Study type	Mixed methods	Quantitative	Quantitative
Focus of Article	Assessment of Depression	Medicaid and Nursing Home Characterises	Quality of Life
Conclusions	Depression Rating Scale when used has advantages-Observable rather than self-reporting; proxy scoring OK; it can be integrated into the Resident Assessment Instrument.	Nursing staff training in well-being is important. To obtain resources for training, nursing homes with high Medicaid use could collaborate with other nursing homes and social service agencies. Nursing homes with a higher number of ethnic minority residents have lower level of detection rate for psychosocial well-being issues. Culturally appropriate care should be a component of quality improvement plans.	The 5-star rating system did not reflect the quality of life of long-stay nursing home residents with intact cognitive state. Pain not associated with quality of life, but physical impairment and depression were.

Title of article	**Which organizational characteristics are associated with increased management of depression using antidepressants in US nursing homes?**	**Use of PASRR programs to assess serious mental illness and service access in nursing homes.**	**Influence of Mental Health Assessment on Prescription of Psychoactive Medication Among New Nursing Home Residents.**
First author	Lapane	Linkins	Molinari
Year	2004	2006	2013
Country	USA	USA	USA
Study type	Quantitative	Mixed Methods	Quantitative
Focus of Article	Organizational Characteristic in Nursing Homes and Anti-Depressant Use	Effectiveness of PASARR	Assessment and pharmacology
Conclusions	Few structural characteristics were associated with anti-depressant prescribing; size of the facility was associated with anti-depressant use. Nursing homes with more beds were less likely to detect depression, if depression was detected, there was a higher chance it would be treated with anti-depressant medication. Reimbursement source was linked to anti-depressant use. Findings suggest interventions consider the resourcing and structural context in which nursing homes operate.	Compliance with the administration and documentation in PASARR was challenging. PASARR does indicate nursing homes are not admitting inappropriate numbers of people with serious mental illness. PASARR has not enhanced the nursing home's ability to access services for residents' needing specialist mental health.	Provision of mental health assessment and intervention can promote quality mental health care by reducing psychoactive medication and increasing psychosocial interventions. This approach could lead to reducing medical costs, which would then offset expenses related to additional assessments.

Title of article	**An initiative to improve depression recognition and management in long-stay nursing home residents.**	**Improving the Quality of Care of Long-Stay Nursing Home Residents in France.**	**Commitment to Care: A Plan for Long-Term Care in Ontario.**
First author	Murphy	Rolland	Smith
Year	2005	2016	2004
Country	USA	France	Canada
Study type	Qualitative	Quantitative with qualitative written feedback	Review
Focus of Article	Recognition and Management of Depression	Quality of Care	Focused review
Conclusions	The identification of depression identification improved between July 2002 to March 2003. Faculty leaders believe depression is no longer considered normal and dismissed by staff. Traditionally, state certification and licensing agencies have seen their role as being limited to inspection and enforcement of regulatory requirements. The Pennsylvania department of health initiative, which was to develop and evaluate the use of best practice interventions so that nursing homes can improve their quality of care is unique. The Managing Depression Programme used the MDS assessment and care planning processes in a structured, way, by focusing on depression as a quality problem.	Audit feedback along with educational and professional support interventions can improve healthcare quality in nursing homes. IQUARE shows a contribution from the collaboration between hospital geriatricians & nursing home staff. Costs related to the intervention study are most likely less than the cost of unnecessary admissions to emergency rooms and hospital. The channels of communication following the intervention showed impacts on pressure ulcer risk assessment; pain assessment. Communication improvements and improved problem solving in palliative care and psychiatry were also seen. IQUARE has no effect on functional ADL decline.	Report focuses on five areas for government action in the long-term care industry: improving quality of life; public accountability; developing clear and enforceable standards with tougher inspection / enforcement; improving staffing and system administration; reviewing legislation and funding formula.

Title of article	**Psychotropic drug use in a nursing home: a 6-year retrospective.**	**CNA Training Requirements and Resident Care Outcomes in Nursing Homes.**	**The introduction of a nursing guideline on depression at psychogeriatric nursing home wards: Effects on Certified Nurse Assistants.**
First author	Taylor	Trinkoff	Verkaik
Year	2003	2017	2011
Country	USA	USA	Netherlands
Study type	Mixed Methods	Quantitative	Quantitative
Focus of Article	Pharmacology	Certified Nurse Aide Training	Guideline Introduction
Conclusions	OBRA 1987 is being translated into practice, though nursing homes are subject to structural forces which challenge attempts in providing care (e.g. staffing; funding; regulation; unrealistic expectations from families). Advocates of change may not notice the unseen ramifications of that change.	Additional training for CNAs may help to identifying residents at risk from depression.	The nursing guideline had a positive effect on professional autonomy.

Title of article	**Treating depression in nursing homes: practice guidelines in the real world.**
First author	Wagenaar
Year	2003
Country	USA
Study type	Mixed method
Focus of Article	Treatment of Depression
Conclusions	There are discrepancies between importance and feasibility of combined modes of therapy. Experts agreed that the treatment modalities were important but did not feel they were feasible within a nursing home setting. Barriers include clinical access, financial issues, attitudes and patient-selection criteria. The MDS scale poorly correlates with other well-proven assessment tools. The GDS was important but not feasible. Formal guidelines and recommendations issued by public and private organizations may not match the needs of residents.

CHAPTER 4: METHODOLOGY

4.1 STUDY DESIGN

Instrumental case study methodology (Stake, 1995) was used in this study. There were several features in this methodology which meant it was appropriate approach to address the research question. It is philosophically positioned in the constructivist paradigm, which values the inter-subjectivity between researchers and participants (Weaver & Olson, 2006; Guba & Lincoln, 1994). Other approaches, such as Yin (2014), lean toward the positivist epistemology which were not aligned to the research design in this study, where I was exploring the experiences of participants. This research was exploratory; it did not seek to offer generalizations and was not designed with the goal of testing a specific theory or hypothesis. Rather, by using an instrumental case study we were able to explore 'the case' to develop insights into regulation in a LTCH, and the role of regulation in the care of people living with depression in LTCHs (Stake, 1995). Using Stake (1995) allowed the study design to evolve as the research progressed. In the LTCH, whilst I had a notion of the structure of the study, the unpredictable workflows in the environment, allowed me to adapt the design as necessary.

4.2 METHODS - IDENTIFYING 'THE CASE'

In identifying the 'case' in our study, we were guided by the literature describing instrumental case study methodology. It was previously suggested that in a case study, the case should be "deviant" (Creswell, 2013) to show the extremes of a phenomenon. Stake (1995) suggests the case should be a 'typical' case, suggesting that an 'average' or unremarkable case is studied which reflects the normal, everyday occurrence of a phenomenon.

Site selection

We decided on a single site typical case given that instrumental case study is not designed to generalize (Stake, 1995). In order to choose a site for the research I visited several LTCHs in the Ottawa region including LTCHs in urban and rural centres and LTCHs with different ownership and sizes. There are 626 licenced LTC facilities offering over 75,000 beds in Ontario (www.oltca.com). However, regardless of the location, ownership, or size, LTCHs: (1) are subject to similar structures and processes, (2) are accountable to the MOHLTC regulations (MOHLTC, 2007), (3) have a director or manager who is accountable for the provision of services, (4) provide care to similar populations, and (5) have a funding model which is a co-pay arrangement between residents and the province (depending on the type of accommodation and the LTCH itself). That said, we deliberately identified a large LTCH as the site in our study for several reasons. First, we expected that a large LTCH offered a range of levels of nursing care; had residents with different acuity levels and provided the necessary scope to explore the 'issues' from different perspectives (Stake, 1995). Second, because we identified a large LTCH, the higher numbers of staff, residents and informal caregivers, meant that we were able to reduce the research burden on participants. Third, and finally, by identifying a large LTCH as our case, we were able to access multiple perspectives about the 'case' (Stake, 1995).

We also selected a site which was not newly established, meaning the LTCH had experienced several MOHLTC inspections, which would allow participants the ability to share insights about these processes. Our site needed to be primarily English speaking as we felt that having a translator present during interviews with participants would have been intrusive and a barrier to gaining a deeper understanding of the issues.

We identified that the director of care in the LTCH needed to have worked in the same or a similar role in the LTC sector for a minimum of 3 years, which ensured they had enough experience and knowledge of the organizational structures and processes in a LTCH and had an understanding of the legislative and regulatory context of the sector.

The LTCH in which our study was based was a large home with over 280 beds in central Ottawa and provided different levels of nursing care to a population of mainly older people, which we define in our research as 65 years and older (www.WHO.org). An overview of the inclusion and exclusion criteria for selecting the case can be seen in Appendix 3.

We gained access to our site by initially linking with the director of care, who in turn facilitated a presentation to the board of directors and other key stakeholders, including senior nurses, the family council chairperson, and the spiritual care lead. The presentation outlined the aims of the research, how we planned to collect data, the process of analysis, as well as the risks and benefits for the LTCH. We also presented the perceived relevance of the study to the LTC sector and the influence the study would have on the individual residents living in LTCHs. Finally, in the presentation we acknowledged that the LTCH is a unique setting for research, as it is the residents' home (MOHLTC, 2007), in many cases, is a commercial enterprise, and research participants living and working in LTCHs can be vulnerable. All data collection strategies minimised any vulnerabilities for all participants and potential participants, which are detailed in the following section.

4.3 ETHICS

The most obvious vulnerable group in this research were the residents living in the LTCH. However, given that instrumental case study methodology is situated in the

constructivist paradigm, participation in the research by all stakeholders is essential to develop insight into the issues (Guba & Lincoln, 1994; Stake, 1995; Weaver & Olsen, 2006). Older peoples' voices are not always heard in research for several reasons. The processes around recruitment can prove lengthy (Jacelon, 2007); they are protected from participating by well-meaning families and carers (Mackin et al., 2009); or can feel reluctant to speak out or "make a fuss" (Edwards, Courtney, & O'Reilly, 2003; Owen et al., 2012). In our study, we approached residents with sensitivity and ensured they were happy to be involved, did not feel coerced into participation, and understood that in whatever choice they made regarding participation, it would have no detrimental effect on their care.

Being based in the LTCH for extended periods of time meant that a researcher was available to explain and discuss the research with residents, which appeared to have increased participation in the research (Hickson, 2008). Information was provided to residents and informal caregivers about the research and the potential benefits for them as individuals and the LTCH. As we expected, we found that in approaching residents about the study, that they had a wide range of functional abilities, and we needed to tailor how information was shared with residents and their informal caregivers about the study. That said, we found that residents were pleased to be asked about their perspectives related to the research and we had no difficulty in recruiting them as participants in the research.

Care staff working in LTCHs may also be vulnerable. The sector employs many internationally educated nurses (Grant Thornton, 2010; North, 2011) and we were mindful that some cultures might have been reluctant to challenge the position or views of their managers (Crick, Pool & Page, 2015), although this could have applied equally to members of the team who were born in Canada. Being visible in the LTCH, and

spending time talking face-to-face with the team, explaining to them about the research and its potential benefits mitigated against this. No one was coerced into participation. We were also aware that the research site was a commercial environment, where concerns about reputation and what is shared in research might have been a factor for participants; as such, confidentiality was assured to all parties. We did not envisage that there would be any risk of harm to any participant who agreed to be involved in this research, however, all participants were issued with a copy of a booklet "Depression in Older Adults; A guide for seniors and their families" (Canadian Coalition for Seniors' Mental Health, 2009), and ensured that participants did not require any additional support after the interview.

This study was approved by the Research Ethics Board at the University of Ottawa, reference H66-17-02.

4.4 MAINTAINING QUALITY IN THE RESEARCH

Traditionally, the academic rigour of research has been judged based on validity, reliability, generalizability, and objectivity (Denscombe, 2007). Guba and Lincoln (1994) suggested an alternative framework for assessing trustworthiness in qualitative research, using credibility, dependability, confirmability, transferability, and authenticity.

Credibility in our research was achieved by prolonged engagement in the LTCH, helped to build trust and rapport (Patton, 1990), having an opportunity to debrief as a research team meaning we did not overlook important issues (Denscombe, 2007; Flick, 2002; Wolcott, 1990), and using thick description, by eliciting different perspectives from the participants (Stake, 1995).

We achieved dependability in our study by maintaining a clear audit trail around research decisions. To support this, we kept a research journal and field notes during

data collection. During data collection, we revisited the research proposal, the research question and 'issues' (Stake, 1995) frequently and maintained transparency around any research decisions in the process. Transparency was maintained during analysis by using a thematic analysis approach (Braun & Clarke, 2006) to analyse the data and by using a qualitative data analysis computer software package (Atlas-ti 8.0) to organize the analysis and ensure that this process was clear and transparent.

Confirmability in our study was achieved by ensuring that during data collection we were open and transparent with participants about the research and by being reflexive about our influence as researchers during data collection (Streubert, 2011; Parahoo, 2006). Maintaining the research journal during data collection was used to reflect on any decisions taken or to consider challenges that occurred during data collection.

Gathering multiple perspectives enabled us to achieve thick description (Creswell, 2013; Sandelowski, 2011; Stake, 1995; Thomas, 2010), which will enable readers of the research to determine transferability of our findings into their own areas (Streubert, 2011). Binding the case in our research ensured there was a focus during the data collection phase of the study and allowed us to keep a check on whether the case was measuring what it was meant to measure (Stake, 1995).

4.5 DATA COLLECTION STRATEGIES.

In our research, we used various data collection strategies to ensure that we had multiple perspectives from participants to develop understanding and intensive descriptions of the relevant aspects of the case (Sandelowski, 2011; Stake, 1995; Thomas, 2010). Data collection included: semi-structured interviews with managers, staff, residents, and informal caregivers in the LTCH, reviewing operational documents, such as training schedules, policies and role descriptions, and reviewing clinical charts.

A summary of the sampling and recruitment approaches which were used have been summarized in Table 1.

Table 1 - Summary of Sampling & Recruitment Approaches

Participant	Data Collection Approach	Sample	Recruitment Approaches
Senior Managers / Directors of Care	Interviewed at start and end of data collection period	Director of Care and 3 senior managers	Agreed to participate as part of access to site
Residents	Single interview	Select participants until saturation is reached	Resident Council presentation given to residents about the research; posters and leaflets on site; information given on site; answering questions; being a presence in the LTCH to discuss research
Informal caregivers	Single interview		Meeting with chair of Family Council; posters and leaflets on site; information given on site; answered questions; being a presence in the LTCH to discuss research
Staff	Single interview		Attend meetings; posters and leaflets on site; information given on site; answered questions; being a presence in the LTCH to discuss research
Document Review	Review of operational documents	To be decided in the field - dependant on interviews	Specific documents were reviewed as outlined in this proposal
Clinical Chart Review	Review of selected clinical charts	Resident who were interviewed	Residents were asked at interview

Recruitment for Interviews

We not only aimed to capture the insights of a range of participants but also needed to ensure that participants approached for interviews would have enough experiences to share. Managers and other senior leaders were recruited via existing site governance forums, such as the leadership meetings, and were recruited based on the specific insights they were able to share. The inclusion/ exclusion criteria for managers can be seen in Table 2.

Table 2 – Inclusion/ Exclusion Criteria for Manager Interviews

Criteria	Included	Excluded
All disciplines and professions	✓	
Permanent employee of LTCH	✓	
In post (or similar) for 3 years +	✓	

Recruitment of staff took place by presenting the research to the staff teams who met in existing forums. We asked for volunteers initially, but as we collected data it was clear there were some staff who potentially had specific insights into the case. For instance, Behavioural Support Workers offered an alternate perspective to PSWs. In these cases, we approached these staff individually to ask if they were able to participate. The inclusion / exclusion criteria for staff can be seen in Table 3.

Table 3 – Inclusion/ Exclusion Criteria for Staff Interviews

Criteria	Included	Excluded
All clinical disciplines and professions	✓	
Volunteers	✓	
Support & ancillary staff	✓	
Admin & clerical team	✓	
Permanent employee of LTCH	✓	
Agency staff		**X**
In post for 3 months +	✓	

Residents in the LTCH were recruited by the director of care, or their proxy. However, we also shared information about the study at the Resident's Council meeting. Since not all residents were able to attend the presentation, we used other strategies to inform potential participants about the study, which included issuing information leaflets (Appendix 4) and displaying posters (Appendix 5) about the research at different locations in the LTCH. Being present in the LTCH meant researchers were able to talk to potential participants individually about the study, and answer questions as required. In our study, we did not exclude participants who had cognitive impairment. Since previous studies suggests that there are links between physical ill health, dementia and depression (Bruce et al., 2002; Cummings, 2002; Dennis, 2005; Dow et al, 2011; Phillips et al, 2011; Zuidema et al., 2007), we were felt it was important not to exclude any group based on these conditions. The inclusion / exclusion criteria for residents are summarized in Table 4.

Table 4 – Inclusion/ Exclusion Criteria for Resident Interviews

Criteria	Included	Excluded
Consenting resident (or proxy)	✓	
Aged 65 old and over	✓	
Lived in the facility for at least 3 months	✓	
All clients (with or without depression)	✓	
No legal capacity to consent and proxy consent not possible		X

Recruiting informal caregivers was more challenging than we expected. We began by speaking to the chairperson of the Family Council who was able to identify individuals who might be willing to be interviewed. Several informal caregivers were initially agreeable to be interviewed but they found they did not have the time to spare. Information about the study was shared and available in the LTCH but we still found there was a lack of interest in participating. Following support from a member of the

leadership team, we were able to identify a total of 5 informal caregivers who were willing to participate in an interview. The inclusion /exclusion criteria for informal caregivers can be seen in Table 5.

Sampling for Interviews

Participants who were interviewed were able to provide insights into the role of regulation on the care of depression in the LTCH (Baker & Edwards, 2012; Stake, 1995). When on site in the LTCHs, we used three sampling approaches. First, we employed a maximum variation sampling approach for residents and staff, which ensured we had representation across the different participant groups to enable us to understand a variety of experiences (Patton, 1990).

Table 5 – Inclusion/ Exclusion Criteria for Informal Caregiver Interviews

Criteria	Included	Excluded
Aged 18 years old and over	✓	
Informal caregivers of resident in the facility	✓	
The resident they lined with to has lived in the facility for at least 3 months	✓	

Participants were selected to represent disparate perspectives across these participant groups. Throughout data collection, we frequently checked that we were achieving the maximum variation parameters which we had identified, which are outlined in. Table 6.

Table 6 – Maximum Variation Sampling Approach for Residents and Staff Participants

Participants	Maximum Variation Parameters
Residents.	Age Gender Diagnosis of depression No diagnosis of depression Physical and mental health status Time living in LTC
Staff.	Length of service Experiences Age Gender Qualifications

Second, we also used a convenience sampling approach, where participants were "first to hand" (Denscombe, 2007). Whilst there have been concerns around credibility in using this approach (Creswell, 2013), we found it was more practical in a LTCH, which had unpredictable workflows, and where the opportunities to meet with people arose as their schedules allowed, without interfering with the usual care processes in the LTCH. Being available at the site meant we were able to conduct interviews when someone consented and was available at short notice. Third, we used a purposive sampling approach where we identified specific managers who were able to provide specific insights (Creswell, 2013) into the case. We interviewed the RAI / MDS manager who was able to offer specific insights relating to the mandated reporting systems within the LTCH, both from the MOHLTC perspective as well as how this influenced the behaviour of the staff and managers in the LTCH. The director of care was interviewed as they were directly involved in the majority of the MOHLTC inspections and had overall accountability for care in the LTCH. The Quality Improvement Coordinator in the home had oversight for the quality improvement plan

and quality reporting in the LTCH and was able to offer insights into how these processes affected the care of residents with depression in the LTCH. The CEO was added as a participant in the interviews when it was clear that other senior staff and managers had limited outward facing insights.

Although we intended have a maximum variation sample in our recruitment of informal caregivers, we were not able to achieve this in our sample, as we had challenges in recruiting in this group. In this group we adopted a convenience sampling approach and selected informal caregivers who were able to schedule an interview. We had not identified the number of interviews that we intended to carry out beforehand, and the literature had no definitive answer as to how many would be enough (Baker & Edwards, 2012). However, having not predetermined a specific number of interviews we continued until theoretical saturation was reached and we saw repetition of the data collected (Streubert, 2011), when there was enough information to replicate the study, and finally, where no new insights were evident (Baker & Edwards, 2012; Fusch & Ness, 2015). We would have preferred to interview greater numbers of informal carers, but despite our best efforts we were only able to recruit 5 participants in this group. That said, we conducted 31 interviews in total, 25 participants were interviewed once, but 3 managers were interviewed twice, once at the start of data collection and then again at the end of data collection. Follow up interviews with managers offered an opportunity to address specific questions and to seek clarification on issues which arose during data collection. The interviews consisted of 10 staff members, 4 managers, 5 informal caregivers and 9 residents which resulted in over 600 minutes of transcribed interviews.

Interviews

Participants who we interviewed in this study enabled us to explore the thoughts and perspectives of the interviewee in a safe environment (Patton, 1990; Stake, 1995). We used semi-structured interviews to gain an in-depth understanding of the perceptions of participants related to the research question and the 'issues' (Kelly, 2013; Streubert, 2011). As an experienced registered nurse, I was able to use my interviewing experience to conduct the interviews in a sensitive way (Denscombe, 2007), which resulted in developing a rapport with participants to gain insights into their perspectives (Patton, 1990). Open questions were used when possible to facilitate responses (Denscombe, 2007; Stake, 1995).

Using semi-structured interviews in the study allowed for flexibility during the interviews to understand the subjective experiences of participants (Parahoo, 2006; Stake, 1995). Interview schedules, based on the 'issues' in this research, were designed to be able to evolve as the research progressed and new insights were shared. This is aligned to instrumental case study methodology (Stake, 1995) where the research design can be adapted according to what participants share. Interview guides are available in Appendix 6. All interviews were audio recorded on a digital device and were transcribed by a third party who had signed a confidentiality agreement.

Document Review

We used document review methods in this study, which was an efficient mechanism for collecting data, and whilst it may not have been a verbatim account (Denscombe, 2007; Staniland, 2013), it provided a rich source of evidence (Denscombe, 2007) in our study. In our research, the documents reviewed were able to corroborate other sources of evidence (Angrosino & Mays de Perez, 2000; Bowen, 2009) and provided context (Appleton & King, 1997; Bowen, 2009). Document review

also allowed us to access data which would be hard to observe, such as the Ministry of Health and Long-Term Care inspection in progress, but nevertheless, offered rich insights to the case (Denscombe, 2007; Stake, 1995).

Sampling in Document Review

We used a purposive sampling approach to identify documents for review (Creswell, 2013; Streubert, 2011), based on what participants shared in their interviews (Streubert, 2011). Where participants referred to specific documents, this was noted and the documents were accessed at a later point. For example, a participant referred to the Responsive Behaviour Policy during the interview. This Responsive Behaviour Policy was then noted for review. A total of thirty-one documents were reviewed including operational documents, such as policies, MOHLTC Inspection reports, training information, and strategic plans relating to quality in the LTCH.

To manage the data collected in the document review, we used a data extraction form which was developed based on a document analysis template for use in qualitative research (Mayan, 2009). An Extended Quality Framework (Crick et al., 2017) which had been developed from a previous review of the quality literature, was used to guide data collection and analysis (see Appendix 7). The Extended Quality Framework was based on Donabedian's domains of structure, process, and outcome (Donabedian, 1966), but which also incorporated the multi-level approaches to quality described by Banerjee and Armstrong (2015).

Elements from this framework were included in the data extraction form, so that each document was reviewed with these domains in mind. As well as including aspects from the Extended Quality Framework, the data extraction form outlined why a document existed, its general purpose, who had access to it, who wrote or completed it,

how the information within the document was used, and whether the document offered any insights on the role of regulation and the care of residents with depression in LTC.

Clinical Charts

Clinical charts in the study were identified separately from document review, as we approached them, as a source of data, differently from the general document review. Using clinical charts as a source of data in this research was advantageous. We were able to include contextual information relating to care without placing an additional research burden on residents, informal caregivers, staff and managers at the LTCH. The clinical records also helped to elaborate, provide deeper insights, and add context to other data collected (Appleton & King, 1997; Bowen, 2009).

Sampling Clinical Charts

In this research, we identified the clinical charts which were examined based on what residents shared in interviews. We only examined only the clinical charts of residents who prior to their interview consented to us accessing their chart. The purpose of reviewing the clinical charts was not to describe the prevalence of depression but was a means of exploring any role that regulation had on the care of residents with depression living in the LTCH. An example of was how that a resident shared in their interview that they were not asked about depression on admission to the LTCH, but when the chart was reviewed it stated a Depression Rating Scale had been completed. We used the recommendations in Common Mental Health Disorders and Management of Depression in Primary Care (MOH, 2008b) as a guide for data extraction, which outlined best practice in the care of depression, which were related to assessment, medication, intervention, and liaison. The data extraction tool can be seen in appendix 8.

Consent

We obtained written informed consent from all participants in this study. This included managers, staff, residents, and informal caregivers. Many residents in LTCHs have some degree of cognitive impairment (Care Quality Commission, 2010; Ontario Long Term Care Association, 2016; Wong, Gilmour & Ramage-Morin, 2016). It was important to offer all residents the opportunity to participate, especially given the known links between dementia and depression in the LTCH population (Dow et al., 2011; Phillips et al., 2011).

We were prepared to use surrogate or proxy consent, which has been used increasingly where individuals cannot give informed consent. Surrogates are normally a spouse, a carer, or an individual that knows the person well (Alzheimer's Association, 2011; Cubit, 2010). Although some residents had a mild cognitive impairment, they were all able to consent to participation in interviews, and proxy consent was not required by any resident we interviewed, as we determined they were able to understand the research and what they were consenting to. Staff in the team, who knew the resident well, helped to guide these decisions. However, even where residents gave consent, we used assent alongside any informed consent. We observed for signs of dissent, including disengagement, agitation, or distress. In any event, we had no cause to end interviews with resident participants early and found in all cases they were happy to interact with us.

Before we commenced data collection, all potential participants were given an information sheet about the research (see Appendix 4) and had the opportunity to discuss the research before their participation was confirmed. We adopted different approaches to participants depending on their individual needs. When sharing

information about the study, we revisited the information with the potential participants as was required.

Participants were advised of their rights to withdraw from the study at any stage and were reassured that all information would remain confidential. All participants signed a consent form and were issued with a copy of the consent form (see Appendix 9). Residents who consented to interviews all agreed to us accessing their clinical charts.

Data analysis

As expected, this case study generated large quantities of data (Stake, 1995). All data were analysed using a thematic analysis approach (Braun & Clarke, 2006), which was supported by a qualitative data analysis computer software package (Atlas-ti 8.0). Whilst thematic analysis is not explicitly linked to an epistemological position, it is widely used in qualitative research (Braun & Clarke, 2006), and so was congruent with the constructivist approach taken in our instrumental case study (Stake, 1995).

First, the digital recordings of interviews, and data extraction tools from documents and charts were reviewed, and initial ideas were noted, and connections were made as a first step in developing meanings based on the data (Stake, 1995). The primary researcher systematically examined and assigned initial codes to the data, which were then shared with the research team. In the initial stages of this process we opted not to assign codes to the data using the Extended Quality Framework. Coding was an iterative process and only when we were satisfied that the coding accurately reflected the data collected, did we search for themes. At this point we decided to assign data to themes which were aligned to categories within the Extended Quality Framework where themes were grouped by local, provincial, federal and global domains. Using the framework meant we were able to explore the issues in the research question by considering the data from using the perspective of an extended approach to

quality (Banerjee & Armstrong, 2015; Donabedian, 1966). At this stage we presented an overview of the initial findings to the administrator in the LTCH, where there was an opportunity for discussion on the themes identified.

Reflexivity Statement

Reflexivity is an important aspect of qualitative research (Doyle, 2013; Houghton, Casey, Shaw, & Murphy, 2013) as it helps the reader to understand the researcher's perspective. My reflexivity statement outlines why I chose this topic for my research along with my own experiences working in mental health services with older people.

Although this study explores the Role of Regulation in the Care of Older People with Depression Living in Long-Term Care in Ontario, the idea started life in Wellington, New Zealand, when I was working as a research assistant and conducting interviews with managers about business models in LTCHs. I noted that participants were highly skilled and wondered whether these skills would be represented in the New Zealand LTCH inspections. I left the interviews and examined corresponding inspection reports on line and noticed there was no correlation between the skills I had seen with how the LTCH was portrayed in the reports. I began to wonder what the inspection captures.

Much of my professional career as a nurse has been working with older people with mental health needs, not only with dementia but with depression and other functional mental health problems. I identified depression as the issue in my study for 2 reasons. First, because depression is very responsive to treatment and compared to other mental health problems (such as dementia or psychotic disorders) is curable, and so not to address it seems unethical for a nurse. Secondly, there is very strong evidence that

the prevalence of depression in LTCHs is significant, and so there is a real issue that should be addressed.

Understanding reflexivity had an impact on the study design, data collection and analysis. As a registered mental health nurse, I have skills which are transferable into the research and academic worlds, particularly those of communication with people from all backgrounds. This was particularly useful when approaching the site for the case study, and in recruiting participants as I was able to outline the study and reach out to individuals and teams. My nursing skills in assessment, also proved useful in this research as I was able to collect data, record my findings and analyze what was shared with me. Also taking a holistic view in the mental health setting, when working with individuals as a nurse, is aligned to the multiple perspectives with the instrumental case study.

Throughout the process, though more so during data collection and analysis, I maintained a journal to allow me to reflect on decisions I made during this journey.

CHAPTER 5: DOES MINISTRY OF HEALTH AND LONG-TERM CARE REGULATION MAKE A DIFFERENCE TO OLDER PEOPLE WITH DEPRESSION LIVING IN LONG-TERM CARE? *(FORMATTED AND SUBMITTED TO THE CANADIAN JOURNAL OF AGEING ON 8 NOVEMBER 2018)*

Title

Does Ministry of Health and Long-Term Care Regulation Make a Difference to Older People with Depression Living in Long-Term Care?

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Abstract Word Count: 240

Word Count Manuscript: 11241

5.1 ABSTRACT

The prevalence of depression is high in older people living in long-term care homes (LTCHs). It is less likely to be reported by the residents themselves and by professionals and is associated with loneliness, physical ill health and suicidality. Regulation has been linked to quality, but the difference is questioned. This study explored the role of regulation in the care of older people with depression living in a LTCH in Ottawa. We used case study methodology to understand the regulation in place supporting the care of residents with depression living in LTCH and how regulation supports improvements in the care of residents with depression living in LTCHs.

Using instrumental case study methodology, we interviewed managers, staff, informal carers and residents, and reviewed documents and clinical charts. We noted that Ministry of Health and Long-Term Care (MOHLTC) regulations influenced strategic planning, educational priorities, resourcing decisions and direct care. The findings from this study suggest an alternative approach to regulation is needed in LTCHs which places accountability for standards of care at a provincial level, adopting a more supportive and collaborative approach to regulations for LTCHs, enabling them to achieve MOHLTC mandated standards and improve the care of residents with depression.

5.2 INTRODUCTION

The global population of older people (65 years of age and older) is predicted to grow to 1.5 billion by 2050 (Suzman & Beard, 2011). In a recent census, almost 17 % of people living in Canada were over 65 years of age and almost 7% of them were living in long-term care homes (LTCHs) (Statistics Canada, 2016). It is projected that by 2026 an additional 131000 LTCH beds will be needed for Canadian seniors [LTCHs] (Hermus, Stonebridge, & Edenhoffer, 2015).

In LTCHs, the prevalence of depression in older people is higher than in the general population (Ellard, Thorogood, Underwood, Seale & Taylor, 2014; Knight, Davison, McCabe & Mellor, 2011; Smallbrugge, Jongenelis, Pot, Beekman & Eefsting, 2005). A study of over 55000 seniors living in residential care facilities in five Canadian jurisdictions found 44% of residents had a diagnosis or symptoms of depression (Canadian Institute of Health Information, 2010). Recognizing depression in older people is challenging. They are less likely to report depression than younger adults (Barg et al., 2010), and furthermore, professionals may see it as a normal part of the ageing process (Burroughs, Lovell, Morley, Baldwin, Burns & Chew-Graham, 2006; Pachana, Helmes, Byrne, Edelstein, Konnert, Pot, 2010). Depression impacts the well-being of older people residing in LTCHs (Khader, 2011); it is associated with loneliness (Alpass & Neville, 2003; van Beek, Frijters, Wagner, Groenewegen & Ribbe, 2011), health related problems and suicidality (McDougall, Matthews, Kvaal, Dewey & Brayne, 2007).

Regulation in LTCHs has been linked to quality (Ferrino, 2013; Lai, 2015), although there are contradicting views as to whether it makes a difference. It has been suggested that the Ministry of Health and Long-Term Care (MOHLTC) regulations distract LTCH care workers from providing quality care to residents in that they are

preoccupied with meeting the requirements of the inspectors, and their attention is taken away from residents (Lai, 2015). Lobel (2012) argues that control and command approach to regulation, which focus on failure, are ineffective. Ferrino (2013) reported on LTCH regulatory approaches in New Zealand and the US and found that responsive approaches to regulation. Responsive approaches are a hybrid of deterrence and compliance, where there are sanctions when needed, but with a greater emphasis on support and development (Ferrino, 2013; Walshe, 2001).

Although we have seen an increase in regulation in LTCHs in Ontario (Daly, 2015), the provision of quality services in the LTCH setting continues to be a concern, not only in Ontario, but in many jurisdictions. This is evidenced by reports and studies from the past 30 years relating to quality in the LTCH sector (Kane, 1995; Long-Term Care Task Force on Resident Care and Safety, 2012; OECD, 2013). Regulation in LTCH continues to adopt a deterrence-based approach (Ferrino, 2013), and has failed to incorporate current knowledge of depression into the regulations (Verkaik, Francke, van Meijel, Spreeuwenberg, Ribbe & Bensing, 2011; Wagenaar, Colenda, Kreft, Sawade, Gardiner & Poverejan, 2003). The concepts of regulation, long-term care and depression have been extensively addressed in the literature. However, there is limited literature which has examined the relationships between the role of regulation on the care of older people with depression who are living in LTCHs.

This research used instrumental case study methodology (Stake, 1995) to address the research question: "What is the role of regulation in the care of older people with depression living in a long-term care home in Ontario?". Stake (1995) describes 'Issues' to define the aims of the research. The 'Issues' in this research are:

1. What regulation is in place to care for older residents with depression living in LTCHs?

2. How does regulation support or hinder improvements in the care of older residents with depression living in LTCHs?

5.3 METHODS

5.3.1 Theoretical framework

The theoretical framework, which can be seen in Figure 1, describes an extended approach to quality in LTCHs based on Donabedian's Quality Framework domains of structure, process, and outcome (Donabedian, 1966). Donabedian's framework was developed to assess the quality of medical care by understanding its outcomes (Donabedian, 1966). He suggests the structure of how care is organised and the process of care influences the outcomes of care. In order to address the increasing complexity in LTCHs, this framework also incorporates the multi-level approaches to quality described by Banerjee and Armstrong (2015) who argue that quality is influenced at different levels across the long-term care landscape.

Figure 1 – Extended Quality Framework

Level		Structure	Process	Outcome
Global-Influencing the International Agenda in Long-Term Care	*Deterrence*	International agreements with providers operating in Canada	Expectations of international corporate providers to operate and build LTC facilities across Canada?; legislation for new build LTC facilities	Canada's voice on world stage (e.g. WHO); research outputs on word stage; world class research in LTC field
Federal -What Does Canada Need in Long-term Care?	*Regulatory Approaches*	Political direction; policy development; funding priorities	Political direction into implementation to regulation; support for smaller facilities	Federal data reporting systems
Provincial - Acknowledging Diversity		Licensure for registered staff; staffing levels; requirements for care provision	How are policies translated into local need; alternatives to residential care	Needs assessments understand provincial need; funding apportioned to local need.
Local- Establish the Needs of Local Facilities	*Compliance*	Operating to deliver care to local population; patient councils; family councils; consideration of local culture	Local targets; staffing culture; developing relationships with inspectors.	Responsive regulation; measuring what is relevant; celebrating success and good practice

5.3.2 Study design

We used an instrumental case study design (Stake, 1995) which is philosophically positioned in the constructivist paradigm, valuing the inter-subjectivity between researcher and participant (Weaver & Olson, 2006; Guba & Lincoln, 1994). This allowed us to design a study which incorporated multiple perspectives. Rigour was enhanced by prolonged engagement at the LTCH, peer de-briefing with the research team, gathering deep insights from multiple perspectives of the participants, and by using field notes and a journal to show a clear audit trail in decisions related to data collection and analysis.

5.3.3 Sampling and recruitment

We used a maximum variation sampling approach when identifying residents, staff, managers and informal caregivers for interviews to provide representation across the different participant groups (Patton, 1990). Participants were selected because of their insights into the 'issues' of the case (Denscombe, 2007), and to represent disparate perspectives in the participant groups by seeking variation in age, time living or working in the LTCH, experience, and physical and mental health status. Table 1 outlines the parameters of the maximum variation approach in this research for residents, staff and informal caregivers.

Table 1 – Maximum Variation Parameters

Participants	**Maximum Variation Parameters**
Residents.	Age; Gender; Diagnosis of depression; No diagnosis of depression; Physical and mental health status; Time living in LTC
Informal Caregivers.	Age; Gender; Relationship to resident
Staff.	Length of service; Experiences; Age; Gender; Qualifications
Managers	Length of service; Experiences; Age; Gender; Qualifications

We also used a convenience sampling approach, where participants are "first to hand". (Denscombe, 2007). Although the credibility of using this approach has been questioned (Creswell, 2013), we felt it was likely to be more practical in a LTCH which had unpredictable workflows and where opportunities to interview participants arose as their schedules allowed. We were aware that the research site was the residents' home and were eager not to interfere with the usual care processes in the LTCH.

We also conducted document and chart review using a purposive sampling approach (Creswell, 2013). Documents were identified for review based on what participants shared in interviews (Rohwer, Schoonees, & Young, 2014) for example, when a staff member referred to orientation training, we subsequently reviewed the content of any orientation documents. Documents which were related to regulation and standards in LTCH, for instance MOHLTC inspection reports and quality improvement plans, were reviewed. Clinical charts were reviewed to elaborate, provide deeper insights and to add context to other data that were collected (Appleton & King, 1997; Bowen, 2009). Only the clinical charts of residents who participated in interviews and who consented were reviewed.

To encourage participation in the research, the primary researcher (MC) was based at the LTCH for over a month on different days and times. Before and during the research period, presentations about the research were provided to various groups, including the Resident's Council, the LTCH board, the senior management group and via informal meetings with staff. The researchers' goals and reasons for undertaking the study were shared during these interactions. Being present in the facility meant the primary researcher was available to potential participants to explain and discuss the research (Hickson, 2008), and to build trust with residents, staff and managers (Angrosino & Mays de Perez, 2000). Working closely with the LTCH meant that

potential participants were able to get to know the primary researcher and the motivation for conducting the study. To supplement this approach, leaflets and posters with information about the research were displayed throughout the facility. Some residents and their informal caregivers had different levels of physical and cognitive functioning, and as such information was delivered in a format which recognised any impairments. Residents in LTCHs are a vulnerable group, but we were keen they should be given opportunities to be involved in this research. Older people can be protected from participating by well-meaning families and carers (Mackin et al., 2009), or can feel reluctant to speak out or "make a fuss" (Owen, Meyer, Cornell, Dudman, Ferreira, Hamilton, Moore & Wallis, 2012). To mitigate against this all participants, including residents, were approached with sensitivity to ensure that they were happy to be involved and did not feel coerced into being involved. After each interview all participants were offered additional support in respect of any issues which had arisen in the interview and were given a copy of a booklet "Depression in Older Adults: A guide for seniors and their families" (Canadian Coalition for Seniors' Mental Health, 2009).

5.3.4 Setting

The LTCH chosen for the case study was a large, primarily English speaking and well established not for profit LTCH, situated in central Ottawa. The LTCH provides care to older people across a spectrum of care. The director of care at the LTCH had held a senior post in the LTCH sector for several years, which ensured they had enough experience and knowledge of the site, and the legislative and regulatory context in which LTCHs operate.

5.3.5 Data collection

Interviews

We used semi-structured interviews as a data collection tool for managers, staff, residents, and informal caregivers to gain an in-depth understanding of their perceptions related to our research question and the 'issues' in this case study (Kelly, 2013). Interviews were focused on what regulation there is in place to care for older residents with depression living in LTCHs, how regulation might be a barrier or facilitator to improvements in the care of older people with depression living in LTCH and what other influences affect care of people with depression in LTCH. Table 2 outlines semi-structured interview schedules for the 4 participant groups.

Three managers were interviewed twice, once early in the data collection period and then towards the end of this period. Having a follow-up interview with the managers enabled us to ask further questions which arose to address specific questions about regulation in the LTCH. The manager, who was interviewed only once, was not initially included in the sample, but during data collection it was clear she had specific insights to offer.

Interviews, document reviews and chart reviews were conducted by the primary researcher, a doctoral candidate with a background in care of older people and who had interviewing experience for data collection. All interviews were recorded using a digital recording device. Field notes were also made during the interviews.

Residents all chose to be interviewed in the privacy of their own room in the LTCH. Staff and manager interviews were also held at the LTCH, though they were given the option to meet off site. Informal carers were interviewed either in their own home or at the LTCH, whichever was most convenient to them. Interviews lasted for 30 to 60 minutes.

Table 2 -Semi-Structured Interview Schedules

Participants	**Semi-structured Interview Guide**
LTCH Staff	Experience, length of service, qualifications What regulation is in place to care for older residents with depression living in LTCH ? How does regulation support or hinder improvements in the care of older people with depression living in LTCH? What other influences affect care of people with depression in LTCH? Sociodemographic information
Director of Care / Managers	Experience, length of service, qualifications What regulation is in place to care for older residents with depression living in LTCH? How does regulation support or hinder improvements in the care of older people with depression living in LTCH? What other influences affect care of people with depression in LTCH? Sociodemographic information
Residents	Personal story-leading to moving into LTCH Personal experience of low mood or depression. What regulations are in place to care for older residents with depression living in LTCH? How does the organization implement processes CURRENTLY which support improvements in the care of older people with depression living in LTCH? How might the organization implement processes which support improvements in the care of older people with depression living in LTCH? What other influences affect care of people with depression in LTCH? Sociodemographic information
Informal Caregivers of Residents	Personal story-leading to resident moving into LTCH What regulation is in place to care for older residents with depression living in LTCH? How does the organization implement processes currently which support improvements in the care of older people with depression living in LTCH? How might the organization implement processes which support improvements in the care of older people with depression living in LTCH? What other influences affect care of people with depression in LTCH? Sociodemographic information

We did not have a predetermined number of interviews and continued until we saw repetition and no new insights evident in the data (Baker & Edwards, 2012; Fusch & Ness, 2015).

Document and Chart Reviews

A data extraction form was used as part of the document review (Mayan, 2009) and can be seen in supplementary document 1. The clinical chart review in the research was not intended to explore the prevalence of depression in the LTCH but was a means to explore the role of regulation in the care of residents with depression living in the LTCH. A framework for data extraction of the clinical charts, based on Common Mental Health Disorders and Management of Depression in Primary Care Framework (Ministry of Health, 2008), was developed (Supplementary Document 2) to assist in data collection.

5.3.6 Analysis

All data were analysed using a thematic analysis approach (Braun & Clarke, 2006), supported by a qualitative data analysis computer software package (Atlas-ti 8.0). The primary researcher listened to the digital recordings of interviews and reviewed documents and charts, which increased the proximity to the data (Denscombe, 2007). During this process, initial ideas were noted, and connections were made to develop meanings based on the data (Stake, 1995).

To generate initial codes, the primary researcher systematically examined and assigned codes to the data, which were then shared and discussed with the other members of the research team to ensure that we were satisfied with the process. In the initial stages of this process we opted not to assign codes to the data using the theoretical framework. Coding was an iterative process and once we were satisfied that the coding accurately reflected the data collected, we searched for themes. At this stage

data were assigned to themes which were aligned to categories within the theoretical framework. Transcripts, document reviews, and chart reviews were revisited. Themes were grouped by local, provincial, federal and global domains to enable us to explore the issues in the research question by considering the data from this extended view of quality. An overview of the initial findings was presented to the LTCH, where there was an opportunity for discussion on the themes identified.

5.4 FINDINGS

Thirty-one interviews were conducted in total, with participants consisting of 10 staff members, 4 managers, 5 informal caregivers and 9 residents. Almost 600 minutes of interviews were transcribed. Nine clinical charts and 31 documents were reviewed.

All residents who were approached were willing to participate in the interviews, however one person was not willing to have the conversation recorded and so was not interviewed. Staff overall were very eager to share their insights. Two members of staff had agreed to be interviewed, but scheduling meant they were unable to commit to a time to be interviewed. It was challenging to recruit informal caregivers. Three were initially agreeable to be interviewed but they found they did not have the time to spare. Following support from a member of the leadership group, we were able to identify a total of 5 informal caregivers who were willing to offer an interview.

5.4.1 Characteristics of the Sample

In this research we were aiming for maximum variation in our sample. Tables 3-6 give an overview of the characteristics of the sample.

Table 3- Characteristics of the sample – Residents

Characteristics		**n**
Marital Status		
	Single	1
	Married	3
	Divorced	1
	Widowed	4
Gender		
	Female	8
	Male	1
No current or past symptoms of depression		4
Current or past symptoms of depression		5
Time living in LTCH	**Mean (range)**	4 years (1 -8.5)
Age of resident	**Mean (range)**	81.8 years (79-85)

Table 4 Characteristics of the sample – Informal Caregivers

Characteristics		**n**
Relationship to resident	**Adult children**	**3**
	Spouse	**2**
Gender of resident	**Female**	**4**
	Male	**1**
Resident with no current or past symptoms of depression		**3 residents**
Resident with current or past symptoms of depression		**2 residents**
Time family member living in LTCH	**Mean (range)**	5.6 years (1-11)
Age of family member (resident)	**Mean (range)**	82.8 years (79-87)

Table 5 Characteristics of the sample – Staff*

Working in LTCH (average)		**6.8 years**
Gender	**Female**	**7**
	Male	**3**
Role: Clinical role		**8**
Role: Supervisory / administrative		**2**

*Staff included representatives from across the LTCH (Registered Nurses; Registered Practical Nurses; Social Workers; Spiritual staff; Clerical staff; Personal Support Workers and Behavioural Support staff)

Table 6 Characteristics of the sample – Managers

Working in LTCH (average)		**21.5 years**
Gender	**Female**	**3**
	Male	**1**
Role: Clinical oversight		**1**
Role: Administrative / reporting		**3**

We reviewed several operational and clinically focused documents, such as MOHLTC inspection reports, organizational charts, clinical policies and training materials.

The clinical charts reviewed included assessments, prescription charts, care plans, and progress notes of the 9 residents who were interviewed and who consented for us to review their clinical charts.

Results have been presented against the themes of local, provincial and federal domains, taken from the theoretical framework described in figure 1. Insights into global perspectives were limited. The quotations have been attributed to the participants groups of Managers (M); Staff (S); Residents (R); and informal caregivers (F). Documents reviewed are noted as DR. A summary of the findings can be seen in Table 7.

Table 7 Summary of Findings

Domain	Findings
Local	Awareness of the Ministry of Health and Long-Term Care Regulations The Impact Ministry of Health and Long-Term Care Regulations on Care Resident Assessment Instrument- Minimum Data Set Resources Local Approaches to Quality Improvement The Impact of MOHLTC Regulations on Local Policy The Impact of MOHLTC Regulations on Education
Provincial	Attitudes Toward Ministry of Health and Long-Term Care Regulations Provincial Influences on Quality Approaches to Regulation at a Provincial Level Impact of Provincial Regulations on Long-Term Care Ministry of Health and Long-Term Care Regulation Misaligned with the Provision of Care for Residents with Depression Provincial Influence on Education Strategies The Influence of Ministry of Health and Long-Term Care Regulations on Operational Decisions
Federal	Funding Impact of Media Attention Federal Role in Oversight of the Long-Term Care Sector

5.4.2 Local

The MOHLTC regulation process was a driver for many areas in the LTCH, including care issues, decision making, quality improvement, awareness of regulations, education, policy and resourcing. All these areas were identified by participants as having impacted on the lives of residents, informal carers, staff, and managers in the LTCH.

Awareness of the Ministry of Health and *Long-Term Care Regulations*

The MOHLTC regulations impacted on decision making at a local level but not all participants had the same level of understanding of the MOHLTC requirements. Participants were aware of the MOHLTC regulations to a lesser or greater degree. There were differences in understanding not only between different groups of staff, but also within these groups of participants. The differences in knowledge and understanding between health care professionals were not always aligned to seniority, which was highlighted by a senior staff member:

"Yeah, I know about the regulations, but can I tell you about it? No" [S2]

Registered staff are usually members of a regulated profession such as nurses or social workers, whose competency is defined by laws in a particular jurisdiction (Canadian Nurses Association, 2015; Ontario College of Social Workers and Social Service Workers, 2015). Registered staff with a clinical role also had an awareness of the MOHLTC regulations but had limited understanding of the process. In the document review conducted as part of this study, it was noted that all registered staff (such as Registered Nurses [RN] and Registered Practical Nurses [RPNs]) are required to have 'knowledge of the MOHLTC regulations' which is incorporated into their job descriptions: (DR 6 -7). Some groups had a clear impression on how the regulations might impact on care, as one staff member identified:

"if the ministry finds anything and they will ask questions of the staff, and even restorative stuff, like the wheelchair, seatbelt, and the restrains. They include

everything, even the meal service, the medication policy, and the care. They cover pretty much everything." [S4]

Residents, informal carers and staff also highlighted specific pressures which impacted on residents living in the LTCH because of MOHLTC regulations. Participants shared several instances of the rules which related to the timing of food service, and whilst this is not related to depression, it demonstrates the degree to which the LTCH must adhere to certain regulations. The document review corroborated that there were strict rules around food service, the length of time between meals and how residents were to be served food in the LTCH (DR 30 -31).

We noted that the staff was also aware of regulations which were related to high profile, critical incidents, in this case a reported death in another LTCH, which a member of staff relayed:

"One time I was working here, they came to check the railings of the bed, because of the news that somebody died in another facility. Somebody came to check the bed rail… So that it's safe for residents" [S3]

The Impact Ministry of Health and Long-Term Care Regulations on Care

Whilst there was a degree of insight into the purpose of the MOHLTC regulations, there was a lack of insight into what the regulations meant for care of people with depression living in LTCHs. The study found that at the local level, there was little insight into how regulations impacted on the care of residents with depression. When asked about whether regulation focused on depression in LTCH, staff participants were generally not sure, which was shared by a clinical member of the team:

"I'm not exactly aware about those things." [S2]

Managers, however, were generally more attuned to the impact of MOHLTC regulations on the care of people with depression, which was highlighted by one manager:

"We do the right assessments we have to; we have a depression scale and a behavior scale, and we look at each individual. Mostly we do it on all admissions and where there is a significant change in status. We also check it annually and every week we have a meeting about those things and we discuss residents according to that and then we try to figure out why the depression scale or the behavior is going up and down" [M2]

Resident Assessment Instrument- Minimum Data Set

In the document review we found several examples of the mandated Resident Assessment Instrument- Minimum Data Set (RAI-MDS) and how it guided staff within the LTCH in the completion of assessments, both in terms of what to complete and timeframes (DR 20-21). We found that this included the assessment tools for depression that LTCHs were obliged to use, as well as the frequency of their completion. One manager shared concerns about the frequency of using these tools which were mandated as part of the RAI-MDS system, but that they may not address resident needs:

"It's also not, in my view, necessarily timely. It's only every three months, that the outcome measures really get reported. It has to be done within 92 days…that's quite a long period of time." [M3]

One staff member highlighted how data from these mandated processes are intended to be used to inform clinical decision making, though they indicated they did not feel professionals should need to be guided in this way:

"We have our [professional] meetings the data produced will show us how many people on our floor have increased or decreased symptoms of depression. I'll have a glance at that, but I feel like I'm on top of things. But it's not how I practice [my profession], having to have some regulating body tell me" [S10]

Resources

Challenges with resources were a common theme throughout this study, especially the impact that the lack of resources had on the care of residents with depression. Staff described how multiple demands were made of them, which resulted in a lack of time available to understand residents' mental health needs, as well as being able to provide appropriate care to residents with depression. One member of staff shared:

"the only reason that she was able to vocalize with me she wasn't feeling her best, was that I kept checking and I was able to finally get what was really bothering her. Usually you don't have that because there is a time constraint. We don't mean to be task oriented. There's just so much to do." [S7]

More encouragingly, however, at a local level, individual staff appear to notice depressive symptoms in residents who they know well and felt empowered to discuss this with the multidisciplinary team. It was apparent in this study that this knowledge of the individual resident gives context to the data which are produced for managers in the LTCH. One manager explained how this helps:

"the Personal Support Workers know the resident, so we, as managers, would say 'So and so, they're depressed. What's going on?' They might say 'Oh, their husband actually passed away a few weeks ago.' " [M3]

We observed the level of activity and workload in the LTCH environment affects staff in their day to day roles, which has a subsequent impact on the care of residents with depression. Staff also reported that depression is not noticed when they are juggling other MOHLTC priorities from the regulations, as reflected in this comment:

"if a resident or an older person that is suffering from depression, it's sort of a silent diagnosis, I think they are negative symptoms. In long term care where the staff is so busy and where we are more focused right now on responsive behaviors -making sure that we're doing everything we can in that regard. I think there's a very good chance that there would be a resident with depression who just gets missed." [S5]

Funding that is specifically targeted to training and education was a specific aspect of resourcing which was highlighted in this study. Although the LTCH can decide its own education strategy, strategies were usually determined by the MOHLTC regulation. Aligning funding to meet priorities to ensure staff were equipped with the

knowledge and skills to enable staff to deliver care to residents with depression was seen by managers to be an important aspect of quality in caring for residents with depression in LTCH. However, depression as a specific issue did not feature in the orientation or mandatory training materials as they were focused on areas within the MOHLTC regulations (DR 3-5).

Local Approaches to Quality Improvement

Local compliance with MOHLTC regulations was seen to have an impact on how the team in the LTCH approached quality improvement. The LTCH in this study had an extensive Quality Improvement Plan, but participants suggested the MOHLTC inspection process distracted the team from reaching their goals. A staff member noted:

"the compliance inspections can divert your implementation plans so you may have it set - OK we're doing this by the end of January and then you get an unexpected visit from compliance and they have you headed off on a tangent" [S5]

Furthermore, whilst we noted that there was an emphasis on quality improvement in this LTCH, the Quality Improvement Plan did not include any strategies to improve the care of individuals with depression in the LTCH. The team explained the lack of attention to the care of residents with depression, suggesting it was the result of depression not featuring in the requirements of MOHLTC regulations, and so was not seen as a priority compared to other quality indicators which were mentioned by a manager:

"we are looking at quality improvement and trying to keep on improving, but depression's not an indicator. That's not something they ever asked. 'What about your people that have depression?'" [M1].

The Impact of MOHLTC Regulations on Local Policy

Policy development at a local level within the LTCH is directly influenced by the priorities laid out in the MOHLTC regulations. Depression did not feature in local guidelines or policy in the LTCH. One manager expressed his/her views:

"We have policies on wounds and skin, we have responsive behaviors, we have falls, we have restraints, but we don't have one on depression or mental health, right? I think it's something that's been overlooked… There should be something around mental health that includes depression, there is no focus on that because we're not a mental health institute? That's not the mandate of long-term care, but it's part of the person, right?" [M1]

Despite the local knowledge and understanding of the need to focus more on depression in LTCHs, this study found that depression, and associated issues, such as suicidality, were absent from some local policies such as Pain Management Policy or the Physicians role in Documentation Policy (DR 14; DR 16). A Suicide Risk policy is in place in the LTCH, but in the document review analysis, this was not seen to reflect the needs of the older residents in LTCHs and was more targeted to the risks associated with a younger population with suicidal risks (DR 13).

The Impact of MOHLTC Regulations on Education

Education to equip the LTCH workforce was an issue raised by many participants in this study and was felt to be a priority area which warranted appropriate investment. One resident suggested:

"a well-informed employee will produce a lot better for you. Because they can be held accountable and you can put it on their performance assessments. You can make them accountable, you know?" [R1]

A family member expressed his/her frustration that training opportunities were linked to the availability of resources:

"do you want to put somebody's life ahead of the mighty dollar?"[F2]

There were many opportunities for staff education in the LTCH, which included orientation, annual mandatory training, and in-service education (DR 3; DR 5). Staff participants described how education was focused on specific clinical priorities such as dementia and responsive behaviours, which they felt were influenced by the MOHLTC regulations. This focus was reflected in the document review of training schedules (DR 3-5; DR 9; DR 19) and was an issue highlighted by a senior nurse:

"Within the mandatory training there are subjects that must be covered and responsive behaviors is one of them, including dementia. I think because of our compliance issues right now we have been focused quite strongly on responsive behaviours." [S5]

The need for more specific training was noticed by care staff, who in some cases had taken steps to address gaps in their own knowledge. One participant shared his/her realization that he/she was not equipped to deal with the issue of suicidal ideation in the residents:

"I was reading the psychologists progress notes, I thought, 'Oh, my God, like this is brilliant.' He just really seemed to uncover how she was feeling, why she was feeling this way, and then identifying some possible strategies and resources for him. I thought, 'Wow, what would I do if I was confronted by somebody who wanted to commit suicide?' And I realized I just didn't have any skills or training, so I thought, okay, well, let' see if there's any training available." [S9]

Staff competency was noted by residents and was believed by them to influence their care. One resident summed up how she felt about the competency of staff in the LTCH in caring for people with depression:

"One, they're not trained. Well that goes along with it, they don't have the mental ability. Two, they're here to get their weekly or monthly money. And they don't care past that." [R6]

5.4.3 Provincial

This study showed how Ontario MOHLTC regulations had significant a role in how care was delivered to residents in LTCH in terms of attitudes, prioritises and approaches to regulation.

Attitudes Toward Ministry of Health and Long-Term Care Regulations

Attitudes towards the regulations varied according to the participant group. In general, informal carers welcomed inspections, staff felt it was somewhat onerous and managers were divided in their attitudes towards it. Some informal carers were able to recall a time where there was limited regulation in LTCHs, which they felt was detrimental to the sector. One informal carer reflected:

"Ministry regulations in Ontario are wonderful. I remember the time when there were no regulations. That wasn't a good thing. You'd be pulling people off the street to be looking after this vulnerable population." [F2]

However, whatever the attitude to the inspection process, the MOHLTC regulations and inspections were a prominent feature in LTCHs and was evidenced in the document review which revealed numerous mandatory inspections reports and protocols in the LTCH (DR 1 -2; DR 23- 25; DR 27 -33).

Provincial Influences on Quality

The LTCH in this study had an extensive Quality Improvement Plan which was influenced by priorities set by Health Quality Ontario (HQO). There was an assumption that HQO is attuned to the priorities in the sector, and the sector relies on them to navigate the current priorities. A manager shared insights into how this happens

"HQO is really the body governing improvements of the sector. We rely heavily on them to tell us, not at the home level, but at a provincial level, whether there are flags out there on certain issues, like depression. If we're not seeing things come down the

pipeline from places like HQO, who really should know what's going on, then they're telling us this is not as big an issue. Right?"[M3]

That said, depression as an issue in LTCH, was not seen to capture the attention of provincial policy makers, or feature in the MOHLTC regulations, which in turn has a direct impact on how care is delivered in LTCHs which is reflected in this comment:

"Depression is not sensationalized, unless you have a suicide. If a couple of long-term care homes had some suicides in a short period of time, I'm willing to bet it would be enough of a catalyst for HQO to say, 'maybe we should be looking at depression?'. But we haven't seen it" [M3]

Approaches to Regulation at a Provincial Level

Participants in this study agreed that the MOHLTC approach to regulation in LTCHs is based on a quality assurance model rather than a quality improvement model. This is evidenced by the MOHLTC inspection protocols, which are checklists on whether the LTCH has achieved aspects of the inspection (DR 28 -33). Indeed, in this study participants generally perceived the MOHLTC to be unsupportive and are not mandated to support the LTCH to improve quality, but rather to point out failures. One manager shared:

"They're not here to support the home. They're there to identify deficiencies in the home and make us very aware of it. It's not supportive or consultative. It's punitive. You don't want to tap the Ministry on the shoulder at all. It's all about head down, don't recognize us over here." [M3]

Some managers recalled the previous system of MOHLTC inspections and suggested there was more value placed on the relationships between the LTCH and individual MOHLTC inspectors. Participants recalled this approach was supportive and responsive, meaning the LTCH was able to approach the MOHLTC inspectors (formerly Compliance Advisors) for advice, which is a reversal in how they see the current system. A manager described this in their comment:

"*They used to be Compliance Advisors. You could call them and say, 'we're having this issue, do you have any advice, how can we meet the regulation?' They would talk about it. You had one advisor assigned to you, so you could build a rapport with them. But now they're inspectors and the regulations changed. You can't ask them. If you ask for any advice. They do an inspection on that issue." [M1]*

Participants suggested the current approach to MOHLTC inspection, is in part, governed by the political and social context of LTCHs, where there have been several high-profile reports of failures. A manager described his/her frustrations:

"There was a huge shift in the inspection process, prior to that we didn't have really clear inspection protocols. Our act changed, and with the act came in the increased inspection obligation. The Ministry probably needed to inspect more and advise less, but it just went total pendulum swing the other way. The ministry digs in and says, 'Yeah, see, we need these inspections. We need more penalties for these kinds of homes.'. Well, you're just reinforcing that whole cycle of inspecting and pointing" [M4]

Impact of Provincial Regulations on Long-Term Care

We did not find that the MOHLTC regulations had a positive role in the care of residents with depression. On the contrary, the study highlighted how the MOHLTC approach to inspection influences the care clinical staff can provide as they plan for the inspection and focus on the MOHLTC priorities which exclude depression, to satisfy inspectors. It was also suggested that staff may adjust their behaviour when they know the MOHLTC inspection is due to be carried out:

"We will discuss the priority issues, 'Okay, this is a situation coming up and the inspectors are coming.' I think it's a natural trickling down when you're being scrutinized. Institutions sometimes protect themselves. We're going to protect ourselves. And then that might affect care." [S8].

The focus on MOHLTC priorities and their effect on staff in the LTCH is noticed by residents who noticed changes in staff behaviour during MOHLTC inspections. One resident explained:

"When the inspectors have finished the staff go back to the way that they were doing things, they're on their best behaviour and then they revert to the normal practice" [R5]

Staff in the LTCH also reported feeling that the MOHLTC regulations were so onerous that it added to the workload in an already over-stretched service, which was a barrier to delivering care. They felt there was increased paperwork and documentation. A member of staff shared how they felt about the regulations:

"I don't like all the regulation honestly, like I don't understand the point of it. I guess it's to keep a certain baseline standard, but I think that it causes a lot of bureaucracy, a lot of bureaucracy. And I think that hinders good care." [S10]

It was perceived by participants that inspections happened on a frequent basis, which was seen in the document review in this study, where 6 MOHLTC inspections were carried out over a period of less than 2 years in the LTCH (DR 1-2; DR 23 -25; DR 27).

Ministry of Health and Long-Term Care Regulation Misaligned with the Provision of Care for Residents with Depression

This study highlighted many examples where participants felt that provincially mandated MOHLTC regulations were misaligned with the care needs of residents and were a barrier to providing care for people with depression, because staff felt they needed to be focused on other mandated priorities within LTCH. A senior nurse explained:

"I would say in the regulations that there may not be enough focus on depression itself. There's a lot of focus right now on agitation and physical abuse between residents which, you know may be triggered by a component of depression. I'm sure that our attention is really drawn to identifying that, and not seeing depression." [S5]

Informal carers of residents in the LTCH did not necessarily perceive depression to be a priority. One manager had noted that depression is not the focus of complaints and concerns raised by informal carers:

"Depression is something that families don't really get too concerned about. I don't really think I've ever had a complaint saying, 'my mom's depressed', It's more like, 'My mom had a fall' [M1].

Participants in this study described how the competing priorities in the MOHLTC regulations result in managers and staff continually balancing resources to be able to meet care needs in the context of finite resources. The competing priorities impact on the way they organize care for residents with depression, as it is perceived there is less attention paid to it at a provincial level, which is reflected in this comment:

"you have to set priorities based on resources that are available. There are 35 quality indicators that come out of RAI -MDS, you cannot tackle all of these and so you must set priorities based on resources that are available. But, if the ministry were to put their weight behind depression, we would be actioning depression much more than we currently are." [M3]

Participants generally agreed there were limited resources and less political attention focused on depression in favour of other initiatives in LTCHs, which was highlighted by one manager:

"depression is not the pressing issue within long-term care. The ministry doesn't tend to jump on issues like depression and mood and so it doesn't have as much weight.

Unfortunately, the pressing issue is people with responsive behaviors, potentially beating up other people. That gets a lot more political profile than the little lady staying in her room and suffering in silence, right? There's no political will to have that dialogue." [M4]

Provincial Influence on Education Strategies

Documents reviewed (DR 3-5) and participant interviews highlighted how education was focused on the MOHLTC regulations, rather than on education which would support them in caring for older people with depression. A staff member noted:

"we've never really had a training on just depression, for example like we've had our training on ministry expectations, but I don't think we had in-service training on other things, we should really be watching for, especially with seniors – we should really watch for depression you know." [S7]

Many participants, which included staff, managers as well as residents and informal carers, discussed education. Staff and managers felt that education about depression should be a separate item in the educational offerings, to ensure staff have the appropriate skills and knowledge to care for residents with depression. One manager reflected this, in their comment:

"There is a lot of education training around dementia and responsive behaviors. I know you can't talk about dementia and responsive behaviors without really covering a little bit of depression in there too, but it's not the same as providing education and training about depression" [M3]

We explored educational priorities in the LTCHs strategic plan and found that mandatory training requirements were directly influenced by the MOHLTC regulations. One manager shared how decisions around education were reached:

"We try to plan education based on what we feel are the priorities from complaints, surveys, and inspections. We just did an exercise a couple of weeks ago, the first thing we did was 'Hey, what are our mandatory training obligations? What's expected based on regulation and legislation?' [M3]

The Influence of Ministry of Health and Long-Term Care Regulations on Operational Decisions

Managers described how the MOHLTC regulations influence operational decision making. One example was relayed by a manager who shared an experience s/he had observed in a different LTCH, where a person had jumped from a window and died. The response to this incident was felt to be misaligned with clinical needs. Rather than addressing the root cause of incident, which was related to the recognition and assessment of suicide risk, the LTCH took physical measures to prevent residents from opening windows:

"A resident jumped and died. So, they changed the regulations around window opening. Because of the suicides where residents jumped out a window, the MOHLTC says let's just make sure the depressed people can't open a window anymore, which misses the point" [M1]

MOHLTC regulations were believed to be a driver for many of the operational decisions in the LTCH. This study highlighted how the MOHLTC regulations were a barrier to delivering person-centred care, especially where regulations restrict practices that affect how LTCHs develop their systems and processes:

"the downside is that some of the regulations are not person centred and in order to offer a person-centred approach, you really have to work around what the regulations says." [M1]

This lack of flexibility in the MOHLTC regulations has created tensions for some informal carers who have struggled to understand why care cannot be person centred. Although residents and informal carers did not specify how the MOHLTC regulations influenced the care of depression, they were able to share examples of how the regulations impacted on seemingly trivial matters, even as to what time salads were served. An informal carer shared their frustrations in this matter:

"I've had arguments with dietary services because the Ministry says you can't serve the salads till 5pm, so meantime all the salads are being dished out, and they're trying to get 17 people fed, so when meals come out, they're cold. I find it hard to believe that [the LTCH] can't go to the Ministry and say, 'Hey, this is what we're doing.' This is all because the ministry says you have two vegetables with your meal" [F4]

5.4.4 Federal

This study attempted to explore the federal influences on MOHLTC regulations in LTCHs, but we found there were limited insights around how federal issues impacted on MOHLTC regulations or the provision of care to residents in LTCH with depression.

Funding

Funding was a key issue at the federal level for many participants. All participants agreed that lack of funding was an issue in the LTCH sector. Although LTCHs are highly regulated and their performance is measured, the LTCH perceived they had little influence on how funding is apportioned to meet the needs of residents in their LTCH. A manager explained:

"Sometimes we get more federal funding that goes into the province, but the province decides how that's disseminated" [M1]

Indeed, the study indicated there was a disconnect between federal processes, funding and reporting in the LTCH, in that accountability for standards of care, was not seen to be the federal government's role. Participants were asked to describe the role of the federal government in improving the care of residents in LTCH with depression. Although they generally had limited insight, this response from an informal carer was typical:

"The federal government really only deals with funding, doesn't it? I don't know that the federal government could do anything other than money? What more could they do?" [F5]

It was suggested in this study that clinical staff working alongside residents in the LTCH are less concerned about budgets and funding, but more concerned as to whether they can maintain quality care and support residents. All staff with clinical roles have a range of obligations for providing care within their job descriptions (DR 6-

8), though staff often reported feeling frustrated at not being able to deliver care to residents with depression in the way they would want to. Many staff suggested that being able to spend more time with residents was needed to support someone with depression, and they saw limited resources being a barrier to this:

"we need to look after people on an individual basis. We need to be able to spend that time we need to get to know these people what they like? What they don't like? They deserve better than what we're able to give to be honest, and unfortunately we don't have the manpower" [S6]

Impact of Media Attention

Many participants suggested negative attention from the media, also impacted on how the LTCH sector prioritized the care of people with depression living in LTCHs. It was suggested the symptoms of depression are less likely to capture the attention of the national media, and as such the issue is not seen as a priority by the public:

"Depression is subtle. It's not in your face. It's not out there in the public. It's not in the media. The issues that are in your face, are those that unfortunately what gets the attention of everyone and the work follows." [M3]

Participants described the lack of external attention concerning the care of depression in LTCHs as a reason for an absence of policy direction and support. One manager reported how there was a lack of guidance from government:

"there's no real ... there's no legislative direction." [M4]

This study highlighted how reports of serious failures in the provision of care for residents in the LTCH setting have had an impact on the attitudes of staff and informal carers towards the MOHLTC regulations. A comments from a staff member reflected this:

"When families are aware of negative press, they'll put undue stress on the staff, there's more checking, the level of trust is not there. It's challenging, how much time do we really have to give them? It creates unnecessary barriers through distress and misunderstanding.

Yes, there are guidelines that we must meet, but it's not necessarily about providing care, it's about not being written up in the newspaper." [S8]

Informal carers in the study were confused about how to interpret MOHLTC inspection reports when the media had presented an opposing view to the inspection report relating to a specific LTCH. One informal carer was particularly concerned:

"The articles in the news have been fantastic. We need to read about that. We need to know the conditions, because [named LTCH] for instance was at the top of my mother's list, we went and visited it, it was a beautiful facility, I spoke to some of the residents when they went in, they said they were very happy to be there. And then you read these horror stories…"[F5]

Federal Role in Oversight of the Long-Term Care Sector

Participants were asked for their opinions on what could be done at a federal level to improve the care for people with depression living in LTCH and whether it would be possible to regulate these measures. There were several similar responses to this question, which normally included ensuring there was appropriate resourcing, which would allow staff to provide the care that they felt was necessary to the residents. One staff member stated:

"Staff who like their jobs, and who are well paid for it, and who come to work and want to give good care and not think, 'I'm just getting paid minimum wage to wipe somebody's poop.'

People who feel valued and feel like they're contributing to the well-being of other human beings. Provide a positive community and a positive environment. And I think that goes for mental health anywhere." [S10]

A suggested approach to raise the profile of depression in LTCHs, on the federal agenda, was to engage the LTCH sector and its external agencies in research and development:

"The other way you might be able to do it, is to focus more from the research perspective, we may be able to work with the Centres for Learning, Research and Innovation, get them to do a program and publish, that sort of thing. But again, depression is not where the focus is."[M4]

5.4.5 Summary of Findings

The findings in this study highlighted how the MOHLTC regulations were a driver influencing many aspects of care provision as well as organizational decisions in the LTCH. We also noted that despite MOHLTC regulations being a significant factor in the LTCH, the knowledge of the regulations was variable, even amongst more senior staff. The approach to how MOHLTC regulations are implemented was found to impact on all participants in the LTCH. They were seen by staff, residents and managers, to be intrusive, onerous and restrictive and, in many ways, hindered person-centred approaches to care. Informal carers interviewed felt regulation was warranted, with some advocating for increased regulation.

We found that depression in LTCHs was not perceived to be a priority at a provincial level, which was influenced by several factors, including the lack of attention depression receives from the media and policy makers, and how the illness itself presents with more subtle symptoms in older people. Despite the LTCH team appreciating the significance of depression in the LTCH, the lack of attention paid to depression at the provincial level influences the way that the LTCH prioritises depression in its care provision, policy development and education for staff. Federal and global influences on the care of people with depression were less significant to participants, and very little time was dedicated to looking beyond provincial boundaries as to what was happening in the LTCH sector beyond Ontario.

5.5 DISCUSSION

5.5.1 Depression as a Priority in Long-Term Care Homes

Many participants acknowledged that depression ranks as a lower priority compared to other aspects of care in the LTCH, which was described in the literature (Mental Health Taskforce, 2016; Proctor, Hasche, Morrow-Howell, Shumway & Snell,

2008). Our study highlighted a variety of attitudes towards the care of residents with depression, from an experienced RN who did not feel depression was a widespread issue, to other participants who were committed to supporting residents, and even undertook study on depression and suicide, at their own cost. Staff attitudes to supporting people with depression has been identified as an important aspect of care (Dening & Milne, 2009; Mellor, Kiehne, McCabe, Davison, Karantzas & George, 2010; Mellor, Davison, McCabe, & George, 2008; Snowdon, 2010). It has been suggested that Personal Support Workers (PSWs) do not have the skills or positive attitudes to support residents with depression in LTCH (Kramer, Allgaier, Fejtkova, Mergl, & Hegerl, 2009; Snowdon, 2010). In our study we found that PSWs not only recognized depression, but also contributed to a wider understanding of why the resident may be depressed by sharing those insights with the multi-disciplinary team. Furthermore, residents recognized how certain PSWs were highly committed to supporting residents, some arriving on-duty early, with the sole intention of being able to spend quality time with them when they knew they were feeling depressed.

At the provincial level, there was minimal interest in depression in LTCHs, and subsequently there was little guidance or direction for the sector. Although there are forums where LTCH administrators can advocate for residents' needs, such as their LTC professional associations, our study found that the LTCH industry as a whole looks to government funded agencies for guidance on priorities for improvement efforts (Health Quality Ontario, 2015a, 2015b).

Participants in our study acknowledged that depression was a significant issue in the LTCH, however if depression is a known problem at a local level, which is supported in the academic literature, it raises the question of why it does not feature more prominently on the public, media, provincial, federal, and global agenda?

In this study it was apparent that within LTCHs there was very little time dedicated to issues on the global agenda which influence regulation and care of residents with depression. Staff and residents were aware of the burden of an aging population, and the potential impact this has on LTCH, suggesting they were attuned to external pressures. Participants did not indicate how global perspectives of aging and depression might influence legislation and subsequently regulation in LTCHs. We observed that most participants were not able to explain where the current MOHLTC regulations had originated, and what had driven the development of some priorities over others. One area which may have influenced the development of regulation in LTCH is the tendency to adopt a medical model of care in LTCHs. This belief was echoed by several participants, even though they recognized LTCHs were trying to move away from this philosophy of care.

Is the lack of focus on depression in LTCHs a reflection of other issues relating to the sector? Could the overall lack of attention towards depression in LTCHs be a reflection on how mental health problems are seen in society, including the attitudes and stigma relating to mental health (Corrigan & Bink, 2017). Research relating to the care of older people with depression, found stigma to be a barrier to individuals accessing mental health services (Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014), which could be exacerbated in the LTCH where older people feel less likely to report depression, for fear of negative associations (Barg, et al., 2010; Chapman & Perry, 2008; Walker, Lofton, Haynie, & Martin, 2006). Interestingly in this study, we had significant challenges in recruiting informal carers and family members to participate in the study, despite several different approaches to engage them. Is this indicative of a general lack of interest in depression, or that people do not feel depression is a problem and did not feel the study was relevant to them? Could families and carers be

disengaged because of the high burden caring has on individuals (Steinhauser et al., 2006), thus affecting their willingness to get involved in research?

5.5.2 Funding

Funding presents a challenge in the LTCH sector (Snowdon, 2010) and was also highlighted as a challenge for LTCHs in this study. Limited resources and funding issues in the LTCH meant that operations were affected both in terms of system level issues and care delivered to residents. Clinical staff were continually balancing what care they were able to deliver, with what care they would have like to deliver to residents with depression. On most days PSWs were providing care for up to as many as 10 people per shift and cannot spend time supporting residents who are depressed. Higher ratios of PSW or nurses to residents is widely considered in the literature to be associated with improved quality (Dellefield, Castle, Mcgilton, & Spilsbury, 2015; Seblega, Zhang, Unruh, Breen, Seung Chun & Wan, 2010), and is often a measure of quality which is used by families, residents (Garcia et al., 2012) and advocate groups (Mor, Miller, & Clark, 2010). However a shortage of care hours means there is limited time to assess residents with depression which is known to be a complex process (Kjølseth & Ekeberg, 2012; Simons, Connolly, Bonifas, Allen, Bailey, Downes & Galambos, 2012; Wu, Schimmele & Chappell, 2012). Furthermore, evidence suggests that the assessment of depression should not be a one-off exercise (Harris, Caswell, Woods, Gibbs, Mackay, Maloney-moni & Pye, 2011; Registered Nurses' Association of Ontario [RNAO], 2010). Arguably, assessment should be person centred, which is linked to improved outcomes for residents (Brownie & Nancarrow, 2013) and is associated with quality in LTCHs (Edvardsson, Watt & Pearce, 2016). The literature suggests older people who are newly admitted to a LTCH are at risk from a new or worsening depression (Boyle, Roychoudhury, Beniak, Cohn, Bayer & Katz, 2004;

Neufeld, Freeman, Joling & Hirdes, 2014; Pullen, 2016) and therefore screening and assessment should occur in a timely manner. However, in our study, no participants were aware of any increased vigilance relating to the residents' mood in the first weeks and months at the LTCH, which arguably could result in depression being under recognized at a particularly risky time.

Whilst managers had the freedom to develop their financial plans as they deemed appropriate in the LTCH, they are acutely aware of resource constraints, balanced with the need to comply with MOHLTC regulations. Managers commonly focused on the structural issues of organizing care, such as budgets and compliance, rather than focusing on outcomes of care, though we found that they had little choice to but to attend to MOHLTC regulations. The continual tension between compliance with the MOHLTC regulations and exploring other aspects of care, meant they had little flexibility to focus on what matters to residents at a local level (Ferrino, 2013; Lai, 2015).

An area that was highlighted in this study by participants was whether funding in LTCHs is out of step with the changing needs of the sector. The population in LTCHs has become increasingly complex (Canadian Institute for Health Information, 2011). People move into a LTCH at a much later stage in their life, when there is increased chronic ill health (Ontario Long Term Care Association, 2016) and many residents in LTCHs have acute, palliative, and end of life care needs (Ibrahim & Davis, 2014). Arguably funding has not kept pace with these changing needs (Daly & Szebehely, 2012), and especially in this study where we highlighted that meeting MOHLTC regulations meant further demands on already limited resources. Whilst LTCHs continue to focus on the priorities in MOHLTC regulations, this is likely to result in depression in LTCH continuing to be under recognized (Barg, et al., 2010) and

undertreated in LTCH (Dow et al., 2011). This, in turn could impact on suicidal risk (Barnes, Veith, & Raskind, 2017; Marcus, Yasamy, van Ommeren, Chisholm & Saxena, 2012; Murphy, Bugeja, Pilgrim, & Ibrahim, 2015) and quality of life (Sivertsen, Bjørkløf, Engedal, Selbæk, & Helvik, 2015).

5.5.3 MOHLTC Regulations as a Driver for Decisions in Long-Term Care Homes

This study highlighted the level of importance which managers and staff placed on MOHLTC regulations. It was apparent when discussing regulations within the LTCH, that they focused primarily on MOHLTC regulations, often at the expense of other issues, including depression. Although the MOHLTC regulations were a driver for a range of issues in LTCHs, many clinical staff had little insight into what the regulations entailed, except that they happened at regular intervals and that they were important. The extent to which the MOHLTC regulations had a role in the care of residents with depression was not clear to clinical staff caring for residents.

The study showed MOHLTC inspections were a cause of stress and distress for most participants, in the main because the approach to the inspections in LTCH are based on a deterrence (Daly, 2015a) or quality assurance approach, which focuses on what the LTCH fails to achieve. Participants felt that adopting this approach creates a level of distrust between the MOHLTC and the LTCH (Ferrino, 2013; Walshe, 2001). The literature describes how this formal, sanctions based approach to quality, can achieve rapid change (Ferrino, 2013; Walshe, 2001), but has led to defensive behaviour in LTCHs. In our study rather than feeling able to discuss an issue with inspectors, the LTCH felt they should not raise any issue which might result in further scrutiny. A more collaborative approach, where there is a balance between sanctions and a development focused approach could be more effective (Ferrino, 2013; Walshe, 2001).

The findings in this study reflect recent literature, which shows families support the regulations (Lai, 2015) whereas staff find the approach time consuming (Daly, 2015a; Ferrino, 2013). However, we found in this study that residents felt the MOHLTCH inspection process to be intrusive, as well as raising concerns that practice reverts to its normal state after the inspections. If the increasing inspections are carried out using a deterrence approach (Ferrino, 2013), but there continues to be alarming reports describing the breakdown of quality services in the LTCH sector, is the approach working and should be continued?

The most significant drawback of the MOHLTC regulations driving the care and organizational environment in LTCHs, is that in this study we found that regulations were misaligned with the needs of residents with depression living in LTCHs. One example is the RAI/MDS which is the basis for most assessment and care planning, within which there was minimal attention paid to depression except for a rudimentary scale within the RAI /MDS. The Depression Rating Scale in the RAI/MDS has not performed well against other depression rating scales (Anderson, Buckwalter, & Buchanan, 2003), with concerns it is not an adequate measure (Penny, Barron, Higgins, Gee, Croucher & Cheung, 2016). If depression is not measured using an appropriate scale then it may never be accurately reported at a provincial level and therefore may not become a priority in the policy agenda. Following on, if it is not a priority in the provincial agenda, it will not be prioritized within the MOHLTC regulations, which will lead to LTCHs not focusing their resources on depression. The same is true for the lack attention which depression in LTCHs generates in the general population. In a study of the general population, Coppens et al. (2013) suggest the stigma towards depression impacts on how people seek help and that public media campaigns should focus on these matters. Although depression has been studied extensively and has been shown to

be a significant issue in LTCHs (Ellard et al., 2014; Knight, Davison, McCabe & Mellor, 2011; Smallbrugge et al., 2005), it has not captured the attention of the local and national media in the same way as other more sensational news items, such as incidents of resident on resident abuse, poor care provision, and resident abuse by staff. These type of incidents feature in the MOHLTC inspections, but issues related to depression do not (Ministry of Health and Long Term Care, 2007).

This study highlighted how managers and staff in the LTCH organized care services and prioritised their resources in line with MOHLTC regulations. Depression was featured as a part of the "responsive behaviour" agenda, which is which is primarily a range of behaviours such as wandering, aggression, resistance to care, and inappropriate behaviours (Alzheimer's Society of Ontario, 2010). In this study, responsive behaviours were a priority for the LTCH. In several interviews exploring support for residents with depression, staff and managers described interventions which were part of responsive behaviour protocols. However, responsive behaviours do not focus on depression, with literature suggesting they are associated with dementia (Alzheimer's Society of Ontario, 2010). Whilst policies are in place to address responsive behaviours in the LTCH, there was no policy to guide staff in the care of people with depression. Furthermore, depression was not incorporated into polices where it might be expected to feature, such as the policies on the management of pain or care at the end of life, where the assessment of depression is recommended as best practice (Brignell & Tigchelaar, 2009; RNAO, 2013; 2011). A suicidality policy was available in the LTCH but this was more focused on a community-based population and therefore would not have adequately guided the staff on what they should do to assess this risk and provide appropriate care to an older person with suicidal ideation living in a LTCH, which might require a multi-level approach, looking at population approaches,

risk reduction and support in the aftermath of suicide (O'Riley, Nardoff, Conwell, & Edelstein, 2013).

5.5.4 Limitations

As with all research there were limitations in this study. We chose to use a single site for the study, based on an instrumental case study design. Whilst we could have chosen to explore several cases to offer different perspectives, we chose to focus on a single case to have deeper, multiple perspectives of the case, giving us greater insights to address the research question. Whilst there are several types of LTCHs in Ontario, from profit to non-profit, rural versus urban and different sized LTCHs, all must meet the same requirements set by the MOHLTC, and we felt assured that any site would have enabled us to address the research question.

A further limitation in this study might have been not to have included a MOHLTC inspector, who carries out the inspection in the LTCH. The decision not to interview an inspector was deliberate and based on several issues. First, instrumental case study methodology explored the case, which is this study was our site, to understand an external phenomenon, in this case the role of regulations on the care of residents with depression. Additionally, at the outset of the study we had not restricted the study to MOHLTC regulations, this was an outcome of how participants interpreted the notion of regulations. As such, the study used the inspection reports for the LTCH in the document review to gain insights into the process.

We expected to have more success in recruiting informal carers and family members, and despite the various strategies we employed, we were not able to interview the numbers of carers we anticipated. There were less carers in and around the LTCH than the research team expected. There may have been many reasons for this, including whether people are fatigued in the caring role, or whether our recruitment

strategies were ineffective for this group of participants. There is room for further research in the areas of recruitment, particularly of informal carers, in the LTCH setting to ensure their voices are heard in research.

5.6 CONCLUSION

This study explored the role of regulation in the care of older people with depression living in a LTCH in Ontario, and whether regulations made a difference to care for residents with depression in the LTCH sector. We found that whilst there are various accreditation bodies which are involved with the LTCH sector, the MOHLTC regulations were the primary concern for managers in LTCHs.

The study highlighted how most clinical staff and managers, were aware that depression was an issue for many residents and were motivated to provide care and support to these residents. However, there were several barriers which prevented staff from delivering care to their residents. Not surprisingly, time, resources and funding presented barriers to caring for people with depression, but these areas were influenced by the priorities which were set at a provincial level.

MOHLTC regulations were a driver for most operational decisions as well as clinical care priorities for residents. The focus on the MOHLTC regulations has meant that issues, such as depression do not feature as key priorities for the LTCH sector, and as such care of older people with depression in LTCH is seriously under resourced. Despite the provincial government driving the quality agenda in LTCHs through regulatory frameworks, most of the accountability to maintain quality is directed at a local level on the individual LTCHs. This means that the LTHC has no choice but to focus its attention and resources on the specifics of the MOHLTC regulation, even if they know that depression is a problem for residents which remains unaddressed.

Regulations in LTCHs are an important element of quality improvement and monitoring, this research questions whether the approach taken to improve quality for residents with depression is the most effective. Quality assurance approaches to inspections dominate the landscape of inspections within the LTCH sector, but serious problems with quality remain in many jurisdictions. Is there scope to explore different approaches to regulation across Canada, perhaps by developing a model of regulation where the federal government has an increased profile in setting standards across the Canadian LTCH industry? Should the accountability for delivering quality and reaching those standards rest at the provincial level, where the provincial government can act as conduit for understanding provincial needs and apportioning funding? Shifting accountability for meeting standards to a provincial level, might allow flexibility to adjust budgets to meet specific local needs. Literature has highlighted that a responsive approach to regulation, which is hybrid of deterrence and compliance approaches, is more effective in it allows for inspectors to use more formal approaches or to adopt a more supportive role, dependant on the needs of the LTCH (Ferrino, 2013; Walshe, 2001).

There are several avenues for future research in this area, including research to explore the role of regulation on depression in other national and international jurisdictions as well as exploring the impact of MOHLTC regulations on care in other health care settings.

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CHAPTER 6: INTEGRATED DISCUSSION

6.1 INTRODUCTION

This final chapter presents an integrated discussion of our research, which incorporates the manuscripts which have been submitted to academic journals, and a modified version of the Extended Quality Framework which was adapted as a result of this research. The contribution this research makes to nursing and healthcare knowledge and policy is described, concluding with the limitations of the study and ideas for future research.

6.2 SUMMARY OF SUBMITTED MANUSCRIPTS

This thesis presents two articles which have been submitted and formatted for peer review journals. The first article in chapter 2, which was submitted to BMC Geriatrics, presents a systematic scoping review of the literature, examining the concepts of regulation, LTC and depression in order to explore the role of regulation on the care of older people with depression who are living in LTC.

A search strategy for peer-reviewed literature was developed in consultation with a subject expert librarian, searching relevant databases to identify studies including: Embase (using the OVID platform); MEDLINE (using the OVID platform); Psych info (using the OVID platform); Ageline (using the EBSCO platform); and CINHAL (using the EBSCO platform). Seven-hundred and seventy-eight unique articles were retrieved and screened by at least two reviewers. Twenty-one articles were included in the final review and data were charted by one reviewer with quality control checks undertaken by a second reviewer.

The 21 articles retrieved in the scoping review were grouped into 3 themes: regulatory requirements, funding issues, and organizational issues. The articles revealed evidence that regulation in LTC has been linked to quality (Ferrino, 2013), although Lai

(2015) argues it does not necessarily have a positive impact in the care of older people with depression. The articles retrieved in the scoping review identified how administrators in LTCHs are often so preoccupied by meeting the standards which are mandated, that they are limited in what other quality initiatives they can implement (Kim et al., 2014; Lapane & Hughes, 2004). This manuscript describes the complexity in LTC (Ontario Long Term Care Association, 2018) and the many demands on administrators and the team, including meeting regulatory requirements, though the scoping review identified that these regulatory requirements were often inconsistently interpreted across different jurisdictions (Holtkamp, Kerkstra, Ooms, van Campen, & Ribbe, 2001; Huang & Carpenter, 2011; Linkins, Lucca, Housman, & Smith, 2006).

It was noted that, despite existing evidence in the literature describing the prevalence of depression in LTCH residents (Ellard et al., 2014; Knight, Davison, McCabe & Mellor, 2011; Smallbrugge et al., 2006) and evidence of improved treatment regimens for older people with depression living in LTCHs (Conn et al., 2008; Registered Nurses' Association of Ontario [RNAO], 2010), regulation in the LTC sector has not always captured this evidence, best practice and contemporary knowledge which could be implemented. Indeed, in our study we found that regulation was misaligned with funding incentives as well as there being organizational barriers, such as electronic health records (Bao, Eggman, Richardson, & Bruce, 2014). Our findings from the scoping review highlighted how there is a need for further exploration around the role of regulation on the care of older people with depression living in LTCHs and whether regulation can improve care for this population.

The second article, in chapter 3 of this thesis, was formatted and submitted to the Canadian Journal of Ageing and presented the findings from a study where we sought to understand what regulation is in place to support the care of older residents

with depression living in LTCH, and how regulation supports or hinders improvements in the care of older residents with depression living in LTCHs. In this submitted manuscript we chose to highlight the 3 key themes from the data for the study, which were MOHLTC regulations as a driver for decisions, funding, and depression as a priority in the LTCH sector.

The role of regulation in the care of residents with depression is an area of research which has the potential to contribute to the care and well-being of a significant number of older people living in LTCHs. The literature has consistently agreed that the prevalence of depression is high in older people living in LTCHs (Ellard, et al., 2014; Knight, et al., 2011; Smallbrugge et al., 2006) . Depression in LTC is associated with loneliness (Barg et al., 2010; Kjølseth & Ekeberg, 2012; van Beek, Frijters, Wagner, Groenewegen, & Ribbe, 2011), physical ill health (Bruce et al., 2002; Cummings, 2002), and suicidality (Kjølseth & Ekeberg, 2012) .

In our study we investigated the role of regulation in the care of older people with depression living in a long-term care home in Ontario by addressing the research question: “What is the role of regulation in the care of older people with depression living in a Long-Term Care Home in Ottawa?”. We used instrumental case study methodology (Stake, 1995), and interviewed LTCH managers, staff, informal carers and residents. We also reviewed operational documents, such as inspection reports, organizational charts, policies, training materials, and clinical charts, which included electronic records, progress notes and prescriptions. A significant finding in our study was that whilst there are several agencies which have a role in quality improvement in Ontario, including Accreditation Canada, Health Quality Ontario (HQO), and Local Health Improvement Networks, in our research participants interpreted our questions about regulation to be the MOHLTC regulations and the inspection process which takes

place at least annually in every LTCH in Ontario (MOHLTC, 2007). Other forms of inspection, accreditation and regulation were rarely mentioned by participants.

Our research identified that MOHLTC regulations and inspections were a driver for many operational and clinical decisions in the LTCH, and that these regulations influenced strategic decisions, educational priorities, resourcing decisions and direct care (Walton, Krisjanous, & Crick, 2014). Whilst the research findings showed that the LTCH was committed to the care of residents with depression, they had little time to implement quality initiatives of their own choosing as the MOHLTC regulations were so onerous there was no time to consider quality outside of the identified mandated areas (Ferrino, 2013; Lai, 2015). The participants also identified that because depression was under recognized (Barg et al., 2010; Pachana et al., 2010), often because there was limited education in the sector relating to depression, which was consistent with what has been previously reported Dow et al., 2011), it had not captured the attention of the policy makers at a provincial level. Consequently, despite their own residents needing additional support, balancing time and resources were a constant struggle due to ongoing funding challenges in the sector. This was reflected in the literature (Snowdon, 2010; Taylor et al., 2003). The findings from this study supported conclusions, which were also identified in the scoping review, where it was suggested that an alternate approach to regulation in LTCHs might offer a more collaborative approach which would enhance quality (Lai, 2015; Lobel, 2012). This research concluded that accountability for standards of care are currently focused on the performance of the LTCH at a local provider level (Walshe, 2001), but might instead be directed at the provincial government who could have responsibility for the outcome of inspections and where the federal government role is to include oversight of the province's performance in improving quality. In addition, our research found that an

approach which is supportive, collaborative and works in partnership with LTCHs is needed to enable them to not only achieve the standards set out in regulations (Ferrino, 2013; Lai, 2015; Lobel, 2012; Walshe, 2001), but also to improve the care of residents with depression.

6.3 INTEGRATED DISCUSSION OF THE RESEARCH

This research first examined the literature around the concepts of LTC, older people, depression and regulation. Our systematic scoping review highlighted that even though the individual concepts are extensively described in the literature, there as was a paucity of evidence which examined the role of regulation on care of residents with depression living in LTC.

Our scoping review highlighted that extensive regulation in this sector does not necessarily impact positively in the care of older people with depression. Although depression is not specifically cited, a program to improve care in mental health in USA nursing homes studied the effectiveness of the OBRA (1987) legislation, which in the USA led to the implementation of the Preadmission Screen and Resident Review (PASARR) program (Borson, Loebel, Kitchell, Domoto, & Hyde, 1997; Taylor et al., 2003). However, the efficacy of the program has been challenged (Linkins et al., 2006).

The current approaches for inspection in Ontario were initiated following the passing of the Long-Term Care Homes Act (2007), which was instigated to improve parity in funding and approaches to how quality standards for non-profit and for-profit providers were implemented across the sector (Daly, 2015; MOHLTC, 2007). Compliance with standards, in order to achieve quality in long-term care is important for several reasons. There have been several reports describing failures in health and LTC in recent history, which have, in part, contributed to the increased interest in

quality improvement across the health and LTC sectors (Francis, 2013; Lloyd et al., 2014; Mor et al., 2010; OECD, 2013).

Lai (2015) noted that the public discourse which has emerged in relation to the intense media reporting on the challenges in the provision of quality care in the long-term care sector, is focused on aspects of care, such as abuse, restraint, violence and aggression in residential care, and quality of care. There is pressure on governments to develop corrective actions to address problems in order to achieve quality and improve care. Similarly, Mor et al. (2010) suggest that governments have a role in monitoring services where the consumer is not able to discern the difference in quality, particularly when this involves vulnerable populations who are easily exploited. However, it could be argued that deterrence approaches are somewhat paternalistic. However, given that LTC in Canada is funded from both the private and public purse (Daly, 2015; Macdonald, 2015), arguably it should be subject to oversight and accountability to an elected legislative body (Walshe, 2001). Current MOHLTC inspections adopt an approach aligned to a quality assurance model or a deterrence-based approach, where the inspectors are looking to find areas of non-compliance (Lai, 2015) despite suggestions that a deterrence approach has been found to have inconsistent outcomes for standards (Greenfield & Braithwaite, 2008; Mor et al., 2010).

It is widely accepted that inspection processes in LTC facilities are demanding, and result in LTCHs being preoccupied with the standards they are required to meet (Lai, 2015), with little time to think about quality (Huang & Carpenter, 2011; Kim et al., 2014). Additionally, it was evident in our study that depression is not a priority at the provincial level with regards to reporting requirements, except for the completion of the depression rating scale in the RAI / MDS, which arguably is rudimentary and not an adequate measure of depression (Anderson, Buckwater & Buchanan, 2003; Murphy et

al., 2005; Penny, Barron, Higgins, Gee, Croucher & Cheung, 2016). Since time and resourcing in meeting the demands of the MOHLTC regulations is often an issue, what role is there for data and reporting in the inspection processes which might relinquish some burden for LTCHs and inspectors in this process? Many of the relevant studies retrieved in the scoping review originated in the USA and most of these articles related to funding arrangements, mainly via Medicare and Medicaid.

The authors of articles retrieved in the scoping review within this study agreed that the LTC population is increasingly complex (Canadian Institute for Health Information, 2011) and that LTC is a highly regulated environment (Berta, Laporte, & Wodchis, 2014), often operating in the context of serious funding challenges (Snowdon, 2010; Taylor et al., 2003). Arguably, the regulatory content and process has not been aligned to the changing needs of the sector (Daly & Szebehely, 2012). A further issue which adds to the complexity is that many LTCHs are operating in a business environment, with shareholders and a 'bottom-line' to consider (Walton et al., 2014).

This study was underpinned by our Extended Quality Framework which incorporated a multi-level approach to quality (Banerjee & Armstrong, 2015) and the seminal work of Donabedian's structure, process and outcome model (Donabedian, 1966). Donabedian's framework has been widely accepted to assess quality outcomes in healthcare and as the basis for evaluation and research (Dellefield et al., 2015; Gardner, Gardner, & O'Connell, 2013; Parry, 2014; Sardasht, Shourab, Jafarnejad, & Esmaily, 2014). However, Donabedian's work might not account for the dynamic context of the LTC environment (Daly, 2015; Ferrino, 2013) or the contextual and complex social framework in which quality exists (Keleman, 2003; Wyer, Alves Silva, Post, & Quinlan, 2014). The Extended Quality Framework explores the domains of structure, process and outcome along with global, federal, provincial, and local perspectives, and is adapted from

the work of Banerjee & Armstrong (2015). It has added value to the quality theory suggested by Donabedian (1966) by placing the accountability for quality at the appropriate level within the LTCH landscape and the opportunity to explore quality in LTC at a local level.

The implementation of MOHLTC regulations was described by participants in our study to be based on a deterrence approach; this was also noted in the literature (Daly, 2015; Ferrino, 2013). Although it has been suggested that deterrence approaches to quality can achieve rapid change (Ferrino, 2013; Walshe, 2001), they have been critiqued as they assume that organizations are breaking the rules (Walshe, 2001). In our study it was highlighted how this approach resulted in the LTCH staff team with direct care responsibilities behaving defensively. In our research, managers and staff explained how the MOHLTC regulations and inspections resulted in them feeling they were not trusted, which was supported in the literature (Banerjee & Armstrong, 2015; Daly et al., 2016; Greenfield & Braithwaite, 2008; Lobel, 2012; Walshe, 2001). Indeed, many participants with a direct care role shared how they were afraid of the MOHLTC inspections because they felt under increased scrutiny.

Arguably, deterrence approaches to regulation are not associated with improving quality, as they are not able to respond to the dynamic nature of caring (Banerjee & Armstrong, 2015; Daly et al., 2016). Indeed, in our study, managers and staff participants described how they would welcome a more responsive approach to regulation and felt this would be more aligned to improving quality for residents with depression. Staff and managers described how the absence of a collaborative relationship with MOHLTC inspectors meant they felt unable to seek advice in helping them to meet standards and expectations; they hoped that MOHLTC inspectors would be more supportive and less punitive. Indeed, managers and staff described how they

actively avoided any such interaction with the MOHLTC for fear this would lead to further scrutiny in the inspection process. In a multi-disciplinary care setting where people are living with depression, being able to share concerns within the professional team is associated with reducing and managing risk (Royal College of Psychiatrists, 2018). Arguably, if LTCHs could share their concerns with inspectors this potentially could reduce risks in people living with depression in LTCHs and improve health outcomes by taking a collaborative approach to challenges.

In our research, we also noted that the current approach to MOHLTC regulations were perceived by staff and families to be intrusive, and to hinder person-centred approaches to the care of residents. Person-centred care (Brooker, 2004) in LTCHs is often the goal of many models of care in the sector which have been shown to have a positive impact on quality in long-term care (Lum, Kane, Cutler & Yu, 2008; Owen, et al., 2012; Zimmerman & Cohen, 2010; Røsvik, Kirkevold, Engedal, Brooker, & Kirkevold, 2011). Indeed, the principles of person-centredness are arguably better aligned to more responsive approaches to inspection (Lai, 2015; Lobel, 2012), given the regulations have limited scope for care to be organized in an adaptive and flexible way to meet the needs of residents.

In our study, most of our participants held negative perceptions about MOHLTC regulations, however, some participants had a more positive attitude towards the MOHLTC inspection process in the LTCH. We noted that families and informal care givers were more inclined to support increased regulation in the LTCH as they felt this was a means to uphold standards and achieving quality. Mor et al. (2010) researched attitudes of providers, consumer advocates and federal officials in the USA, and found that consumer advocates favoured more aggressive regulations and standards to improve quality. Indeed, not all staff in our study understood why MOHLTC regulation

were perceived as so onerous. One manager suggested if direct care staff could use the MOHLTC regulations as a guide to help them achieve quality in their roles, it would not seem to be an additional burden. Arguably, this is an optimistic view given the limited resources in the LTC setting (Snowdon, 2010; Taylor et al., 2003), where personal support workers (PSWs) in our study regularly had to care for 10 to 12 residents per day.

One area we aimed to explore in our study was how the participants from the LTCH believed that global and federal influences affected the mandated regulations. Despite efforts in interviews to facilitate discussions which might offer insights into federal and global issues, most of our data were focused toward local care delivery and provincial governance. Using the Extended Quality Framework as our guide (see Appendix 10), we made a determined effort to discuss federal and global influences, but these were not a priority in all participant groups. Whilst we might have predicted a limited outward facing perspective of the environment from some participants, such as direct care staff, we were surprised that senior staff and managers were not able to share some insights regarding global and federal issues. Overall, these issues were not high on their agendas, and we found that managers and senior staff looked to the provincial government and province-wide agencies (such as HQO) for guidance on LTCH priorities when they were developing their quality improvement plans or being informed on the current priorities for quality in the LTC sector.

In our research, managers did not feel that depression was on the agenda of agencies such as HQO, which they interpreted to mean that depression and suicidality were not deemed to be a significant risk that the LTCH needed to act on; subsequently it did not feature in local quality improvement plans or policies. However, it was evident in this study that there was an overwhelming tendency in the LTCH to align

local policies with the MOHLTC regulations, and again, because depression is not a priority for the MOHLTC regulations, it did not feature in LTCH policies. Arguably, this could have contributed to a lack of training for staff and a general reduced awareness from a policy perspective.

Why is depression in LTCHs not a priority? There is existing knowledge which describes the serious impact of depression in LTCHs, such as the prevalence of depression in older people living in LTC (Ellard, et at., 2014; Knight, et al., 2011; Smallbrugge et al., 2006), a failure to report symptoms (Barg et al., 2010; Burroughs et al., 2006), its recognition being impeded by other complex physiological issues (Dow et al., 2011), and it being seen as a normal part of ageing (Dow et al., 2011; Pachana et al., 2010). Our research found that the LTCH attended to issues which were a priority within MOHLTC regulation, which resulted in less time and resources allocated to the care of residents with depression (Mental Health Taskforce, 2016; Proctor, Hasche, Morrow-Howell, Shumway, & Snell, 2008), even though it was acknowledged to be an issue for many residents in the LTCH. In response to the limited insights into federal and global issues regarding depression in LTCHs, we explored the requirements of other agencies which might also influence and offer guidance on depression standards in LTCHs (Accreditation Canada, 2017; Canadian Medical Association, 2017). For instance, although a large percentage of LTCHs are accredited with Accreditation Canada, in our study external accreditation agencies were not mentioned by participants as a source of information on standards with regard to any areas of care, not least depression, even though Accreditation Canada does briefly mention the notion of suicide risk assessment as one of its required organizational practices (Accreditation Canada, 2017). This finding was particularly interesting as these external accreditation agencies are often used by LTCHs in their marketing and promotional material

(Murakami & Colombo, 2013). We also examined whether Accreditation Canada could offer any guidance for the care of older people with depression, from their international division, but this was not seen.

In our research, where we were aiming to understand the role of regulation in the care of older people with depression living in LTCHs, is a global perspective necessary? Can a global perspective help to improve the care of people with depression living in a LTCH? Perhaps the most effective influence from a global perspective in terms of quality might be reflected in how the MOHLTC approaches regulations and inspections currently and exploring how other approaches might reflect the dynamic LTC environment. There are several international initiatives which are committed to working in partnership across different provider and / or government organizations to develop quality in the LTC sector (IOM, 2010; World Health Organization, 2002; 2003). These initiatives, though not specifically linked to depression, offer 'permission' for providers to work collaboratively to improve quality. In our study we found the LTCH has limited insight of issues beyond their jurisdiction, except for links with LTC associations. For instance, there seemed to be limited evidence that best practice might be shared across LTCHs or that there are other strategies which can be shared across different LTCHs which enable LTCHs to meet their regulatory obligations but at the same time offer individualised care to residents who are living with depression. However, the literature argues that the regulatory obligations are so onerous and that there is little time for quality initiatives because of the demands of the regulatory framework (Ferrino, 2013; Lai, 2015). Arguably, by understanding the broader context, LTCHs could be better prepared for the challenges, barriers and opportunities which face the sector in terms of providing quality care for residents (Ontario Long Term Care Association, 2018).

Following our research, a modified version of the Extended Quality Framework was developed, which places 'local' as a domain as the first perspective, moving to provincial, federal, and then global domains. The rationale for this modification was based on various factors. First, this study showed that despite reports of poor care in LTCHs over the past 30 years (IOM, 1986; Kane, 1995; MOHLTC, 2007), we found there was a commitment in the LTCH from most staff, managers, and families towards improving quality in LTCHs; we were keen to respect the perspectives of the teams working in the LTCH. Second, by placing 'local' as the last domain in the original Extended Quality Framework, it focused on the accountability for performance at the local level, that is, placing responsibility for quality inequitably across the LTCH landscape. Third, in the modified Extended Quality Framework, the shift in emphasis provides the opportunity for local needs and expectations of residents, families and staff to drive decisions about quality for LTCHs. An individualized approach to regulations, rather than the current approach which adopts a quality assurance model to maintaining quality, offers a framework which is more aligned to the notion of person-centred care in the LTCH. Finally, the original Extended Quality Framework interpreted the local domain as the provision of clinical care that is delivered by staff. The modified Extended Quality Framework interprets 'local' as much more than delivering care, by establishing the quality perspectives and needs of all stakeholders at a local level and interpreting those needs into meaningful ways to monitor and improve quality. Failure to capture the local perspectives could result in the issues which are the most important to residents and families not being captured as a priority at a provincial level, where the regulations are determined.

Appendix 11 outlines the modified Extended Quality Framework, and the following section discusses the framework and explores how this shift in emphasis can contribute to improving quality for people with depression living in LTCHs.

6.4 THE EXTENDED QUALITY FRAMEWORK

This study found that the needs of residents living in LTCHs were misaligned with the priorities set out in the MOHLTC regulations. We found there appeared to be a disconnect between the needs of residents and, as shared by participants, the areas which were highlighted within the MOHLTC regulations. This disconnect was seen in several operational decisions which participants described, some of which were a barrier to person centeredness and were contrary to what the care that staff wanted to provide for residents (Benjamin, Rankin, Edwards, Ploeg & Legault, 2016). These included how the MOHLTC regulations required the LTCH to adhere to seemingly minor areas such food service, where there were perceived 'rules' as to the time that salad was served with dinner, or the time which elapsed between meals. However, the care of residents with depression was not seen as a high priority in the MOHLTC regulations. This lack of attention to depression resulted in the LTCH having no clinical policies in place to guide staff in measures they should take when supporting residents with depression. Indeed, the need to be mindful of depression in other care scenarios, such as pain and care at the end of life (Brignell & Tigchelaar, 2009; RNAO, 2011; 2013), was not featured in the clinical polices of the LTCH.

Managers and staff participants interviewed in our study agreed that the inspection process was onerous and was focused too heavily on the local providers of LTC. Ironically, due to the deterrence approach to inspections (Ferrino, 2013; Lai, 2015), have little influence on how MOHLTC regulations are implemented in their LTCH, or being able to have more flexibility for implementing quality initiatives in their own

LTCH to meet local needs and challenges which are most relevant to their own population. Adopting an individualized approach to inspections would offer an opportunity for inspectors to examine the issues that affect residents and families, as well as what matters most to residents and families. Furthermore, if the limited resources in LTCHs could then be targeted to those identified areas it has the potential to truly engage them in quality improvement. This level of adaptability would benefit the care available to people living with depression. Most participants in this study believed that depression was an issue for many residents in the LTCH who would benefit from support in order to be assessed and offered treatment appropriate to their needs. Staff and managers in our study expressed how they wanted to provide support to residents with depression, but they perceived that the low priority assigned to depression by the MOHLTC in LTCHs was a barrier to providing support.

Based on the findings of this study, we propose that the province could have a different role within our modified Extended Quality Framework. The provincial government could act as a conduit by translating local need, as identified by stakeholders, into improved quality by adapting the MOHLTC regulations at a provincial policy level and by influencing their implementation in the LTCH setting. Having an adaptable approach would enable those LTCHs who are already meeting their fundamental obligations in the regulations to extend their quality improvement obligations within the MOHLTC, as well as to supplement this by setting additional quality priorities, which would gain positive recognition for the LTCH. Taking a continuous quality improvement approach to regulation would offer the sector an opportunity to adopt a proactive approach towards quality (The Health Foundation, 2013).

Our research offered limited federal perspectives and it was clear that LTCHs do not invest energy into these federal issues. The federal domain in the Extended Quality Framework presents an opportunity for LTCH teams to understand the national perspectives regarding quality, to avoid repetition and to have a more organized approach to peer learning strategies by looking towards other LTCHs and beyond for innovative or best practice ideas. If the federal government had oversight of how each MOHLTC in every Canadian province maintains quality in LTCHs, they would have the opportunity to look at quality in the LTC sector to ensure that different provincial governments are working together effectively with LTCHs to achieve quality. This would provide an opportunity for understanding what challenges are on the horizon for the sector, understanding for what practices might be shared across different jurisdictions, and exploring and exploiting opportunities for peer learning. The significant impact of change to current practice would be that the provincial government and other provincial-wide agencies would share accountability for quality in the LTCH sector. This would share accountability for quality with the local providers, rather than most of the focus of inspections being levied at a local level.

6.6 CONTRIBUTION OF THE RESEARCH

6.6.1 Implications for Nursing and Healthcare Knowledge of Depression in LTCHs

Our study has contributed to nursing and healthcare knowledge in LTCHs by developing an improved understanding of the role of regulation in care of older people with depression living in LTCHs. Adopting a constructivist approach to the study allowed participants to shape the research by sharing their experiences of the role of MOHLTC regulations in the care of residents with depression in LTCHs. Staff, families, managers and residents who participated in the study had an opportunity

during their interviews to reflect on their own experiences of depression, which meant they were able to offer insights into how the care of depression was influenced by the MOHLTC regulations. Using a constructivist perspective was especially significant given we were keen to include insights of the residents living in LTC, which is a group that is sometimes overlooked as participants in research in LTCHs (Mackin, Herr, Bergen-Jackson, Fine, Forcucci & Sanders, 2009), albeit it with good intentions to protect older people who might be vulnerable.

In this study, we highlighted how many staff, across a range of disciplines, working in the LTCHs were dedicated to improving the care for residents with depression. Contrary to some literature (Kramer, Allgaier, Fejtkova, Mergl, & Hegerl, 2009; Snowdon, 2010), we found that personal support workers (PSWs), as a group, were highly committed to residents in their care who were depressed, and understood their needs. However, although PSWs were highly involved with care, they were the least informed of the participant groups about the importance of or content of MOHLTC inspection protocols. This finding meant that although PSWs were the group delivering the most direct care, they had limited insight into how their role was influenced by the MOHLTC regulations, and vice versa. Our study also noted that although staff with a direct care role had access to a variety of mandatory training provided by the LTCH, none of the training included any formal training for the care of people with depression. We argue that this is a gap in educational offerings for the PSW workforce, which is seemingly influenced by the MOHLTC regulations. Arguably, our research highlighted that there should be increased awareness and education for all staff in LTCHs to equip them in recognizing depression, as well as to understand their role in reporting. Education for staff should also convey how depression should be a consideration in meeting the needs of residents with conditions and care needs where

depression could be a factor, such as management of pain (RNAO, 2013), end of life care (RNAO, 2011) and loneliness.

6.6.2 Implications for Policy

Our research highlighted that some areas of care which were featured in the MOHLTC regulations were prioritized, whereas others, such as depression, were largely absent at a policy and regulatory level. Our research presents an opportunity to review the content of mandatory training and aligning this with the most current knowledge on the care of residents with depression. Our study also highlighted how residents, families, staff and managers are impacted by the MOHLTC regulations in terms of the time and effort invested into the process (Daly, 2015; Ferrino, 2013; Lai, 2015), and the emotional impact of regulation, such as reduced trust (Walshe, 2001) or the lack of respect for care staff (Banerjee & Armstrong, 2015; Daly et al., 2016). Our findings suggest a need to review the MOHLTC policies on how regulations in LTCHs are approached and what is included within them, so that the issue of depression is prioritized and aligned with what is known from contemporary research, existing knowledge and best clinical practice. We propose that an inspection process which reflects the importance of depression for residents living in LTCHs, which was highlighted in this study and is well supported in the literature, is needed so that operational and clinical decisions are driven by the most contemporary and relevant knowledge about depression. Arguably, this is an essential step given that the care delivered in LTCHs is driven by the requirements set out in the MOHLTC regulation. We also noted in the study that participants shared their preference to move away from a model which is based on failure and mistrust (Lobel, 2012; Walshe, 2001), to a participatory, collaborative approach which would empower residents in LTCHs to have a

right to influence their own life choices (Kane, 1995; Knight et al., 2011), which is linked to positive outcomes for older people (Boyle, 2005; Brownie, 2011) and has been seen in other jurisdictions, where healthcare inspectorate fulfil monitoring and advisory roles (Mot et al., 2010; Steering Committee Responsible Care, 2007). We suggest there is an opportunity to explore regulation in LTCHs using the Modified Extended Approach to Quality, which builds on the work of Donabedian (1966) and Banerjee & Armstrong (2015).

Under the current arrangements for MOHLTC inspections, there is little room for creativity or innovation in LTCHs because of the emphasis on rigid approaches to achieving quality, which drive the MOHLTC inspection process and, consequently, many operational decisions (Colón-Emeric et al., 2010; Walton, Krisjanous, & Crick, 2014).

6.7 CONCLUSION

In its current state, the care of residents with depression in LTCHs is not reflected in the MOHLTC regulations and inspections, suggesting that the current MOHLTC regulations in Ontario make little difference to the care of older people living with depression living in LTCHs. There is scope for regulations to be amended to reflect the individual needs in the LTCH which are identified by residents and families, and so capturing the issues that matter to those people living in the LTCH.

6.8 LIMITATIONS OF THE STUDY

As with all research, we have identified limitations in our study. Our decision to choose a single LTCH as a site for our case study, rather than multiple sites, could be viewed as a limitation. However, by using an instrumental case study design meant that we were able to explore the issues within the research using a deep-dive approach and to examine multiple perspectives of the case (Stake, 1995). This approach, in turn, gave us much richer insights into the aims of the research and the ‘issues’ stated at the outset.

Another potential limitation was the 'type' of home which we selected for the research site. There are several categories of LTCHs in Ontario. First, ownership of LTCHs in Ontario is categorized as 'for profit', 'not-for profit', and municipally owned and operated homes. Second, LTCHs are classified as either 'rural', 'urban' or 'northern'. Third, and finally, LTCHs are also classified by size, depending on the number of beds they have. Arguably, we could have attempted to have a multiple site study, which would have included a range of sizes, location, and ownership status. However, choosing a LTCH was not based on these factors as all LTCHs are obliged to meet the same requirements which are set by the MOHLTC, and as such we felt assured that any site would have enabled us to address the research question. In addition, as we adopted an instrumental case study methodology, we were confident that we would be able to offer the time and commitment to undertake our research using the deep dive and multiple perspective approach described in this methodology (Stake, 1995) with a single LTCH.

Our research was designed from a constructivist perspective, and we were keen to interview a range of different stakeholders who were involved in the LTCH. We expected to have more success in recruiting higher numbers of informal carers and family members for interviews but were not able to interview the numbers we had anticipated. In our discussions as a research team and during reflections about data collection we examined potential reasons for this. We found there were less carers present in the public areas of the LTCH, where we were on hand to present the research to interested potential participants, than the research team had expected. There may have been many reasons to explain this, including family fatigue in the caring role or people entering LTCHs at a later stage in their lives when the length of time caring and the burden on caregivers is greater than it was earlier in the course of the resident's

condition (Ontario Long Term Care Association, 2016). Despite utilizing various strategies to engage with family members, including increasing information about the study, changing poster design to be more eye catching, direct approaches, and being referred by other staff members, we still had lower numbers of informal caregiver interviews than we envisaged. That said, during our recruitment we were mindful that our recruitment practices needed to be sensitive to our obligation to remember that the LTCH is the residents' home and that appropriate boundaries need to be observed.

We found that the data collected in the study provided rich insights into the role of regulation on depression in older people living in LTCHs. We also found that although issues relating to global perspectives were discussed as part of the interview with all participants, there was generally limited opportunity for staff and managers working in the organization to look outwardly at the broader picture of LTC from either a national or international perspective. This meant there were few insights to share on this. However, further insights into the federal and global perspectives might have been highlighted if the study were to have included participants who were responsible for policy development and MOHLTC inspectors within the sector. For example, interviewing a MOHLTC inspector might have offered insights into the approaches to undertaking MOHLTC inspections and their attitudes towards the quality assurance versus quality improvement approach. In this study we might have sought out other participants, but we were expecting managers and senior staff to have more knowledge of the outward facing perspectives than was the case.

6.9 FUTURE RESEARCH

Given the challenges with recruitment of informal carers, there is potential to conduct research on successful recruitment of informal carers in LTCHs to ensure that the voices of all stakeholders are represented in research. As a future platform for

research, there is scope to further investigate whether an alternative model of inspection could be implemented in partnership with the provincial government as a means to test whether using the Extended Quality Framework and an individualized approach to inspections would be successful in meeting the requirements set out in regulation, but would offer scope for flexibility and a more collaborative approach to improving quality in LTCH. Future research might also be conducted on other aspects of care within LTCHs which may have limited representation in MOHLTC regulations or be a lower priority in the LTC sector. These issues might include areas such as understanding the impact of loneliness or other mental health problems, such as anxiety.

6.10 RESEARCH TEAM

The roles and contributions of collaborators and co-authors in development of this dissertation are described in Appendix 12, in accordance with the guidelines of the Faculty of Graduate and Postdoctoral Studies at the University of Ottawa (2016).

6.11 STAKEHOLDER AND FUNDING ACKNOWLEDGEMENTS

As a PhD candidate MC participated in seminars and received critical feedback from peers, mentors and stakeholders on her proposal and early research findings.

MC received the following funding support for her dissertation work:

1. Awarded $5000 from the Doctor Maria O. Leite-Ribeiro Scholarship in June 2017
2. Awarded $15000 from the Ottawa Graduate Scholarship (2018 – 2019)
3. Awarded tuition support from the University of Ottawa as part of benefits awards to sources of faculty professors (2015 -2019).

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APPENDICIES

Appendix 1 – Definitions and Terms

Regulation -A rule or directive made and maintained by an authority (Oxford English Dictionary). Regulations are principals, rules, or laws which are generally prescriptive originating with governmental agencies at the federal, state, and local levels, and carry the weight of the law (NAHQ, 2016).

Care- Care is described as "the provision of what is necessary for the health, welfare, maintenance, and protection of someone or something." (https://en.oxforddictionaries.com/definition/care). It is a complex, multi-dimensional concept (Jackson & Borbasi, 2000) and has been described as the essence of nursing (Leiningen, 1988), setting nursing apart from other healthcare activities (Jackson & Borbasi, 2000). Care has been described as patient centred, and is based on dignity, respect and collaboration (Cardillo, 2010). Individuals who receive care experience ease, protection and maintenance of their dignity (Mashek & Aron, 2004).

Depression – Depression is a term that is used to describe a series of signs and symptoms influencing the affect of a person. The World Health Organisation (www.who.org.int) defines depression as "a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration. It can be long lasting or recurrent, substantially impairing a person's ability to function at work or school, or cope with daily life. At its most severe, depression can lead to suicide."

Long Term Care: 'a home like facility that provides care and services for people who are no longer able to live independently or who require onsite nursing care, 24-hour supervision, or personal support'. (www.nursing homeratings.ca). Long term care does not necessarily relate

to older people. In this proposal, it refers to facilities which might be identified as nursing homes, rest homes, residential care, aged and residential care or care homes. This is not an exhaustive list.

Older people – Defining old age is context specific. It is hard to place a number on old age as it is a very subjective issue; what is ‘old’ to some people would not seem that way to others. In western societies, it is generally thought of as 65 years of age and over. (www. WHO.org; www.servicecanada.gc.ca). In this study the term ‘older people’ will refer to people who are sixty-five years and older.

Appendix 2 – Abbreviations Used

Abbreviations Used

CNA	Certified Nurse Aide
GDS	Geriatric Depression Scale
HQO	Health Quality Ontario
LTC	Long-Term Care
LTCH	Long-Term Care Home
LTCHs	Long-Term Care Homes
MDS	Minimum Data Set
MOHLTC	Ministry of Health and Long-Term Care
OBRA 1987	Omnibus Budget Reconciliation Act (OBRA) of 1987
OLTCA	Ontario Long-Term Care Association
PASARR	Pre-Admission Screening and Annual Resident Review Program
PSW	Personal Support Worker
RAI / MDS	Resident Assessment Instrument / Minimum Data Se
RNAO	Registered Nursing Association of Ontario

Appendix 3-Inclusion and Exclusion Criteria for Selecting "The Case"

Criteria	Inclusion	Exclusion
LTCH will be situated in Ottawa region, Ontario.	✓	
Large LTCH – beds over 100 [average number of beds in LTCH in Champlain LHIN = 113] (Ontario Association of Non-Profit Homes and Services for Seniors, 2015)	✓	
LTCH for older people.	✓	
Range of levels of nursing care.	✓	
Agreement from organization to allow access to facility.	✓	
Commitment from senior management (who are clear on the demands and expectations of being involved in the research).	✓	
Management team are familiar with organizational structures and processes (for example accreditation or inspections).	✓	
Experienced Director of Care (in role for a minimum of 3 years).	✓	
New facility and/ or inexperienced director of care (less than 3 years).		✓
Primarily English-speaking facility.	✓	

Appendix 4 – Information Forms

uOttawa

Université d'Ottawa | University of Ottawa
Faculté des études supérieures et postdoctorales | Faculty of Graduate and Postdoctoral Studies

An Introduction to this Research

This leaflet has been written to give you information about my research, which is being undertaken as part of my PhD studies at the University of Ottawa.

Why is the research being undertaken?

The purpose of this study is to explore how regulation in long-term care influences the care of older people with depression, living in those facilities in Ontario. Regulation is a rule or directive made and maintained by an authority, often originating from government or authority.

We know that…

- There are high numbers of older people in long-term care who are living with depression.
- Having depression increases risks to an older person's physical and mental well-being.
- There are increases in depression as people get older, and this is made worse by social issues and chronic ill-health.
- Having depression increases the risk of having suicidal thoughts and of wanting to harm yourself.
- There is lots of research that shows that the treatment and recognition of depression could be better in long-term care.

This Research will try to understand…

- What regulation is in place (in the long-term care facility) to care for older residents with depression?
- How does regulation affect the nursing care of older residents with depression living in long-term care facilities?
- How does regulation support or hinder improvements in care for residents in long-term care facilities in relation to the care of depression?

Making a Contribution.

This research will contribute to the knowledge of nurses working with older people who are living with depression in long-term care facilities. It will enable nurses and other members of the healthcare team, working in the long-term care sector, to be better equipped to improve the quality of services offered to this population. Understanding the influence of regulation in long-term care on the care of older people with depression living in LTC has the potential to contribute to future quality improvement processes in long-term care facilities at both a local and a policy level. The findings of this research will be relevant to owners of long-term care facilities, directors of care, mangers, policy makers, communities, informal caregivers, and older people living in long-term care. The study has the potential to improve the experiences of older adults living in long-term care, who have depression or low mood.

How can I get involved?

Participation will consist essentially of attending one 30 – 60-minute interview to discuss my experiences of how this long-term care facility provides care for residents with depression or low mood.

What other information will the researcher be collecting?

The researcher will collect information about the facility from policies and procedures; and when permission from a resident is given, by reviewing the medical chart.

Will information be kept safe?

Most research must have ethical approval, which means this research has been approved by the Health Sciences and Science Research Ethics Board at the University of Ottawa. The Ethics Board will only approve an application if the researcher has made provision to protect participants and to keep their information safe. All information shared will remain strictly confidential.

More information?

If you would like to have more information about this research, please contact Michelle Crick.

By calling [number withheld] or by emailing [email withheld], or you can speak to [name and number withheld], Vice President of Nursing, for further information or to arrange to meet me.

Many thanks,

Michelle Crick

Appendix 5 – Information Poster

Are you a family member or friend of a resident who has lived at [name withheld] for a minimum of 3 months?
Would you like to be involved in a doctoral study about how regulation influences care in long-term care?
Could you give an hour to participate in a study looking at how long-term care facilities recognize and treat residents with depression?
If you answered "yes" to these questions, I would like to hear from you. I can be contacted on [number and email withheld].

Appendix 6 – Interview Schedules

Semi-Structured Interview Schedule: LTC Facility Staff

a). Script at start of the interview:

"Thank you for giving me the opportunity to explain more about my research, which is being undertaken as part of my PhD studies at the University of Ottawa.

The purpose of this study is to explore how regulation in long-term care influences the care of older people living with depression, living in those facilities in Ontario.

This interview is expected to last between 30 – 60-minutes. It is an opportunity for you to share any experiences of how this long-term care facility provides care for residents with depression or low mood. This could mean sharing your own experiences or sharing ideas and thoughts about what you have noticed. There are no right or wrong answers.

I will be using a recording device during the interviews. I will also make notes. I am happy for you to listen to the recording or see any notes I make. I will take care to keep notes and recording confidential.

Whilst your insights are valuable, participating in this interview is entirely voluntary. You are free to stop the interview at any time if you would like to have a break. All responses are confidential, and any information you share will remain strictly confidential."

b). Interview Prompts

Interview Schedule	**Prompts**
Experience, length of service, qualifications	Role in facility – job, position, and time held, leadership, education? Qualified – as what? Where? How long?? Time worked here.
What regulation is in place to care for older residents with depression living in LTC facilities?	How do staff get involved with the care of residents with depression on a day to day basis? How is care of residents with depression affected by how the LTC facility is operated (think about environment; staffing levels; the way that staff in different roles might work with people who are low. e.g. Registered Nurses vs. Personal Support Workers). What happens in this LTC facility that improves the care of residents with depression or makes things better?
How does regulation support improvements in the care of older people with depression living in LTC?	Examples of ideas that improve the quality for people with depression living in this facility. Examples of how you are involved? How do you think these things are helpful for residents with depression? Can you think of a resident with depression? How might they present? Symptoms? What works well? What is supportive about this? What resources are available to support people with depression in the LTC facility? (think about: activities; other specialist visits; family involvement; better staffing levels; nicer environment; better food).
What regulation hinders improvements in the care of older people with depression living in LTC?	Does how the LTC facility is operated affect how you do your job about helping people who are depressed? (think about environment; staffing levels; the way that staff in different roles might work with people who are low. e.g. Registered Nurses vs. Personal Support Workers)? Can you think of a resident with depression? Can you describe them and how the depression affects them? What about the LTC facility might prevent good care for that resident? What resources would improve support for people with depression in the LTC facility? (think about: activities; other specialist visits; family involvement; better staffing levels; nicer environment; better food).
What other influences affect care of people with depression in LTC?	Are you linked with other facilities? Best practice sharing programmes? What are the national and international issues in LTC? Is there an opportunity to be more aware?
Sociodemographic information	Age Gender
Have I missed anything?	
THANK YOU!!	

Semi-Structured Interview Schedule LTC Facility: Director of Care / Managers

a). Script at start of the interview:

"Thank you for giving me the opportunity to explain more about my research, which is being undertaken as part of my PhD studies at the University of Ottawa.

The purpose of this study is to explore how regulation in long-term care influences the care of older people living with depression, living in those facilities in Ontario.

This interview is expected to last between 30 – 60-minutes. It is an opportunity for you to share any experiences of how this long-term care facility provides care for residents with depression or low mood. This could mean sharing your own experiences or sharing ideas and thoughts about what you have noticed. There are no right or wrong answers.

I will be using a recording device during the interviews. I will also make notes. I am happy for you to listen to the recording or see any notes I make. I will take care to keep notes and recording confidential.

Whilst your insights are valuable, participating in this interview is entirely voluntary. You are free to stop the interview at any time if you would like to have a break. All responses are confidential, and any information you share will remain strictly confidential.
If you are happy to proceed, I will ask you to read and sign a consent form. If you have any questions, please ask."

b). Interview Prompts

Interview Schedule	**Prompts**
Experience, length of service, qualifications	Qualified – as what? Where? How long? Role in facility – job, position, and time held, leadership, education? Time worked here. Other experiences. Previous managerial experience.
What regulation is in place to care for older residents with depression living in LTC facilities?	How are clinical staff deployed to support the care of residents with depression day to day? How is care of residents with depression affected by the organizational structures and processes (think about environment; staffing levels; roles e.g. Registered Nurses vs. Personal Support Workers). What organizational structures and processes enhance care of residents with depression?
How does regulation support improvements in the care of older people with depression living in LTC?	Examples of quality initiatives. Examples of how you are involved? (e.g. quality strategic planning; accreditation). How do you think it makes a difference to care? What quality initiatives are there in place in the facility? (Think about – training, supervision). Can you think of a resident with depression? How might they present? Symptoms? How do you ensure the clinical team is equipped to support people with depression and low mood in this facility? What works well? What is supportive about this?
How does regulation hinder improvements in the care of older people with depression living in LTC?	Think about – training, involvement in quality projects, supervision. Can you think of a resident with depression? How might they present? Symptoms? What could be implemented in the organizational structures and processes to improve this? What resources would improve support for people with depression in the LTC facility?
What other influences affect care of people with depression in LTC?	External factors? Global influences? What issues are there on the horizon for the sector? Do you work in partnership with other facilities? Is there best practice sharing programmes? What are the national and international issues in LTC?
Sociodemographic information	Age Gender
Have I missed anything?	
THANK YOU!!	

Semi-Structured Interview Schedule LTC Facility: Residents

a). Script at start of the interview:

"Thank you for giving me the opportunity to explain more about my research, which is being undertaken as part of my PhD studies at the University of Ottawa.

The purpose of this study is to explore how regulation in long-term care influences the care of older people living with depression, living in those facilities in Ontario.

This interview is expected to last between 30 – 60-minutes. It is an opportunity for you to share any experiences of how this long-term care facility provides care for residents with depression or low mood. This could mean sharing your own experiences or sharing ideas and thoughts about what you have noticed. There are no right or wrong answers.

I will be using a recording device during the interviews. I will also make notes. I am happy for you to listen to the recording or see any notes I make. I will take care to keep notes and recording confidential.

Whilst your insights are valuable, participating in this interview is entirely voluntary. You are free to stop the interview at any time if you would like to have a break. We can continue the interview later; at a future date and time, or alternatively, you may wish to not continue with the interview. You do not have to give a reason, and whatever you decide will not affect any aspect of the care you are receiving in this facility. All responses are confidential, and any information you share will remain strictly confidential.

If you are happy to proceed, I will ask you to read and sign a consent form. If you have any questions, please ask."

b) Interview Prompts

Interview Schedule	**Prompts**
Personal story	How long have you lived here? What brought you to living in this facility? Personal experience of low mood or depression (describe)
Personal experience of low mood or depression.	How did you feel when you first moved here? Adjustment issues? Did you feel low; sad; emotional? Did anyone notice these feelings? How was the issue addressed? What did they do about how you felt? Did you share your worries / concerns about your low mood; sadness; depression with anyone else? – who? why? Did you feel about the care you received in relation to low mood or depression? NOT PREVALENCE. TO UNDERSTAND HOW CARE IS PROVIDED.
What regulations are in place to care for older residents with depression living in LTC facilities?	Do you notice how the care staff are involved with the care for other of residents with depression day to day? Does how the LTC facility is operated affect how care staff help people who are depressed? (think about environment; staffing levels; the way that staff in different roles might work with people who are low. e.g. Registered Nurses vs. Personal Support Workers)?
How does the organization implement processes CURRENTLY which support improvements in the care of older people with depression living in LTC?	Can you think of a resident with depression? How might they present? Symptoms? What works well? What is supportive about this? What resources are available to support people with depression in the LTC facility? (think about: activities; other specialist visits; family involvement; better staffing levels; nicer environment; better food).
How might the organization implement processes which support improvements in the care of older people with depression living in LTC?	Are there any examples of how you think the facility should have supported people who are affected with low mood or depression, or how the facility might have better supported you? What could the facility do to support people with depression? Can you describe whether residents and informal caregivers are asked to get involved in making things better / making improvements in the facility?
Sociodemographic information	Age Gender
What other influences affect care of people with depression in LTC?	Do you know if the facility works with other LTC facilities to improve quality; make things better? What are the issues for you which affect this setting? – e.g. funding issues in relation to quality; Is there an opportunity to be more aware?
Have I missed anything?	
THANK YOU!!	

Semi-Structured Interview Schedule Families of LTC Facility: Informal Caregivers of Residents

a) Script at start of the interview:

"Thank you for giving me the opportunity to explain more about my research, which is being undertaken as part of my PhD studies at the University of Ottawa.

The purpose of this study is to explore how regulation in long-term care influences the care of older people living with depression, living in those facilities in Ontario.

This interview is expected to last between 30 – 60-minutes. It is an opportunity for you to share any experiences of how this long-term care facility provides care for residents with depression or low mood. This could mean sharing your own experiences or sharing ideas and thoughts about what you have noticed. There are no right or wrong answers.

I will be using a recording device during the interviews. I will also make notes. I am happy for you to listen to the recording or see any notes I make. I will take care to keep notes and recording confidential.

Whilst your insights are valuable, participating in this interview is entirely voluntary. You are free to stop the interview at any time if you would like to have a break. We can continue the interview later; at a future date and time, or alternatively, you may wish to not continue with the interview. You do not have to give a reason, and whatever you decide will not affect any aspect of the care you are receiving in this facility. All responses are confidential, and any information you share will remain strictly confidential.

If you are happy to proceed, I will ask you to read and sign a consent form. If you have any questions, please ask"

b). Interview Prompts

Interview Schedule	Prompts
Personal story	How long has your relative lived here? What brought them to living in this facility? Personal experience of low mood or depression (describe) Adjustment issues? Did they feel low; sad; emotional? Did anyone notice these feelings? How was the issue addressed? What did they do about how they felt? Did you share your worries / concerns about their low mood; sadness; depression with anyone else? – who? why? Did you feel about the care they received in relation to low mood or depression? NOT PREVALENCE. TO UNDERSTAND HOW CARE IS PROVIDED.
What regulation is in place to care for older residents with depression living in LTC facilities?	Does how the LTC facility is operated affect how care staff help people who are depressed? (think about environment; staffing levels; the way that staff in different roles might work with people who are low. e.g. Registered Nurses vs. Personal Support Workers)?
How does the organization implement processes CURRENTLY which support improvements in the care of older people with depression living in LTC?	Are there any examples of how you think the facility supports people who are affected with low mood or depression, or has the facility supported you? Describe any processes in place which enables residents to offer support to others who are affected by low mood or depression. Describe any invitation to be involved in quality processes or initiatives in the facility?
How might the organization implement processes which support improvements in the care of older people with depression living in LTC?	Are there any examples of how you think the facility should have supported people who are affected with low mood or depression, or how the facility might have better supported you? What could the facility do to support people with depression? Can you describe whether residents and informal caregivers are asked to get involved in making things better / making improvements in the facility?
What other influences affect care of people with depression in LTC?	Do you know if the facility works with other LTC facilities to improve quality; make things better? What are the issues for you which affect this setting? – e.g. funding issues in relation to quality; Is there an opportunity to be more aware?
Sociodemographic information	Age Gender
Have I missed anything?	
THANK YOU!!	

Appendix 7- Data Extraction Forms

Document Review Data Extraction Form (adapted from Mayan, 2009)

i.	Name/Title of document	
ii.	Type of document (i.e. policy, guideline, advertisement, journal article, website, poster, etc.)	
iii.	Date of document (or last revision date)	
iv.	Is this an edition of a document, if so explain	
v.	Author/creator(s) of document	
vi.	Position/organization(s) of author/creator(s)	
vii.	Background of author/creator(s) (i.e. credentials, faculty, experience)	
viii.	General overview of the document (brief, broad perspective)	
ix.	Unique characteristics of the document (does anything stand out?)	
x.	Tone/mood of the document (what feelings does the document stimulate?)	
xi.	For what audience was the document written (i.e. public, specific to organization, colleagues)	
xii.	Language of document (i.e. research, medical, layman)	
xiii.	Patterns within the document (i.e. style, paragraphing, numbering)	

xiv.	Symbols, diagrams, pictures, visuals in document (i.e. logos, photos)	
xv.	From whose viewpoint was the document written (may not only be the author's)	
xvi.	Purpose/objective of document (i.e. to convince, provide information, etc.)	
xvii.	Topic/issue of document	
xviii.	Description topic/issue in the document	
xix.	Consistency of definitions & objectives with relation to other documents	
xx.	Does the document conflict or agree with other documents you have read about the topic/issue	
xxi.	What question(s) are left answered by the document (gaps)	
xxii.	Overall theme of the document based on the core elements of Quality in Long-Term Care Framework (based on Banerjee & Armstrong, 2015; Donabedian, 1966)	

Additional Notes:

Appendix 8- Clinical Chart Data Extraction

Based on Recommendations in Common Mental Health Disorders and Management of Depression in Primary Care. (Ministry of Health, 2008b).

Date of Chart Review	
Document Written & Developed by (Role – NOT name)	
Reason for Reviewing this Chart (e.g. To contextualize data from interview ref: x)	
Assessment: For example, how, when and by who was the resident's mood assessed (e.g. GDS Residential, (Sutcliffe, Cordingley, Burns, Mozley, Bagley, Huxley & Challis, 2000). Has a risk assessment for suicide been completed? When? Has the issue of self-harm been included in the assessment?	
Medication: For example, is resident prescribed an anti-depressant medication? When was it reviewed and by who? Are there any adverse effects? Has the dose been titrated to be effective? Who is monitoring the medication? What is the dose? Is there a care plan related to the anti-depressant medication? When was the care plan reviewed and by who?	
Interventions: For example, what non-pharmacological support does the resident have in place? For example, counselling or occupational therapy. Does the care plan in place which addresses low mood involve different professionals and family members? What social support is in place? Does formal or informal activity feature in the care plan? For example, therapy groups.	
Liaison: For example, has there been education for the resident or the family regarding the depression? Are external specialists involved?	
Other comments or additional themes	
Name of Reviewer	
Signature of Reviewer	

Appendix 9 - Consent Forms

Consent Forms for Residents in the Long-Term Care Facility, or the Person Signing Proxy Consent.

Information Letter and Consent Form

Title of the study: How does regulation influence the care of older people with depression living in a long-term care facility in Ontario? - Case study

Principal investigator: Michelle Crick PhD Candidate, School of Nursing, University of Ottawa, 451 Smyth Rd, Ottawa, ON K1H 8L1.

Academic Supervisors: Dr. Chantal Backman and Dr. Wendy Sword, School of Nursing, University of Ottawa, 451 Smyth Rd, Ottawa, ON K1H 8L1.

Invitation to participate: I am invited to participate in the above-mentioned research study conducted by Michelle Crick, PhD Candidate as part of a PhD programme at the University of Ottawa.

Purpose of the study: The purpose of the study to explore how regulation in long-term care (LTC) influences the care of older people with depression, living in those facilities in Ontario.

Participation: My participation will consist of attending one 30 – 60-minute interview to discuss my experiences of how this long-term care facility provides care for residents with depression or low mood. A second interview will only be requested if the original interview is cut short for any reason. The study has the potential to improve the experiences of older adults living in long-term care, who have depression or low mood.

Access to clinical charts: In the interview, I may share information about my clinical needs and nursing care. I give permission for the researcher to access my clinical charts in this long-term care facility. This may include details of my medication, progress notes, care plans, and assessments. The information that is held in my clinical record will remain strictly confidential. I understand that the contents will be used only as part of this study and that my confidentiality will be protected as the data collected from my clinical chart will not be identified by name. I will not be identified in any report published because of this study.

Risks: There are minimal psychological or physical risks anticipated in the study. I may feel uncomfortable discussing my experiences of how this facility cares for people with depression or low mood. I may also experience some physical discomfort if I am sitting in an

interview setting. If this is the case, I can postpone the interview until a later date. Choosing to participate or not in this study will have no impact on the care I receive in this facility.

Confidentiality: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only as part of this study and that my confidentiality will be protected as the data collected will not be identified by name. I will not be identified in any report published because of this study. The research team will do everything possible to protect the confidentiality of what I have said in the interview.

Conservation of data: All electronic data will be stored on a secure server at the University of Ottawa. Paper based data will be safely stored in a locked filing cabinet, in a locked office facility for five years after the completion of the study and only the research team members will have access to this information.

Voluntary participation: This study is independent of [name withheld]. I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without any penalty. If I choose to stop participating, I may also choose to not have my data included in the study. Choosing not participate will have no impact on my care.

Contact names and telephone numbers: If I have any questions about the study, I may contact the researcher: Michelle Crick or Dr. Chantal Backman/Dr. Wendy Sword, Academic Supervisors. Contact details overleaf.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5 Tel.: (613) 562-5387 Email: ethics@uottawa.ca

Confirmation of agreement: My signature below indicates that I have read the information in this agreement and have had a chance to ask any questions I have about the study. My signature also indicates that I agree to participate in the study and have been told that I can change my mind and withdraw my consent to participate at any time. I have been given a copy of this agreement. I have been told that by signing this consent agreement I am not giving up any of my legal rights. By consenting, as a participant I have not waived any of my rights to legal recourse in the event of research-related harm.

Name of Participant (please print)				
Signature of Participant				
Date				
Name of Person obtaining Consent				
Signature of Person obtaining Consent				
Date				
Do you consent to your clinical chart being accessed by the researcher?	**Yes**		**No**	
Name of Participant agreeing (please print)				
Signature of Participant				

Consent Form for all Other Participants in the Long-Term Care Facility
Information Letter and Consent Form (To be printed on University of Ottawa headed paper before issuing).

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Faculté des études supérieures et postdoctorales | Faculty of Graduate and Postdoctoral Studies

Title of the study: How does regulation influence the care of older people with depression living in a long-term care facility in Ontario? - Case study

Principal investigator: Michelle Crick PhD Candidate, School of Nursing, University of Ottawa, 451 Smyth Rd, Ottawa, ON K1H 8L1.

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Invitation to participate: I am invited to participate in the above-mentioned research study conducted by Michelle Crick, PhD Candidate as part of a PhD programme at the University of Ottawa.

Purpose of the study: The purpose of the study to explore how regulation in long-term care (LTC) influences the care of older people with depression, living in those facilities in Ontario.

Participation: My participation will consist of attending one 30 – 60-minute interview to discuss my experiences of how this long-term care facility provides care for residents with depression or low mood. A second interview will only be requested if the original interview is cut short for any reason. The study has the potential to improve the experiences of older adults living in long-term care, who have depression or low mood.

Risks: There are minimal psychological or physical risks anticipated in the study. I may feel uncomfortable discussing my experiences of how this facility cares for people with depression or low mood. I may also experience some physical discomfort if I am sitting in an interview setting. If this is the case, I can postpone the interview until a later date.

Confidentiality: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only as part of this study and that my confidentiality will be protected as the data collected will not be identified by name. I will not be identified in any report published because of this study. The research team will do everything possible to protect the confidentiality of what I have said in the interview.

Conservation of data: All electronic data will be stored on a secure server at the University of Ottawa. Paper based data will be safely stored in a locked filing cabinet, in a locked office

for five years after the completion of the study and only the research team members will have access to this information.

Voluntary participation: This study is independent of [name withheld]. I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without any penalty. If I choose to stop participating, I may also choose to not have my data included in the study. Choosing not participate will have no impact on my role in the facility.

Contact names and telephone numbers: If I have any questions about the study, I may contact the researcher: Michelle Crick or Dr. Chantal Backman/Dr. Wendy Sword, Academic Supervisors. Contact details overleaf.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5 Tel.: (613) 562-5387 Email: ethics@uottawa.ca

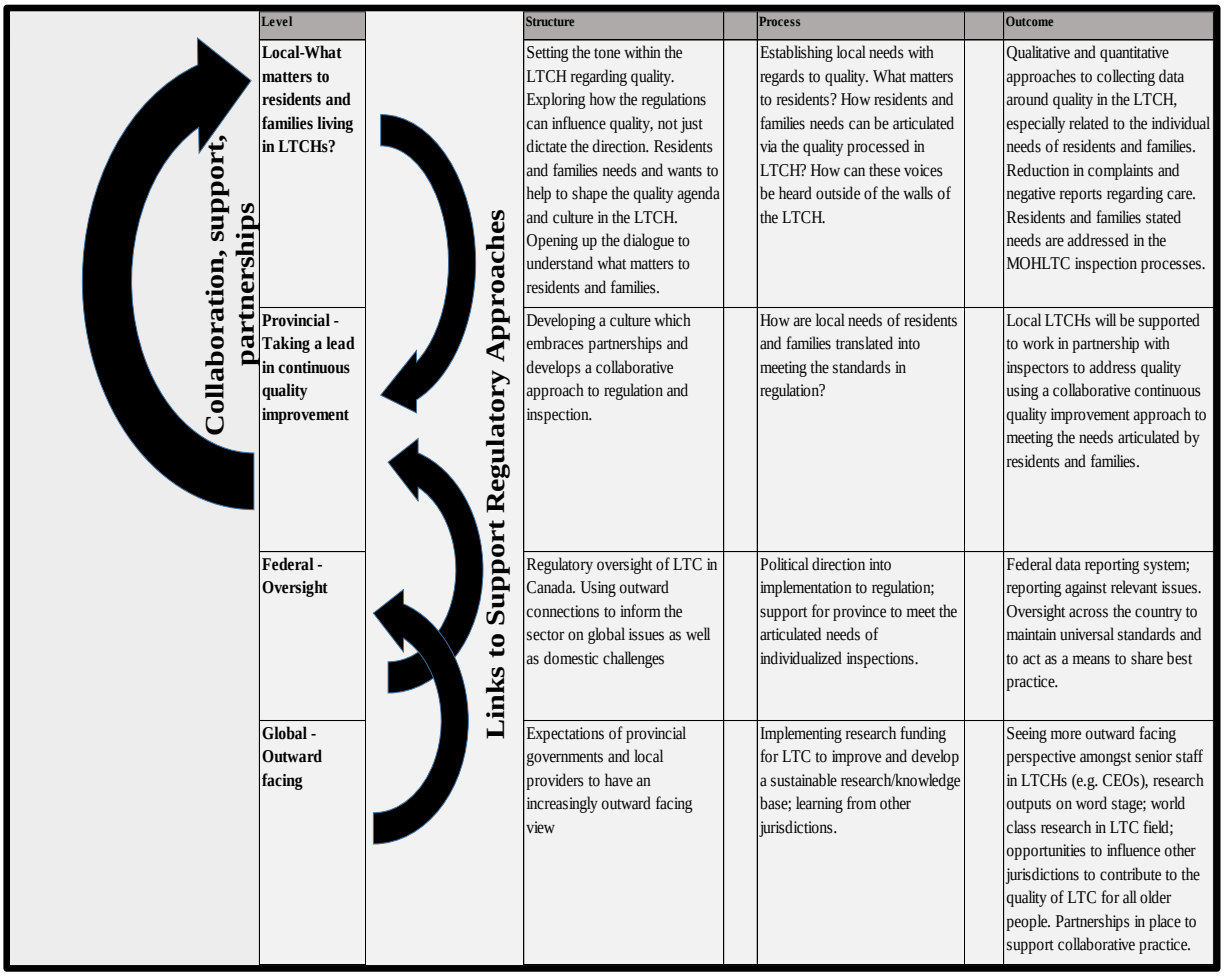
Confirmation of agreement: My signature below indicates that I have read the information in this agreement and have had a chance to ask any questions I have about the study. My signature also indicates that I agree to participate in the study and have been told that I can change my mind and withdraw my consent to participate at any time. I have been given a copy of this agreement. I have been told that by signing this consent agreement I am not giving up any of my legal rights. By consenting, as a participant I have not waived any of my rights to legal recourse in the event of research-related harm.

Name of Participant (please print)	
Signature of Participant	
Date	
Name of Person obtaining Consent	
Signature of Person obtaining Consent	
Date	

Appendix 10 – Extended Quality Framework - Original

Level		Structure		Process		Outcome
Global - Influencing the International Agenda in Long-Term Care		Reliance on markets to achieve quality; international agreements with providers operating in Canada; protecting profits to return to sector		Expectations of international corporate providers to operate and build LTC facilities across Canada?; legislation for new build LTC facilities; research funding for LTC to improve and develop a sustainable research/knowledge base; learning from other jurisdictions.		Contracts in place to protect Canadian citizens in LTC; Canada's voice on world stage (e.g. WHO); research outputs on word stage; world class research in LTC field; opportunities to influence other jurisdictions to contribute to the quality of LTC for all older people.
Federal -What Does Canada Need in Long-term Care?		Political direction; policy development; funding priorities; policy to support smaller facilities; cross disciplinary approaches to policy; alignment of regulation; protection of marginalised populations;		Political direction into implementation to regulation; support for smaller facilities		Federal data reporting system; reporting against relevant issues;
Provincial - Diversity?		Licensure for registered staff; regulation in facilities; staffing levels; requirements for care provision; policy alignment with provincial policy direction		How are policies translated into local need; alternatives to residential care; educational standards to meet provincial needs; provincial leadership education;		Outcomes tools to understand provincial need; provincial quality improvement plans for the LTC sector; funding apportioned to local need.
Local- Establish the Needs of Local Facilities		Operating to deliver care to local population; skill mix; staffing levels; local policies; patient councils; family councils; clinical support for registered staff; consideration of local culture; local benchmarking provision; person centeredness		Local targets; staffing culture; transformational leadership models; developing relationships with inspectors.		Using outcome data to work with facilities to improve care; responsive regulation; measuring what is relevant; celebrating success and good practice; different model of care in residential facilities to meet local need; opportunities to have funded home based services.

Appendix 11 – Extended Quality Framework - Modified



Level	Structure		Process		Outcome
Local-What matters to residents and families living in LTCHs?	Setting the tone within the LTCH regarding quality. Exploring how the regulations can influence quality, not just dictate the direction. Residents and families needs and wants to help to shape the quality agenda and culture in the LTCH. Opening up the dialogue to understand what matters to residents and families.		Establishing local needs with regards to quality. What matters to residents? How residents and families needs can be articulated via the quality processed in LTCH? How can these voices be heard outside of the walls of the LTCH.		Qualitative and quantitative approaches to collecting data around quality in the LTCH, especially related to the individual needs of residents and families. Reduction in complaints and negative reports regarding care. Residents and families stated needs are addressed in the MOHLTC inspection processes.
Provincial - Taking a lead in continuous quality improvement	Developing a culture which embraces partnerships and develops a collaborative approach to regulation and inspection.		How are local needs of residents and families translated into meeting the standards in regulation?		Local LTCHs will be supported to work in partnership with inspectors to address quality using a collaborative continuous quality improvement approach to meeting the needs articulated by residents and families.
Federal - Oversight	Regulatory oversight of LTC in Canada. Using outward connections to inform the sector on global issues as well as domestic challenges		Political direction into implementation to regulation; support for province to meet the articulated needs of individualized inspections.		Federal data reporting system; reporting against relevant issues. Oversight across the country to maintain universal standards and to act as a means to share best practice.
Global - Outward facing	Expectations of provincial governments and local providers to have an increasingly outward facing view		Implementing research funding for LTC to improve and develop a sustainable research/knowledge base; learning from other jurisdictions.		Seeing more outward facing perspective amongst senior staff in LTCHs (e.g. CEOs), research outputs on word stage; world class research in LTC field; opportunities to influence other jurisdictions to contribute to the quality of LTC for all older people. Partnerships in place to support collaborative practice.

Appendix 12- Contribution of Research Team

a. Michelle Crick. RN, MSc, PhD(c)

Michelle Crick is a PhD candidate in the School of Nursing, Faculty of Health Sciences at the University of Ottawa. She is a registered mental health nurse, and has worked in clinical, senior managerial and academic roles in Canada, UK and New Zealand, specialising in the care of older adults with complex mental health needs. She has been involved in various research roles as a co-investigator / research assistant. She is part of a team using an Appreciative Inquiry approach to explore the profession development needs of registered nurses working in aged and residential care in New Zealand and has studied business models in the residential care sector in New Zealand. She currently works as a Knowledge and Education Specialist at the Ontario Center for Learning Research and Innovation in Long-Term Care.

b. Dr. Chantal Backman. RN, MHA, PhD

Dr. Backman is the primary supervisor for this PhD. She is an Assistant Professor in the School of Nursing, Faculty of Health Sciences, University of Ottawa, an Affiliate Investigator in the Clinical Epidemiology Program of The Ottawa Hospital Research Institute, and an Affiliate Investigator at Bruyère Research Institute. She completed a PhD from the University of Alberta in 2011. Prior to joining the faculty, Professor Backman held various positions at The Ottawa Hospital in the departments of Quality and Patient Experience, Performance Measurement and Nursing Professional Practice. Professor Backman's research program is focused on improving the quality, safety and experience of older adults as they navigate the healthcare system.

c. Dr. Wendy Sword. BScN, MSc (T), PhD

Dr. Sword is a past Director and Associate Dean of the School of Nursing at the University of Ottawa and is Professor Emeritus, McMaster University. She has a long-

standing program of research focused on perinatal health and health services, which has included multi-site longitudinal studies of postpartum health outcomes, service use, and costs of care; the development and testing of the Quality of Prenatal Care Questionnaire (QPCQ); work related to knowledge transfer and exchange strategies for addictions agencies serving women in Canada; and factors maternity care providers consider when counselling women on a repeat Caesarean section or trial of labour and factors women consider in making this decision.

d. Douglas Angus. B.Com., M.A.

Professor Angus was a Full Professor in the Telfer School of Management until his retirement in June 2016. He has extensive expertise in health economics and health policy. He was the Director of the PhD Program in Population Health between 2003 and 2010. Previously, he was Vice Dean and Associate Dean between 1999 and 2002, and Director of the MHA Program between 1997 and 2001. Professor Angus continues to have research activities at the international, national, provincial and regional levels in areas related to health economics, policy, program evaluation and health care management. He continues to supervise graduate students in the PhD Program in Population Health and the MSc Program in Health Systems Management.

Roles of Team Members

Michelle Crick (MC) was the primary researcher in this dissertation. As part of the fulfilment of the requirements of the degree of Doctor of Nursing, MC conceived, participated in and led all aspects of the research study.

Dr. Backman (CB) was the dissertation supervisor and Dr. Sword (WS) and Professor Angus (DA) were committee members. CB, WS and DA all participated in different phases of the dissertation that included: (a) providing content and methodological expertise, (b) approving the research proposal, (c) securing ethics approval for the research, (d)

contributing intellectual content to the analysis and manuscript development, (e) providing consultation and feedback on components of the dissertation and (f) reviewing and approving the final version of the submitted manuscripts and dissertation.

Roles in Manuscript - Co-Authorship

In addition to the team members listed in the preceding section, other contributions were made to the manuscripts in this dissertation. In chapter 2 "Exploring the role of regulation and the care of older people with depression living in long-term care? A Systematic Scoping Review Protocol" Lindsey Sikora (LS), CB & DA helped to develop and review the search strategy,

In chapter 3, "The role of regulation in the care of older people with depression living in long-term care: A systematic scoping review.", Lindsey Sikora (LS) helped to develop and review the search strategy, Robin Devey-Burry (RDB) and Jiale Hu (JH), contributed to this paper by screening titles/abstracts and full-text articles. RDB and CB were also involved in the quality assessment of the final full-text data extraction. All co-authors (RDB, JH, DA, CB) critically reviewed and approved the final manuscript. LS is the Specialist Librarian, Health Sciences Library, University of Ottawa, RDB is a RN and PhD Candidate in the School of Nursing, Faculty of Health Sciences, University of Ottawa and JH is a PhD Candidate in the School of Nursing, Faculty of Health Sciences, University of Ottawa.