

The Social Organization of Personal Support Work in Long-Term Care and the Promotion of
Physical Activity for Residents: An Institutional Ethnography

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List of Abbreviations

ADL	Activities of daily living
CCAA	Canadian Centre on Activity and Aging
IE	Institutional Ethnography
LTC	Long-term care
MOHLTC	Ontario Ministry of Health and Long-Term Care
OHIP	Ontario Hospital Insurance Plan
OANHSS	Ontario Association of Non-Profit Homes and Services for Seniors
OLTCA	Ontario Long-Term Care Association
RAI-MDS	Resident assessment instrument-Minimum data set
ROM	Range of motion
RNAO	Registered Nurses' Association of Ontario
RN	Registered Nurse
RPN	Registered Practical Nurse
PSW	Personal Support Workers

Thesis Abstract

Despite the benefits of physical activity for older adults, many residents living in long-term care homes (LTC) are relatively inactive. Previous research has revealed barriers to physical activity at the resident-level, organizational, and environmental level. However, little attention has been paid to other factors influencing physical activity within the broader institutional complex.

The goal of this study was to uncover how the work of personal support workers (PSWs) related to the promotion of physical activity was socially organized. Institutional Ethnography (IE), developed by Dorothy Smith, guided this study. Smith proposed that peoples' everyday experiences in local settings are organized, often unknowingly, by the actions of people located outside of the local setting and that this organization is textually-mediated.

Two LTC homes in Ontario participated in this study. I began data collection by observing PSWs as they went about their work. Next, I interviewed PSWs and other people located inside (e.g. nurses, managers) and outside the LTC homes (e.g. representatives from the Ministry of Health and Long-Term Care (MOHLTC)). Lastly, I collected texts that organized the PSWs' work, such as Ministry standards.

The findings revealed that although the MOHLTC standards were viewed as producing something "good" for the residents, some of the standards disrupted the PSWs' work, which made it challenging for them to support daily physical activity. The promotion of physical activity was seen as an additional program that happened a few times per week and it was parceled out as a professional activity that was socially organized "out" of the PSW role. The findings suggest that local solutions are needed. A good starting point would be to go and talk to PSWs and residents to determine what type of assignments would permit the incorporation of

physical activity into daily care. To embed the promotion of physical activity into daily care, a major rethink and reorganization of PSWs work will be needed, including a greater investment in human and material supports for PSWs.

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Chapter 1: Introduction

“Management and government make all kinds of rules and regulations and they do not even know what we [health care aides/PSWs] do. The people with authority need to work on the floor and along with us to really understand our workload and frustrations. Then maybe they would really listen to us and ask us for our input for better resident care and less burnt-out staff.” (PSW) (Armstrong et al., 2009, p. 75)

These reflections of a personal support worker (PSW) invite us to really understand the work of PSWs in long-term care (LTC) homes. PSWs are essential caregivers in the LTC setting. They constitute the largest proportion of staff, they provide the greatest proportion of direct resident care, and they have an intimate knowledge of residents and their needs. Despite the importance of their work, they are among the lowest paid health care workers and they have no association representing their needs. Many concerns have been raised about the quality of care in LTC homes (Armstrong & Daly, 2004; Armstrong et al., 2009, Canadian Healthcare Association, 2009; Smith, M., 2004; Price Waterhouse Coopers, 2001). A better understanding of PSWs and their work is critical to develop approaches that improve resident care and create a better work environment for these workers.

The focus of this study is the social organization of PSWs' work related to the promotion of physical activity. More specifically, I sought to better understand how the promotion of physical activity is shaped and organized in the LTC setting from the standpoint of PSWs. This decision was based on my belief that PSWs can play a pivotal role in encouraging and assisting residents to be more physically active. My interest in the promotion of physical activity originated from a practice issue that I identified when I was working as a staff nurse in an LTC home in the 1990s. I believed that many of the needless declines in the residents' mobility and

physical function were related to a lack of physical activity. Physical activity is associated with several health benefits even for frail older people living in LTC homes.

Physical activity programs have been shown to prevent falls (Cameron et al., 2010; Gillespie et al., 2009; Norris, Walton, Patterson, Feightner & the Canadian Task Force on Preventive Health, 2003), improve muscular strength and function (Fiatarone et al., 1994; Ouslander et al., 2005a), and facilitate better sleep–wake patterns (Alessi, Yoon, Schnelle, Al Samarrai, & Cruise, 1999; Alessi et al., 2005). However, as shown in a number of studies, and as described in various reports and policy documents, there is a gap between this evidence and usual care practices in the LTC setting. Failure to translate evidence regarding physical activity for seniors in LTC is manifested in sedentary activities and unnecessarily high rates of falls, functional disabilities, pain, and depression (Bell & Goss, 2001; Higgins, Madjar & Walton, 2004; Jongenelis et al., 2004; Ice, 2002; Levin et al., 2004; Loeb, 1999; Norris et al., 2003). These outcomes reduce the quality of life for seniors in LTC and have economic consequences for the health care system. Despite the many benefits of physical activity, evidence suggests that residents are relatively physically inactive. This research into practice gap can partly be explained by many challenges to the promotion of physical activity in the LTC setting.

Recent studies have explored barriers to physical activity in LTC settings (Benjamin, Edwards, & Caswell, 2009; Benjamin et al., 2011; Chen, 2009; Galik, Resnick & Pretzer-Aboff, 2009; Resnick et al., 2006, 2008; Weeks et al., 2008), which can occur at the individual, organizational, and environmental level. Barriers reported include seniors' poor health, fear of falling, and past history of sedentary lifestyles; organizational challenges such as inadequate staffing levels and institutional care routines; and environmental realities such as lack of designated spaces and equipment for physical activity.

These barriers may in part account for the sedentary patterns of LTC residents (Bates-Jensen et al., 2004; Ice, 2002; MacRae, Schnelle, Simmons & Ouslander, 1996; Ruuskanen & Parkatti, 1994; Schnelle et al., 2002). A study conducted with 15 nursing homes in the USA estimated that residents in these homes spent about 17 hours per day in bed (Bates-Jensen et al., 2004). In a Finnish study, 40% of 158 older people surveyed in nursing homes reported they were no more active than was necessary to perform their basic activities of daily living (Ruuskanen & Parkatti, 1994). Findings from a Canadian study involving interviews with 17 older people living in the community and seven older people living in a nursing home indicated that, compared to older people living in the community, people in nursing homes tended to be more sedentary (Weeks et al., 2008).

A few authors have considered some of these barriers when designing their exercise interventions. For instance, to offset funding and staffing constraints, some researchers have implemented exercise interventions that could be delivered by front-line workers during their normal toileting care routines (Ouslander et al., 2005a; Ouslander, Griffiths, McConnell, Riolo, & Schnelle, 2005b; Schnelle et al., 2002, 2003). However, PSWs, who typically do the toileting routines, have very heavy workloads, and translating this intervention into practice would require fundamental changes in staffing levels. Another study used a “train the trainer” approach to offset staffing constraints (Lazowski et al., 1999). Recreation staff from five LTC homes completed a training workshop provided by the Canadian Centre for Activity and Aging, and the recreation staff in turn trained nursing aides and volunteers to assist with the exercise classes.

Provincial initiatives have addressed the need for a greater focus on the promotion of physical activity in LTC homes. For example, the Seniors Health Research Transfer Network (SHRTN) fostered the development of an Activity and Aging community of practice. The leader

of this community of practice is the director of the Centre for Activity and Aging, and members of the group recently developed guidelines for physical activity for older people living in LTC homes (Seniors Health Research Transfer Network [SHRTN], 2009). The director of the Canadian Centre for Activity and Aging also assisted the Registered Nurses' Association of Ontario in developing best-practice guidelines for fall prevention. Finally, the Canadian Centre for Activity and Aging provides training and certification for fitness leaders for seniors' community-based fitness programs, as well as fitness classes for seniors living in the community (Canadian Centre for Activity and Aging, 2011).

Setting the Context

To understand how physical activity might be addressed in the LTC setting, it is important to appreciate the historical, organizational, and policy context. In the next section, LTC organizations and residents are described, the historical development of the LTC sector is presented, and key policy documents related to LTC are discussed. Next, PSWs are introduced, and topics including PSWs' training, certification, regulation, and roles are discussed.

Historical Context: Milestones

Prior to the Second World War, health care was typically provided by charitable, religious, municipal, or small, privately owned facilities, especially for LTC (Armstrong et al., 2009). According to Baum (1999), the 1950 Ontario Health Survey Committee Report, which was the first detailed review of nursing homes in Ontario, called for the provincial licensing of these homes. Subsequently, the first Nursing Home Act came into force in 1966. Some of the smaller homes were taken over by larger chain-operated homes or were forced to close because

they were unable to absorb the increased costs associated with the new licensing standards (Baum, 1999). In 1972, the Ontario Hospital Insurance Program was extended to cover some nursing home costs.

In the 1980s, new and existing advocacy groups and professional associations such as the Concerned Friends of Ontario Citizens in Long-Term Care Facilities and the Canadian Medical Association mobilized to address growing concerns regarding the quality of care in nursing homes. These concerns were partly due to a trend towards for-profit ownership (Baum, 1999). It was also during this time that the Registered Nurses' Association of Ontario joined with other nurses in Canada to fight for the Canada Health Act. In an address to the Standing Senate Committee on Social Affairs, Science and Technology, the Registered Nurses' Association of Ontario recommended that the principles of the Canada Health Act be extended to areas of health care that were not yet covered by this Act, including care provided in the home or in LTC facilities (Registered Nurses' Association of Ontario, 2001). In response to the growing concerns regarding the quality of care in LTC homes, the Ontario government enacted the Nursing Home Reform Act in 1987. This Act brought about changes such as the creation of a residents' bill of rights, the establishment of residents' councils, and the requirement that the Ministry of Health and Long-Term Care (MOHLTC) hold public forums prior to granting new nursing home licences (Baum, 1999).

During the 1990s, other changes within the health care system also had an impact on LTC homes. Hospital restructuring in the early 1990s resulted in bed closures and shorter hospital stays, which, in turn, meant that patients being admitted to LTC homes were older and sicker and their condition was more medically complex, resulting in greater care needs (Smith, M., 2004). In the late 1990s and early 2000s, there was an increased focus on quality assurance,

accountability, and fiscal responsibility in LTC. This trend was partly due to an increase in media coverage of stories of abuse and neglect among LTC residents. The trend was also fuelled by escalating costs in all health care sectors and increasing difficulties in staff recruitment and retention in the LTC setting.

Organizational Context

LTC homes are designed for people who are unable to live independently in the community and require some level of assistance to meet their daily care needs (Ministry of Health and Long-Term Care [MOHLTC] of Ontario, 2008). According to the Continuing Care Reporting System 2009–2010, from the Canadian Institute for Health Information, there were 102,739 residents in 627 continuing care facilities in Ontario. These LTC homes can be categorized based on ownership as non-profit (such as Charitable Homes for the Aged and Municipal Homes for the Aged) or for-profit (nursing homes). About 62% of LTC homes in Ontario are for-profit homes (Berta, Laporte, & Valdmanis, 2005). Each LTC home is inspected at least annually by the MOHLTC to ensure that the home meets Ministry standards. Participation in accreditation is voluntary for LTC homes in Ontario. In total, 393 LTC homes have been accredited by Accreditation Canada (Accreditation Canada, personal e-mail communication, March 2, 2011).

According to the Continuing Care Reporting System 2009–2010, from the Canadian Institute for Health Information, the average age of residents in continuing care facilities in Ontario was 83 years. Nearly three-quarters of the residents (72.6%) had mild to severe cognitive impairment such as dementia. Most residents (86%) required some assistance to

complete one or more of their activities of daily living (such as dressing), and 43.5% and 31.1%, respectively, had bladder or bowel incontinence.

Over the past decade, the age of people being admitted to LTC homes and the medical complexity of their condition have increased, resulting in heavier care needs (Smith, M., 2004). Despite this shift, there has not been a corresponding increase in the number of workers in LTC homes to meet the additional care needs of residents (Armstrong & Daly, 2004; Smith, M., 2004).

Policy Context

During the past decade, several surveys were commissioned to examine issues surrounding health care, including quality of care, in LTC. Four key surveys will be addressed in this section. The first of these was undertaken as part of a review of the provision of services in Ontario LTC homes initiated by the Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Long Term Care Association. This Price Waterhouse Coopers survey (2001) compared levels of services between Canadian and international jurisdictions (Manitoba, Saskatchewan, Michigan, Maine, Mississippi, South Dakota, Sweden, Finland, and Holland). Findings relevant to physical activity revealed that LTC residents in Ontario received less nursing care and fewer rehabilitation services than similar populations in other Canadian and international jurisdictions (Price Waterhouse Coopers, 2001). Residents in Ontario received 2.04 hours of nursing care per day, compared to 2.44 hours in Manitoba and 3.06 hours in Saskatchewan. Furthermore, only 10% of LTC residents in Ontario with rehabilitation potential received rehabilitation, compared to 13% in Manitoba and 38% in Saskatchewan.

In 2003, partly in response to the findings of the Price Waterhouse Coopers survey, the Honourable George Smitherman, Ontario Minister of Health and Long-Term Care, requested Monique Smith, Parliamentary Assistant, MOHLTC, to undertake a review of LTC facilities in the province. The resulting report, entitled “Commitment to Care: A Plan for Long-Term Care in Ontario”, was based on stakeholder consultations with over 100 individuals and unannounced site visits to 24 nursing homes varying in size, location, and ownership (Smith, M., 2004). Key stakeholders included residents, families, LTC staff and other health care professionals, administrators of LTC homes, seniors’ groups, and other stakeholders active in the LTC community. The report focused on five areas: quality of care, staffing levels, accountability, legislation, and funding models. Key recommendations of the report included: (a) the creation of more full-time front-line staff and nurse practitioner positions, (b) the implementation of nursing best practices, (c) adequate training for management, (d) mandatory yearly family and resident satisfaction surveys, (e) whistle-blower protection, (f) penalties for failure to report suspected and actual abuse, and (g) consolidation of the Nursing Homes Act, Homes for the Aged and Rest Homes Act, and the Charitable Institution Act (Smith, M., 2004).

In response to this report, a study was commissioned by the Canadian Union of Public Employees, which represents about 18,000 workers in LTC homes in Ontario (Armstrong & Daly, 2004). Categories of workers included in this study were: (a) nurses, (b) PSWs, (c) dietary, (d) maintenance, (e) housekeeping, (f) therapists, and (g) recreational workers. This report, entitled “There are Not Enough Hands: Conditions in Ontario’s Long-Term Care Facilities,” examined four key topics: staffing, quality of life, standards and compliance, and accountability. Staffing shortages were found in all categories of workers, and shortages were considered underestimated because absent workers were not being replaced. Tasks were often

left undone because of lack of time. The physical space in LTC homes was inadequate to meet residents' needs. The incidence of violence among residents and towards staff was high, resulting in injury and illness among workers and negative effects on their personal lives. Standards were reported as being low and minimally enforced. Lastly, workers felt that they had little control over their work schedules and routines, were seldom consulted about resident care, and did not feel comfortable in reporting practices that were unsafe to their employers or to the government.

Other specific concerns cited in the document included reports by workers that the provision of emotional support for residents was left undone about 60% of the time, walking or exercise was left undone 52.3% of the time, and feeding was left undone 8.5% of the time (Armstrong & Daly, 2004). Many workers reported caring for up to five residents who were completely confined to bed (44.1%), required assistance to walk (45.5%), or could walk with supervision (61.4%).

The authors provided several illustrative quotes to reflect the key findings in each of the four main topic areas (staffing, quality of life, standards and compliance, and accountability) (Armstrong & Daly, 2004). For instance, the following quote reflects a respondent's concerns regarding staffing, quality of life for residents, and accountability:

“We probably spend only twenty minutes max with a resident per shift . . . Also with cutbacks, us health care aides are expected to serve food, put laundry away and do some cleaning while serving the dining room. By the time we get to feed our total care residents, their food is cold. Much to our dismay the standards are going downhill fast.” (Armstrong & Daly, 2004, p. 22)

Another illustrative quote highlights the impact of workload issues on staff and resident well-being:

“The pressure at work is also evident, as many duties are being downloaded as nursing aide duties (i.e. we had a recent cut in our activation department, laundry and kitchen staffing). As such nurses aides will now be required to assist with activation of residents (i.e. walking residents). We are required to serve dining rooms at meal times and put away all residents’ laundry and linen daily. This is difficult as there are many residents who require additional assistance, ‘extras’ as we call them, and we are simply not able to meet that need, which is a stress on the resident, as well as on us. Other than basic personal care that is about all that is available for residents now.” (Armstrong & Daly, 2004, p. 18).

In 2009, factors such as the lack of educational opportunities for staff, lack of outcome-focused standards and indicators, insufficient budgets, the growing trend for unregulated retirement homes and assisted-living facilities to offer care, and the absence of provisions for LTC in the 2003 and 2004 Health Accords provided the impetus for the Canadian Health Care Association to undertake a review of LTC. Results of the review were presented in the document “New Directions for Facility-Based Long Term Care” (Canadian Health Care Association, 2009). Key recommendations included the provision of adequate and sustainable funding, increasing investment in human resources, ensuring residents’ access to similar services, and the transferability of health care benefits across provinces and territories in Canada.

In summary, the four key reports described above identified staffing shortages as a core problem, with detrimental effects on quality of care. Despite recommendations, the establishment of staffing standards for nursing in LTC in Ontario has yet to be acted upon. Although the reports addressed a wide breadth of quality of care issues, there are a number of findings with particular implications for physical activity in LTC homes. Staff shortages can affect all aspects of care, but the promotion of physical activity may be particularly sensitive to staff shortages. Although there are mandated standards within regulatory requirements for the provision of recreational and physiotherapy programs and services, there are none for the promotion of daily physical activity. In addition to these reports, other research studies have

identified staffing constraints as a major barrier to the promotion of physical activity in the LTC setting (Benjamin et al., 2009, 2011, Lazowski et al., 1999).

PSWs provide the greatest proportion of direct care in LTC homes. Given the benefits of physical activity for elderly LTC residents, the predominance of sedentary activities in LTC homes, and research evidence suggesting that staffing constraints are one of the core issues in the LTC setting, it is important to gain a broader understanding of how the daily work of PSWs is shaped by, organized by, and linked to the work of other people. The next section introduces PSWs, who are a focus of this study. Topics addressed include the size of the PSW workforce, training and certification, regulation, and role definition.

Personal Support Workers

PSWs have been employed in LTC homes since the 1950s. Prior to 1990, they were known by other titles, such as nursing aide and health care aide, and were typically trained on the job. It is difficult to precisely estimate the number of PSWs since they are usually grouped with other categories of unregulated health care workers. In 2006, the Health Professions Regulatory Advisory Council concluded that there were about 100,000 people working across all health care settings as PSWs or in similar roles in Ontario (MOHLTC, 2006).

Although there is a data gap related to the PSW workforce, a recent book by Armstrong et al. (2009) provides some insights about direct care workers¹ including PSWs. In Armstrong et al. (2009) study of long-term residential care in Canada², 95.2% of direct care workers were

¹ Direct care worker refers to housekeepers, dietary aides, personal support workers, licensed practical nurses, registered practical nurses, and registered nurses.

² Data from three provinces (Ontario, Manitoba, and Nova Scotia) will be referred to as Canadian data. When available, data from Ontario will be presented separately.

female, 51.8% were 45 years or older, and 63.3% had 10 or more years of experience. In the Ontario sample, 13.3% of direct care workers were born outside of Canada. Although the salary for PSWs in Ontario varies with location and employer, the current hourly rate is \$11.56 to \$18.36, and many PSW positions are casual or part-time (Personal Support Network of Ontario, 2011).

There is no universal certification for PSWs, and certificates are typically issued by the training organization. In Ontario, there are two training options for PSWs: they can receive in-service training provided by their employer, or they can be trained in classroom programs provided by community and private colleges, education boards, or non-profit organizations. Typically, a formal training program for a PSW lasts about eight months and includes classroom theory and a clinical practicum.

In 1993, The Personal Support Worker Program (Personal Attendant Program) was established through an extensive consultation process jointly led by the Ontario Ministry of Health and the Ontario Community Support Association (Government of Ontario and the Ontario Community Support Association, 2009). The program received final government approval in 1997. Many private colleges provide training programs that are similar in content to the community college programs, although they are not mandated to do so. As such, variations in PSW training continue to exist, resulting in challenges to PSWs, their employers, and their clients (Government of Ontario and the Ontario Community Support Association, 2009).

There is no regulatory body that oversees the practice of PSWs, and they do not have to write provincial or national examinations for entry into practice. However, within the past decade there have been discussions regarding the potential regulation of PSWs. In 2006, the Health Professions Regulatory Advisory Council recommended that PSWs not be regulated

under the Regulated Health Professions Act because they do not meet the requirements for regulation (MOHLTC, 2006). In response to this decision, the Personal Support Network of Ontario indicated that they would work with the government to find solutions to support the advancement of their role. The Personal Support Network of Ontario is preparing a discussion paper on this issue.

In the LTC setting, the main role of PSWs is to assist residents with their basic activities of daily living, which include bathing, dressing, feeding, toileting, and transferring. Within the context of activities of daily living, transferring refers to moving a resident from one surface to another surface such as from a bed to a chair. Transfer methods include the use of mechanical lifts, one or two-person assist with transfer belts, and stand and pivot transfer. Training standards in the MOHLTC Personal Support Worker Program specify that PSWs are able to assist residents with their active range of motion exercises and with their ambulation as outlined in the resident's care plan (Ontario Community Support Association, 2009). For example, a PSW could assist a resident to walk in the hallway or to do active range of motion exercises while lying in bed. However, since the provision of physical activity and exercise is currently not a role for PSWs, a PSW would not typically lead a group exercise program or do passive range of motion exercises for residents. Therefore, although many PSWs have been trained in how to assist a resident with walking or active range of motion exercises, the provision of exercise is typically in the purview of the physiotherapy or recreational department in the LTC home.

Research Goal and Questions

Although some investigators have reported on barriers to physical activity in the LTC setting, to my knowledge, no study has explored how the work of PSWs related to the promotion of physical activity in LTC homes is shaped by, organized by, and linked to the actions of people outside of their daily experiences. The following research questions were addressed:

1. How does the nature of PSWs' everyday work affect the promotion of physical activity for residents in LTC settings?
2. What texts shape and organize the PSWs' work related to the promotion of physical activity?

Overview of the Method of Inquiry: Institutional Ethnography

Institutional ethnography (IE) (Smith, D. E., 1987, 1990a, 1990b, 1999, 2001, 2005, 2006) guided this study. IE is a method of inquiry that allows a researcher to uncover how things work or how things happen. The main assumption of IE is that people's everyday experiences are shaped and organized, often unknowingly, by factors that lie outside of their everyday experiences. In contemporary industrialized societies, this organization is most often mediated by text-based materials (such as documents, media, posters, and photographs) (Smith, D. E., 2005, 2006). One of the critical features of an IE project is that of standpoint, which is the entry point for the project, and a place for the researcher to begin his/her inquiry. It is the particular social location or position of those who are being studied within the institutional arrangements. For example, PSWs are positioned within the institutional rules and regulations differently than registered nurses or residents. IE "takes the standpoint of those that are being ruled" (Campbell & Gregor, 2004, p. 16). For this study, I took the standpoint of PSWs because

they provide the greatest proportion of direct resident care in LTC and could play a significant role in assisting residents to be more physically active.

Organization of this Thesis

Chapter 1 has set the stage for this thesis. Chapters 2 and 3 consist of manuscripts that will be submitted for publication, and chapter 4 provides an integrated discussion. A third manuscript is provided in the appendix. This manuscript was prepared as part of this thesis work but is placed in the appendix because it does not fit into what would be considered a typical format for an IE-guided thesis. The manuscript is entitled “Barriers to Physical Activity in Long-Term Care Homes: A Review of the Literature.” It will be submitted to the *Journal of Aging and Physical Activity*.

The manuscript that constitutes chapter 2 is entitled “Reflections of a Novice Institutional Ethnographer.” These reflections originated from my experiences while completing my doctoral thesis. The purpose of this article is to provide newcomers to IE with some guidance on how to better understand and use this method of inquiry. I begin this manuscript by providing background about IE and discussing the reasons why I choose this method of inquiry. Next, the challenges I experienced while learning how to conduct an IE-guided study and the strategies used to overcome these challenges are presented. Challenges included learning how to read and use the empirical literature differently, understanding the language of IE, looking for the right data, and completing data analyses. This manuscript will be submitted to the journal *Qualitative Inquiry*.

Chapter 3 is a manuscript entitled “Personal Support Work in Long-term Care and the Promotion of Physical Activity for Residents: An Institutional Ethnography.” This manuscript

presents the main findings of this research. Chapter 3 is divided into three main sections: background, methodology, and findings. The background section reviews some of the empirical literature that addresses the topic of physical activity for elderly people in LTC. The methodology section discusses the concepts of standpoint and problematic, which are two key methodological tools of IE. The findings section begins with a vignette that illustrates a typical day for a PSW. This is followed by a description of how mandated standards developed to produce something “good” for residents were actually disrupting the work of PSWs, making it difficult for them to support residents with their physical activities. I then show how the promotion of physical activity is viewed as a program separate from the everyday activities of residents and from PSWs’ daily work. Finally, the last section addresses the limitations and rigour of the study, and the implications for practice, policy and future research. This paper will be submitted to the journal *Qualitative Health Research*.

Chapter 4 presents an integrative discussion of the three manuscripts and introduces new insights based on my data that were not presented in chapter 3. Chapter 4 discusses two main topics: (a) work environments and (b) standardization of care. The chapter concludes by discussing the limitations and rigour of the study; contributions of this research to new knowledge; and implications for future research, policy and practice.

In summary, most residents living in LTC homes have relatively sedentary lifestyles. This is a serious health and quality of life concern. PSWs are important health care workers who work in a highly regulated, bureaucratic, and complex environment. They provide most of the direct care for residents and could play an important role in the promotion of physical activity. Improving the physical activity levels of LTC residents is an important health care goal that could ultimately improve the quality of life for frail older adults living in LTC homes.

Chapter 2:
Reflections of a Novice Institutional Ethnographer

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This manuscript will be submitted to *Qualitative Inquiry*. It is presented in the formatting style of this journal.

Abstract

Institutional ethnography (IE) was developed in the 1980s by Dorothy Smith, a Canadian sociologist. This method of inquiry helps to uncover how the everyday experiences of people in local settings are organized by and linked to the work of others. The purpose of this article is to provide newcomers to IE with insights gained from my learning as a novice institutional ethnographer. These insights stem from my doctoral thesis, which examined how the promotion of physical activity was socially organized in long-term care homes. The benefits of using IE are considered, and the challenges encountered in trying to thoroughly understand and use this method of inquiry are examined. Strategies used to overcome these challenges are discussed.

Keywords: physical activity, institutional ethnography, long-term care

Reflections of a Novice Institutional Ethnographer

This article is a description of the process of a novice institutional ethnographer. The purpose of writing it is to assist other novices planning to use this approach. The insights are based on my doctoral research, which sought to better understand how the promotion of physical activity was socially organized in long-term care (LTC) homes. The lessons learned will be relevant to other novice researchers using institutional ethnography (IE). I begin this article by providing an overview of my doctoral research project. Illustrative examples from this study, as well as examples from other nursing and health issues, are used to explain some of the concepts of IE. The benefits and challenges of using IE and the strategies used to overcome these challenges are discussed.

Overview of My Doctoral Study

Despite the many benefits of being physically active, many older people living in LTC homes are sedentary. Although some studies have determined some of the barriers to physical activity in the LTC setting, our understanding of influencing factors is limited. The purpose of this research was to uncover how the social organization of personal support work in LTC homes influenced the promotion of physical activity. Data were collected in two LTC study sites in Ontario, Canada by conducting participant observations and interviewing personal support workers (PSWs) and other people such as nurse managers and representatives from the Ontario Ministry of Health and Long-Term Care (MOHLTC). Texts were also collected.

The features of the data and the process of data analysis described here focus on two significant work processes that absorb PSWs' time. At first glance, these work processes seem to have little to do with physical activity, especially in the first line of analysis, focusing on

PSWs' work in the dining room. The second line of analysis, perhaps with a more direct relationship to what one would look for when studying physical activity, focuses on PSWs' performance of transfers (lifting a person from bed to chair and back to bed). My examination of the social organization of two work processes, one related to meals and the other to transfers, leads to a new understanding about the social organization of LTC residents' physical activity. It produces an analysis that departs from many of the currently circulating explanations about physical activity (Benjamin, Edwards, & Caswell, 2009, Benjamin et al., 2011, Chen, 2010; Schutzer & Graves, 2004). Rather than looking at education, attitudes, awareness, and time limitations, I link the work practices to MOHLTC standards for LTC homes and discover that, despite views that the standards are producing something "good" for residents, some of the standards result in practices that, in the setting, seem rather bizarre. The standards actually constrain the efforts of PSWs to support physical activity in the daily lives of residents.

Moreover, my analysis reveals how the standards not only organize particular work processes but also organize a mindset among the people who work in LTC homes. The mindset relies on knowledge about how physical activity can be achieved. It is an approach to activity that categorizes physical activity as "exercise," something different from the activities of daily living. This understanding seems counterintuitive to what we know about how elderly people, living independently, maintain physical strength as a component of their daily practices related to such activities as bathing, dressing, and meal preparation. In the LTC setting physical activity is organized as separate from its routine dailiness. It is regarded as a program "add-on" that happens only a few times per week. Consequently, promoting movement and physical resilience is parceled out as a professional activity that is predominantly the purview of physiotherapists or activity aides. Formulating activity this way is what institutional ethnographers call a "ruling

relation” (about which more is said later) that actively limits the ability of PSWs to integrate physical activity as a feature of residents’ daily routine.

Introducing Institutional Ethnography

IE is a method of inquiry that was developed by Dorothy E. Smith, a Canadian sociologist, in the early 1980s. It has its basis in Marxist and feminist philosophy (Smith, D. E., 1999). Smith’s feminist consciousness, rooted in the women’s movement of the 1970s, informed her thinking about IE (Campbell & Gregor, 2004; Smith, 2005). Her thinking emerged, in part, from the period when she worked in a predominately male-dominated sociology faculty. Here she began to recognize that her knowledge and experiences as a single mother were largely invisible in the sociology that she taught (Campbell & Gregor, 2004; Smith, D. E., 2005). She began to recognize how the everyday work of women (such as housekeeping and grocery shopping) was essentially concealed within the privileged “head world” in which she also participated (Campbell, 2003; Smith, D. E., 1987, 1990a, 1990b). The head world, abstracted and objectively removed from the particularities of “real life,” consistently “eclipsed” (Smith, 1987) the knowledge of women. Influenced by her distinctive reading of Marx (Marx & Engels, 1976), Smith embarked on a sociology that could account for women’s knowledge-based work that had heretofore been subordinated. Her project was an activist enterprise that was invested in social justice. The sociology she established was directed towards learning about how the social world is organized. Thus, her method guides a material discovery to learn about how it happens that certain forms of knowledge are overlooked within the authorized formulations about what counts as knowledge. Although IE was initially developed as a sociology for women, it later

became known as a sociology for people and is being used to explore a broad field of social injustice (Campbell & Gregor, 2004).

IE has been used to study various social processes such as education (Coffield, 2002; Limoges, 2010; Paterson, Osborne, & Gregory, 2004), nursing (Angus, 2001; Hamilton, Mathur, Gemeinhardt, Eschiti, & Campbell, 2010; MacKinnon, 2006; Rankin, 2003; Rankin & Campbell, 2006), health care (Diamond, 1992, 2006; Green & Moehr, 2003; McCoy, 2005; Townsend, 1992; Townsend, Langille, & Ripley, 2003; Townsend, Sheffield, Stadnyk, & Beagan, 2006), and other law/policing/social processes such as immigration, abuse of women in military families, and the historical social organization of housing and childrearing (Goodman, 2008; Grahame, 2003; Harrison, 2006; Luken & Vaughan, 2003, 2006; Sharma, 2001). Collectively, regardless of the social process, these IE studies begin to paint a mosaic that illustrates the social organization of people's experiences across many different social processes.

One of the unique features of Smith's (Smith, D. E., 1987, 1990a, 2001, 2005) method of inquiry is how it directs the careful examination of texts and people's activities related to texts. Smith identified that textual practices are commanding contributors to the social organization of knowledge; they are powerful coordinators that produce dominant and subordinate knowledge practices. Peoples' daily experiences in local settings are shaped and organized, often unknowingly, by peoples' actions in more distant places (extra-local). Commonly, this organization across time and geography is mediated by texts such as policies and memos (Smith, D. E., 2005). Thus, texts coordinate practices among multiple people. Nursing, for example, is heavily regulated by textual practices. This can be seen when nurses activate the standards of practice that are developed by the Ontario College of Nurses. Embedded in the annual registration processes, and taken up by health care authorities in policy documents or hiring

practices, the textual coordination that arises within nurses' regulatory framework organizes practices of nurses, clerical staff, and managers across Ontario.

The underlying tenet of Smith's method is that all knowledge is socially organized (Campbell & Gregor, 2004). When knowledge about the world is regarded as a totally social activity, we can examine how it is structured within practices of dominance and authorization and can begin to see how contradictory things that go on become taken for granted (Campbell & Gregor, 2004). For example, a PSW's knowledge regarding the individualized needs of a resident may be overlooked because it does not fit within the routines and knowledge that officially organize that work. In my research, this was apparent when PSWs cajoled residents to eat their meals in the dining room, although some residents may have preferred to eat in their own rooms. The PSW was organized, in part, by a policy that directs the sharing of meals in the dining room as a standard of practice.

Typically, an IE study originates from a trouble or puzzle that the researcher is experiencing or already knows something about. For example, my doctoral research derived from a trouble that I witnessed in my clinical practice as a staff nurse in a nursing home in Ontario. I noticed that PSWs would wheel residents to the dining room despite the fact that some of the residents could walk with assistance. Many residents spent most of their day lying in bed or sitting in wheelchairs. They were not encouraged to be physically active. I witnessed declines in residents' physical function, which I believed were related to a lack of physical activity. I knew that this was not best practice but felt helpless to make a change. This was the trouble that I wanted to explore.

Timothy Diamond's important analysis (1992) also explored the LTC setting using IE, although the starting point of his study was different. Diamond is a sociologist, not directly

involved in health care. His interest in nursing homes developed through regular, friendly encounters with two nursing assistants who worked in a nursing home across the street from a coffee shop he frequented. When the nursing assistants failed to show up at the coffee shop Diamond missed them and began to make inquiries. He learned that their absence was related to a change in the working conditions of the assistants; a new company directive required them to remain onsite at the care home for their coffee breaks. Diamond's curiosity about these nursing assistants and nursing homes led him to enroll in a nursing assistants' training program. He completed the training and worked as a nursing assistant while conducting his study.

These two examples illustrate that the topic of an IE study can stem from the researcher's personal interest and knowledge about a situation that he/she is experiencing, has experienced, or has heard about. With this as the entry point, the researcher embarks on the IE journey, a research journey that has some distinctive departures from other forms of qualitative work. In the next section, I present some of my reflections at various stages of the research in order to open up some of the twists and turns that I encountered.

Reflections at the Various Stages

My Introduction to Institutional Ethnography

My initial reaction when I was introduced to IE in my second year of doctoral studies was excitement. This method of inquiry looked promising. I believed that it would help to fill gaps in my knowledge regarding the promotion of physical activity in LTC. Prior to commencing my doctoral research, in 2006, I conducted a research study that examined factors influencing the promotion of physical activity in nine LTC homes in Ontario (Benjamin et al., 2009, 2011). A socioecological framework was used to guide this study (Sallis & Owen, 1997; Sallis et al.,

2006). Although the study captured factors that influenced the promotion of physical activity at the individual (resident), environmental, and organizational levels, it did not adequately capture the influencing factors that originate outside of the LTC setting, such as legislation and standards. Based on my nursing practice in LTC and my prior research experiences, I knew that LTC homes were highly regulated environments and that the promotion of physical activity did not happen haphazardly. I had a hunch that something outside of the daily experiences of workers was organizing the way physical activity happened. This is the utility of IE, compared to conventional ethnographic approaches. It provides a method of inquiry that allows a researcher to look beyond the local setting and what can be known from there, to discover other factors that shape and organize people's everyday actions. This feature of IE inquiry made it an appealing and promising method of inquiry that could extend my previous work.

Immersing Myself in the Literature

I began my journey in IE by immersing myself in the IE literature. I started by reading Campbell & Gregor's (2004) *Mapping Social Relations: A Primer in Doing Institutional Ethnography*. This book provided a practical background that supported my understanding of the more theoretically complex writing of Smith (Smith, D. E., 1987, 1990a, 1990b, 1999, 2004, 2005, 2006). I also read two books that were based on IE studies: *Managing to Nurse* (Rankin & Campbell, 2006) and *Making Grey Gold* (Diamond, 1992). In addition, I read journal articles (Campbell, 2003; Smith, D. E., 2001, 2004) and doctoral and master's dissertations (de Ruiter, 2008; Evert, 2008; McGibbon, 2004; Quance, 2007; Rankin, 2004; Webster, 2009). I immersed myself in the discourse of IE by joining an international working group of novice and expert institutional ethnographers who meet monthly by teleconference. This group discusses topics

such as the conceptual underpinnings of Smith's work, as well as the pragmatics of doing IE research.

Understanding the Key Concepts of Institutional Ethnography

Problematic. Learning to understand and apply some of the concepts of IE was a challenge. One of the key concepts discussed by institutional ethnographers is the utility of a research problematic. I was convinced that formulating a research problematic would be necessary to focus my study, but, for me, the problematic was like a slippery fish. On some occasions, I thought that I had a firm hold on the fish (problematic) only to realize it had slipped out of my grasp. This reflects the nature of the problematic in IE research. The problematic is neither the research question nor the problems that people are experiencing (Campbell & Gregor, 2004). Smith states that the problematic "is a territory to be discovered" (Smith, D. E., p. 41) in the early stages of entering the field. She describes it as being "latent" (Smith, D. E., 1987, p. 91).

The problematic can be thought of as those instances in which a researcher notices a contradiction, or what IE researchers would call a "disjuncture," (Campbell & Gregor, 2005, Smith, D. E., 1990b) between the official explanation of how things happen (or even the explanations provided by people who are experiencing the issue or concern) and the observations of what actually goes on. For instance, in my study I observed that the PSWs spent a great deal of time providing a particular form of dining service. The official explanation for why the meals had to be served in such a manner (unhurried, one course at a time) was to create pleasant dining experiences for residents. This is also how the dining service was understood to be happening in official reports and accreditation practices. However, what was actually happening

was somewhat different. Despite the extensive amount of time that the PSWs devoted to the dining experience, they sometimes had to rush the residents through their meals, and the dining room work also created pressures on the other work they were doing related to toileting, bathing, and dressing. The problematic arose at the moment when the official version of what was happening in the dining room (pleasant dining experience) was at odds with what was actually happening (residents being rushed).

Standpoint. Conceptually, standpoint is an entry point that allows the researcher to position himself/herself in the everyday expert knowledge of peoples' daily activities (Rankin et al., 2010). It is a *particular location* within the institutional order. With IE, a researcher typically "takes the standpoint of those that are being ruled" (Campbell & Gregor, 2004, p. 16). The researcher works on behalf of the people who are experiencing the problems (Rankin et al., 2010).

For my doctoral research, I took the standpoint of PSWs to better understand how they are linked and connected to the social and ruling relations in their work processes and what troubles they experience. I adopted this standpoint for two reasons. First, PSWs are the unregulated primary care providers in LTC, delivering the greatest proportion of direct resident care. Thus, they are the backbone of the labour force in these settings. Although they are in a prime position to assist and encourage residents to be physically active, my experience indicated that this does not happen. Understanding how PSW work is socially organized within the roles and responsibilities of nurses, who *are* regulated, and within the other relations that organize their employment seemed the best way to learn how the physical strength of some elderly people decline when they enter residential care.

Second, based on my research and clinical practice, I speculated that it was not a lack of awareness related to the benefits of activity that was the problem. Despite having positive beliefs about the value of physical activity for residents, the PSWs had very heavy workloads, which made it difficult for them to assist residents with their physical activities. However, noting that there “just isn’t enough time” did not seem to explain the complexity of the issue or provide the direction to address it.

As my study progressed, I interviewed participants other than PSWs, who were my standpoint informants. For example, I talked to nurses and managers at the LTC study sites. They provided official explanations as to how the PSWs’ work was organized that were often convincing and compelling. Perhaps because of my training and experience as a registered nurse, whose work is positioned in a ruling relationship to PSWs, it was a challenge for me to keep sight of the knowledge I was gathering from the PSWs. The use of standpoint helped me to refocus my attention on what the PSWs were telling me. Observing the PSWs in their work also helped me to stay firmly grounded in the research standpoint. During my interviews with nurse managers, I had to learn to pay attention to the occasions when the rationality of the dominant logics were activated, trailing with them all the professional ideology, in which I am well trained.

Social relations. In IE, social relations are viewed as something distinct from interpersonal relationships as they are often understood outside sociology. According to Rankin et al. (2010), a social relation is “something happening that links individuals together” (p. 335). Although people’s work intersects across settings, they may never meet in person. An institutional ethnographer conceptualizes social relations as the intersections of people’s actions and their practices. The texts that people produce and work with mediate many of those intersections; they are materially important forms of social relations in IE (Smith, D. E., 2005).

For this research, I examined the social relations of the PSWs' daily work related to the promotion of physical activity and paid attention to how these activities and practices intersected the work of others. I gathered texts and analyzed them to discover material links to the work of people who were not visible in the setting (extra-local). For instance, I observed and talked to the PSWs about their work in the dining room. I then talked to other people such as nurse managers to see how their work intersected with that of the PSWs. The challenge for me was to learn to think of social relations as something more than a personal relationship between two or more people. I had to learn to think of social relations as something "happening" that included the talk and actions linking people's actions across settings.

Texts and ruling relations. A ruling relation can be viewed as a practice occurring in a local setting that infuses the interests of the institution into that local setting and this practice may not be in the best interests of local people (Rankin et al., 2010). For example, the administrative requirement to meet standards of care related to meal service did not seem to make sense in the daily lives of the PSWs and residents. The PSWs sometimes wheeled residents to the dining room rather than assisting them to walk because wheeling is faster. Although wheeling residents is a necessary action in order for PSWs to complete their work, this practice arises as contradictory and may not be in the best interest of residents. Not only does it reduce opportunities for physical activity, but also it appears to override residents' personal preference, as well as PSWs' knowledgeable judgement.

In regards to ruling relations, institutional ethnographers do not view people as passive bystanders but, rather, as active participants in the ruling relations (Campbell & Gregor, 2004). Often, the people in the setting are completely captured by the ruling relation and its apparent rationality. For example, there is a MOHLTC standard mandating that residents be offered two

baths per week. PSWs participate in this ruling relation by taking up and activating the standard as they implement this practice into their daily work. They understand it as a best practice that is necessary. However, when this practice is looked at with a critical eye, it does not always make sense when it is contrasted with how bathing practices unfold in real conditions and with needs for bathing that are individual and personal.

As indicated earlier, institutional ethnographers pay attention to texts in order to explicate ruling relations. It is important to emphasize this point. In contemporary societies, people's activities are often mediated by their work with texts. For institutional ethnographers, who are guided by the materiality³ of Marx, texts are the material threads of ruling relations that can be discovered (Smith, D. E., 2005). People's activation of texts can be observed and analyzed for their institutional traces. Texts can include policies, standards, legislation, procedure manuals, pamphlets, posters, and e-mails; they include all media that can be replicated across time and geography. Texts infuse the interests of the institution into the local setting, and shape and organize people's daily work. An example of a text that organizes PSWs' daily work is the bath list. A taken-for-granted document that PSWs most often do not even look at, the bath list carries traces of its compliance with the textual directions of the MOHLTC standard related to two baths per week and works "behind the scenes" at introducing the ruling relations into the LTC setting as it unfolds in PSWs' daily work.

³ Materiality, a concept based on Marxist philosophy, reminds institutional ethnographers to look for the explanations in the everyday material world of people rather than seeking abstract explanations as to how things happen. Researchers who maintain this view share the same ontological position (what the source of reality is) as other institutional ethnographers.

Looking at the Literature About Long-Term Care Differently

Approaching the literature review in IE was a challenge for me. My previous research training taught me to review the literature to identify gaps and to use this prior knowledge as a basis for developing a research project. In contrast, an institutional ethnographer reads the literature as data to determine an author's position, to determine why the author wrote the account, to try to identify the practices of knowledge that the author is activating, and to consider the practices that the knowledge supports (Campbell & Gregor, 2004).

Thus, institutional ethnographers do not review and use the literature as facts. IE researchers position themselves as sceptics inside the popular discourses of authorized knowledge and empirical evidence. Even studies they judge to be rigorous, interesting, and useful are analyzed for their epistemological and ontological premises. An IE reading of the literature is always done with an eye to the institution and ruling relations. Reading is always framed to elicit an understanding how knowledge is ideological insofar as the dominant discourses operate within a confining circularity that reproduces the logical rationality in which they originate. Institutional ethnographers read for the social organization of published studies and subsequently pay attention to how people's activities carry the traces of the literature to discover where the ideas in the literature appear in the texts that shape and organize people's daily experiences. For example, in my study, I reviewed several LTC policy documents to see whether I could identify traces of the ideological understandings being inserted into the work practices at LTC homes.

Pragmatically, I read the literature (journal articles, documents, legislation, and so forth) to identify the paradigm in which it was generated and, thus, the practices it reproduced. There were two general paradigmatic views. The first contained the official, theorized explanations

about how things happen. The second was the rare paper I came across that framed the issue as socially organized and that held traces of the material world. These were the papers where I could actually see people's "doings" before they were abstracted into categories, concepts, and theories.

Looking for the Right Type of Data

As a novice institutional ethnographer, I had to learn what type of data to look for and identify the type of questions that I needed to ask. Institutional ethnographers do not study subjects' individual perspectives (McCoy, 2005). Instead, they focus on studying work processes, because people doing IE are always interested in material happenings.

I began by observing the PSWs as they went about their typical day and asking them questions about their work. I also conducted interviews. First, I was looking for the contradictions, the things that seemed to make sense until one really looked at what was happening. Concurrently, I was looking for the linkages that connected their work to the work of others. Most people lack a useful analysis about how their daily experiences are socially organized in contradictory ways. They may recognize that something is at odds, but often, over time, people's daily experiences become routine, taken-for-granted practices; this is the way it happens; this is the way it should be. For example, when I asked the PSWs why they served the meals as they did in the dining room, they would typically say that it was just the way things were done around there.

As indicated earlier, data collection in IE moves back and forth between what is learned from observing and interviewing the standpoint informants and work going on outside the purview of that local setting. When I turned my data collection gaze beyond the local

arrangements of the PSWs and their knowledge, I began talking to individuals such as nurses and managers, and MOHLTC representatives. What I learned from the PSWs informed me about who to talk to next and what types of questions should be asked.

In regards to my textual data, initially I was overwhelmed by the huge amount of text-based materials present in the settings where I was doing my fieldwork. I was uncertain as to what type of texts I should collect. However, as my research progressed and as I gained clarity about the work processes that became my focus, I directed attention towards the texts that intersected with that work. I identified pertinent texts by listening for clues in the participants' interviews or by observing texts used or produced in the participants' daily work. For example, PSWs talked about the "paperwork" that they had to do each shift, and I watched and talked to them as they completed the basic care flow sheet each day, paying particular attention to what was included and what was left out. When I directed my data collection to texts outside the setting—with the puzzle related to the dining room work and how it appeared on the basic care flow sheet—I asked a manager about how all this worked, and she/he mentioned that there were standards related to how the meals were to be served in the dining room, which sent me searching for a copy of those standards.

Understanding Data Analyses

For me, understanding how to proceed with analysis of the data was the most challenging aspect of doing an IE study. The way I analysed my data for this study was significantly different from my prior experiences with content or thematic analyses, in which I would assign labels (nodes) to segments of the data and identify emergent themes. An institutional ethnographer does not use this sort of a coding process because this would immediately abstract

the data from its material work processes (social relations), which are central to an IE study (Campbell & Gregor, 2004). IE researchers avoid categorizing data in any way that serves to conceal its materiality (Campbell & Gregor, 2004). People and their doings must remain steadfastly visible in any approach to managing the data in order to avoid the disjunctures that IE researchers problematize. I used several different strategies to facilitate data analyses and analytical writing.

As I read my transcripts and my field notes, I asked questions of my data such as (a) What are the PSWs doing? (b) How is their work connected to the work of others? (c) What is this work intended to produce? and (d) What is it actually producing? As I asked these questions, I searched for traces of the institution in the talk and work of the PSWs so that I could begin to understand these intersections. To remain focused on the social relations during my analytical writing, I frequently asked myself the question, how does this (work) happen? (Campbell & Gregor, 2004). This helped me to remain focused on the social relations rather than on the individual perspectives or the official explanations that were being offered.

After I had collected my preliminary data from my standpoint participants, I began to map out how the activities of PSWs connected to the activities of other people. I did this by taking data excerpts from my transcripts and pasting them onto large sheets of poster paper⁴. This process helped me to visualize the organization of an ordinary day of PSW work and also to begin to see how the work of PSWs was connected to the work of others. For instance, one data excerpt from a PSW described the work related to meal service. This work garnered my attention because of how curiously hurried the rest of the work became in order to organize the time spent on meal service. This observation linked into the interview I had conducted with a

⁴ Other institutional ethnographers who have used a similar technique are Susan Turner and Janet Rankin (Smith, D. E., 2006).

manager and the transcript where she/he referred to the written standards related to meal service. I located these standards in the LTC Program Manual. I pasted these excerpts onto my poster paper to visualize the connections.

I used the analytical writing process as another strategy for data analyses. I began my analytical writing after my first observation. I read my transcripts or field notes and reflected on the data. I wrote an account of what I saw in the data and what was missing that remained curious and unexplained. As I repeated this process, I gained greater clarity from the data about PSW work. For instance, when examining the interviews for traces of dining room work, I found several instances where the PSWs described this work as challenging, hectic, and demanding, and I discovered some of their explanations as to why this was so. I had data excerpts from my field notes that described the PSWs offering meal choices, clearing tables, and scraping plates between courses while all the time noting who was eating and who needed help. All these excerpts were included in my analytic “chunks” of writing.

I used an additional strategy for textual analyses. Primary in an IE analysis is how people engage in specific texts and how these texts are used. Smith (2005) guides the researcher to think about how texts are used and how they shape and organize people’s work, a process she refers to as the text-action-text sequences. To help me think of these sequences, I asked questions such as (a) What is this text used for? (b) Who uses this text? (c) What does it accomplish? (d) What does it leave out? and (e) What happens to the text once it is completed? For example, I retained a copy of the daily basic care flow sheet that the PSWs complete at the end of each shift. This form is used to document the care provided to residents in the areas of personal care, skin integrity, repositioning, assistive devices use, and urinary/bowel elimination. A PSW explained that her understanding about why she had to do this work was because the

MOHLTC could come and check this sheet to see what care was done. Notable in the analysis of this accountability work and what it produced was that there was no section on the form related to the promotion of physical activity. It was here when I began to realize that physical activity was being textually organized as something other than an activity of daily living⁵.

The most successful strategy that helped me with data analyses was engaging in conversations with other researchers who shared the same ontological position as IE. I was fortunate to have an experienced institutional ethnographer on my thesis committee. Together we engaged in two key strategies that were especially helpful in flushing out my data and pushing my analyses forward.

First, she helped me to refocus my attention on the knowledge provided by my standpoint participants (PSWs) when I activated my tendency to move to the abstract or theorized explanations of how things worked. For example, some of the LTC managers said that the meal service was designed as such to provide opportunities for residents to socialize and to have pleasant dining experiences. This official explanation was compelling. However, in actual practice, I did not observe many residents talking to each other in the dining room. In fact, what I had observed could actually be framed as being quite bizarre. When I was redirected to my field notes describing the linen table cloths, the restaurant-like meal service and the descriptions of frail elderly people routinely being subject to some sort of idealistic “five-star” dining experience, I was able to refocus on what the PSWs were showing me and telling me. This attention to my actual observations helped me to drive my data analyses and writing forward.

⁵ I do not imply here that we should work to capture physical activity in the theorized accountability practices of the other aspects of daily living. Rather, I mean that it was here, during this process of textual analysis that I began to see the ruling relation that organized physical activity as something other than an activity of daily living.

The second strategy that my IE advisor taught me to use was how to render the instances of work as fundamentally mysterious (Rankin et al., 2010). I was consistently reminded not to take any of the practices that I was seeing or hearing about for granted. For example, PSWs often mentioned that their assignments were especially heavy on the day shift because they had to provide care for eight to 10 residents. Since I had worked as a nurse in an LTC home, I initially took this statement at face value and did not pay particular attention to it. I was guided to investigate this, to ask further questions such as how the residents' assignments are decided and who makes those decisions. Responding to these questions helped me to flush out my data and to explicate the ruling relations.

A final strategy involved a back and forth reflexive process. I read my transcripts, reflected, and wrote notes and questions. Then I would repeat the process. It was through this process that I could begin to see the institution in the data and could begin to see the links into ruling relations' shaping and controlling the contradictory work of PSWs as it was organized to unfold in the dailiness of residents' lack of physical activity. The next section provides an illustrative example of initial thought processes and reflections, which supported my analytical writing.

Example of My Reflections Regarding the Work in the Dining Room

As mentioned previously, after my first observations, I noted that the PSWs on the day and evening shifts spent a considerable portion of their time working in the dining room. At first I did not pay a lot of attention to this. In my thinking, going into the study, I saw dining in its ideological form, as it is organized within the LTC industry, but when I began to wonder about why the PSWs seemed so rushed and why some residents who could walk with assistance were

wheeled to the dining room, I began to recognize that these dining activities were intricately connected to everything else going on in the residence. I began to pay close attention to this work organization.

In my chunks of analytic writing, I noted that typically a PSW working a 7.5-hour day shift spent about two hours in the dining room. As previously noted, the dining rooms are rather formal, and the way the PSWs served the meals reminded me of a restaurant. The PSWs spent a lot of time transporting residents to and from the dining room, which made meal times a very busy time of day for the PSWs.

Moving to my interviews, I had data from the PSWs about their dining room work. I wrote this into the analytic chunks I was preparing, including their explanations that this work was difficult to complete, especially if they were short-staffed. I made a note to follow up on this institutional feature of being “short-staffed.” In my writing, I included the interview quotes in which the PSWs explained that there were many rules and regulations they had to follow, such as serving one course at a time and removing dishes from the table after each course. This “one course at a time” rule meant that the PSWs had to wait for all residents to finish eating each course of the meal and then clear the dishes before serving the next course. This appeared to lengthen the time period PSWs had to devote to dining room activities. I then turned to my data from the managers and nursing supervisors to locate the excerpts where they talked about the dining room work. I wrote their understanding about the PSW work, about how they saw it as providing a pleasurable dining experience and home-like environment for the residents. I began to articulate and write about the obvious contradiction in the way the PSWs explained their work (and what I had observed) and the way the supervisors and managers talked about this work.

Slowly, in my chunks of analytic writing, I began to locate the contradictory practices that I could formulate as a research problematic and that directed further exploration.

Advancing the work of my analytic writing, I started to describe the standards that I discovered were shaping the PSWs' work in the dining room. Looking back to the work of the PSWs, I could identify instances where I could trace the activation of the textual directions the standards organized, such as the standard that requires courses to be served one at a time. Beyond the one course at a time, I could see and write about the detailed and complicated work this apparently simple standard produced, under conditions where meals were transported on hot trolleys to satellite kitchens and PSWs worked with residents, some of whom had cognitive impairments, to mediate the "one course at a time" rule. I was able to see and to write about how these standards, intended to produce pleasant dining experiences for the residents, produced something contradictory and hampered the PSWs' efforts to promote physical activity. For instance, some of the PSWs reverted to using a mechanical lift to transfer some residents from their bed to a chair rather than using a more independent type of transfer such as a stand and pivot transfer. They believed that the mechanical lift was faster, and getting residents to the dining room on time was a priority for them. However, this practice limited opportunities for the residents to weight bear and to use their bodies to assist with the transfer. Based on this reflective process, I identified the second work process that became the focus of my analysis when I followed the links into the organization of work that supported PSWs to use mechanical lifts to transfer residents. It was here where I learned from PSWs that there were several policies related to the use of mechanical lifts. Foremost was the policy that two staff members had to be present when operating a mechanical lift. Again, I turned to my field note data and the complicated arrangements of finding and waiting for another PSW when a lift needed to be done,

the concurrent work of “getting ready” for the helper, and the contradictions that were embedded there. Similarly, I followed the clues in these data to the MOHLTC standards and occupational health and safety discourse that is organizing the work related to resident transfers.

Conclusion

These reflections are based on my doctoral research. My journey as a novice institutional ethnographer produced occasions when I was caught between my previous training, the advice from my supervisory team, and the significant differences that the “alternative” IE approach demands. It is my hope that this paper, a stepwise reflection of the process of data collection and data analysis, will be helpful to others who take up the IE method of inquiry. I decided to use this method of inquiry because I believed that it would help me to better understand how physical activity actually happened in LTC homes. Lacking a background in sociology, I grappled with some of the complex writings of Dorothy Smith. Data analysis was initially a daunting process, partly owing to the fact that there are limited written resources on how to do data analyses when using an IE approach. The most useful strategy that helped me to flush out my data and drive the analyses forward was having conversations with other researchers who shared the same ontological position as IE, who knew how to keep me grounded in the materiality of my data, and who helped me to resist the dominant propensity to make the shift into abstracted theorizing. Despite the challenges, IE provided a framework that enabled new insights about the promotion of physical activity by PSWs.

References

- Angus, J. (2001). The material and social predicaments of home: Women's experiences after aortocoronary bypass surgery. *Canadian Journal of Nursing Research, 33*, 27-42.
- Benjamin, K., Edwards, N., & Caswell, W. (2009). Factors influencing the physical activity of older adults in long-term care: Administrators perspectives. *Journal of Aging & Physical Activity, 17*, 181-195.
- Benjamin, K., Edwards, N., Guitard, P., Murray, M.A., Caswell, W., & Perrier, M. J. (2011). Factors that influence physical activity in long-term care. Perspectives of residents, staff, and significant others. *Canadian Journal on Aging, 30(2)*, 1-12.
- Campbell, M. (2003). Dorothy Smith and knowing the world we live in. *Journal of Sociology and Social Welfare, 30(1)*, 3-22.
- Campbell, M., & Gregor, F. (2004). *Mapping social relations: A primer in institutional ethnography*. Aurora, ON, Canada: Garamond Press.
- Chen, Y. M. (2010). Perceived barriers to physical activity among older adults residing in long-term care institutions. *Journal of Clinical Nursing, 19*, 432-439.
- Coffield, C. D. (2002). Welfare reform in Indiana: The political economy of restricting access to education and training. *Journal of Family and Economic Issues, 23*, 261-284.
- de Ruiter, H.-P. (2008). *To lift or not to lift: An institutional ethnography of patient handling practices* (unpublished doctoral dissertation). University of Minnesota.
- Diamond, T. (1992). *Making gray gold*. Chicago, IL: University of Chicago Press.
- Diamond, T. (2006). "Where did you get the fur coat, Fern?": participant observation in institutional ethnography. In D. E. Smith (Ed.), *Institutional ethnography as practice* (pp. 45-63). Lanham, MD: Rowman & Littlefield.

- Evert, L. (2008). *Mother knows breast: An examination of breastfeeding knowledge and experiences* (master's thesis). University of Regina, SK, Canada.
- Goodman, P. (2008). "It's just Black, White, or Hispanic?": An observational study of racializing moves in California's segregated prison reception centers. *Law & Society Review, 42*, 735-770.
- Grahame, K. M. (2003). "For the family": Asian immigrant women's triple day. *Journal of Sociology & Social Welfare, 30*, 65-90.
- Green, C. J., & Moehr, J. R. (2003). Decision support for governing boards of integrated delivery networks: Explicating versus eliciting knowledge. *AMIA Annual Symposium Proceedings, 854*.
- Hamilton, P., Mathur, S., Gemeinhardt, G., Eschiti, V., & Campbell, M. (2010). Expanding what we know about off-peak mortality in hospitals. *Journal of Nursing Administration, 40*, 124-128.
- Harrison, D. (2006). The role of military culture in military organizations' responses to woman abuse in military families. *The Sociological Review, 54*, 546-574.
- Limoges, J. (2010). An exploration of ruling relations and how they organize and regulate nursing education in the high-fidelity patient simulation laboratory. *Nursing Inquiry, 17*, 58-64.
- Luken, P. C., & Vaughan, S. (2003). Living alone in old age: Institutionalized discourse and women's knowledge. *Sociological Quarterly, 44*, 109-131.
- Luken, P. C., & Vaughan, S. (2006). Standardizing childrearing through housing. *Social Problems, 53*, 299-331.
- Marx, K., & Engels, F. (1976). *The German ideology*. Moscow: Progress.

- MacKinnon, K. (2006). Living with the threat of preterm labour: Women's work of keeping the baby in. *JOGNN: Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 36(6), 700-708.
- McCoy, L. (2005). HIV-positive patients and the doctor-patient relationship: Perspectives from the margins. *Qualitative Health Research*, 15, 791-806.
- McGibbon, E. A. (2004). *Reformulating the nature of stress in nurses' work in pediatric intensive care: An institutional ethnography* (unpublished doctoral dissertation). University of Toronto, ON, Canada.
- Paterson, B. L., Osborne, M., & Gregory, D. (2004). How different can you be and still survive? Homogeneity and difference in clinical nursing education. *International Journal of Nursing Education Scholarship*, 1(1), 1-13.
- Quance, M. (2007). *The social organization of nurses' labour pain work* (unpublished doctoral dissertation). University of Calgary, AB, Canada.
- Rankin, J. M. (2003). 'Patient satisfaction': Knowledge for ruling hospital reform: An institutional ethnography. *Nursing Inquiry*, 10, 57-65.
- Rankin, J. M. (2004). *How nurses practise health care reform: An institutional ethnography* (unpublished doctoral dissertation). University of Victoria, BC, Canada.
- Rankin, J., & Campbell, M. J. (2006). *Managing to nurse*. Toronto, ON, Canada: University of Toronto Press.
- Rankin, J. M., Malinsky, L., Tate, B., & Elena, L. (2010). Contesting our taken-for-granted understanding of student evaluation: Insights from a team of institutional ethnographers. *Journal of Nursing Education*, 49, 333-339.

- Sallis, F., & Owen, N. (1997). *Health behavior and health education: Theory, research and practice* (2nd ed.). San Francisco, CA: Jossey-Bass, 403-424.
- Sallis, J. F., Cervero, R. B., Ascher, W., Henderson, K. A., Kraft, M. K., & Kerr, J. (2006). An ecological approach to creating active living communities. *Annual Review of Public Health, 27*, 297-322.
- Schutzer, K. A., & Graves, B. S. (2004). Barriers and motivations to exercise in older adults. *Preventive Medicine, 39*, 1056-1061.
- Sharma, N. (2001). On being not Canadian: The social organization of “migrant workers” in Canada. *Canadian Review of Sociology and Anthropology, 38*, 415-439.
- Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*. Boston, MA: Northeastern University Press.
- Smith, D. E. (1990a). *Texts, facts, and femininity: Exploring the relations of ruling*. London, UK: Routledge.
- Smith, D. E. (1990b). *The conceptual practices of power: A feminist sociology of knowledge*. Boston, MA: Northeastern University Press.
- Smith, D. E. (1999). *Writing the social: Critique, theory, and investigations*. Toronto, ON, Canada: University of Toronto Press.
- Smith, D. E. (2001). Texts and the ontology of organizations and institutions. *Studies in Cultures, Organizations and Societies, 7*, 159-198.
- Smith, D. E. (2004). Ideology, science and social relations: A reinterpretation of Marx's epistemology. *European Journal of Social Theory, 7*, 445-462.
- Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. Walnut Creek, CA: AltaMira Press.

- Smith, D. E. (2006). *Institutional ethnography as practice*. Lanham, MD: Rowman & Littlefield.
- Townsend, E. A. (1992). Institutional ethnography: Explicating the social organization of professional health practices intending client empowerment. *Canadian Journal of Public Health, 83*, S58-S61.
- Townsend, E., Langille, L., & Ripley, D. (2003). Professional tensions in client-centered practice: Using institutional ethnography to generate understanding and transformation. *American Journal of Occupational Therapy, 57*, 17-28.
- Townsend, E., Sheffield, S. L., Stadnyk, R., & Beagan, B. (2006). Effects of workplace policy on continuing professional development: The case of occupational therapy in Nova Scotia, Canada. *Canadian Journal of Occupational Therapy – Revue canadienne d'ergothérapie, 73*, 98-108.
- Webster, F. (2009). *The social organization of best practice for acute stroke: An institutional ethnography* (unpublished doctoral dissertation). University of Toronto, ON, Canada

Chapter 3:

Personal Support Work in Long-Term Care and the Promotion of Physical Activity for Residents: An Institutional Ethnography

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Abstract

Despite the benefits of physical activity, residents living in long-term care (LTC) homes are relatively sedentary. Personal support workers (PSWs) are unregulated health care workers who provide the greatest proportion of direct resident care in this highly regulated workplace. Thus, they could play a pivotal role in promoting activity. However, little is known about the work of PSWs related to the promotion of physical activity in LTC settings. Institutional ethnography, which is based on Dorothy Smith's work on the social organization of knowledge, guided this study. This method of inquiry proposes that people's daily actions (work) in local settings are shaped and organized by the actions of people outside of the local setting, and that this organization is textually mediated. Two LTC homes in Ontario, Canada participated as study sites. Data collection methods included participant observations of PSWs as they worked, interviews with PSWs and other individuals who were recruited from within and external to the study sites, and the collection of texts such as provincial government standards for LTC. The findings include: (a) opportunities for encouraging physical activity were often overlooked, (b) although provincial standards were viewed as producing something "good" for the residents, some of these standards made it difficult for the PSWs to support physical activity in the daily lives of resident, and (c) the promotion of physical activity was seen as an "add-on" or a program, and it was designated as a professional activity that was outside the purview of the PSWs' role.

Keywords: physical activity, exercise, long-term care, nursing homes, qualitative research, institutional ethnography

**Personal Support Work in Long-Term Care and the Promotion of Physical Activity for
Residents: An Institutional Ethnography**

“You might have a resident who’s able to walk but is in a wheelchair because of long distances . . . But if she’s at the other end of the hallway and you want to bring her to breakfast but it’s going to take you a half hour to get there, there’s no way that’s going to happen because, you know, nursing or PSWs [personal support workers] need to be tending to their other residents who need to get to breakfast.” (Staff, facility #1) (Benjamin et al., 2011)

These reflections invite us to better understand how the work related to the promotion of physical activity happens in the LTC setting. Most of the direct hands-on care in LTC homes in Canada is provided by PSWs. Despite the fact that they are very important care providers, our understanding of what they do related to the promotion of daily physical activity is limited. A better understanding of PSWs and their work is critical to develop approaches that improve resident care. For this research, I took the standpoint of PSWs since I believed that they could play a pivotal role in assisting and encouraging residents to be more physically active.

It is well recognized that physical activity has many potential benefits for residents living in LTC homes including fall prevention, better sleep patterns, and improved muscular strength (Alessi, Yoon, Schnelle, Al-Samarai, & Cruise, 1999; Alessi et al., 2005; Cameron et al., 2010; Fiatorone et al., 1994; Gillespie et al., 2009; Norris, Walton, Patterson, Feightner, & the Canadian Task Force on Preventive Health Care, 2003; Ouslander et al., 2005a). Despite these known benefits, many residents in LTC are sedentary (Bates-Jensen et al., 2004; Ice, 2002; MacRae, Schnelle, Simons, & Ouslander, 1996; Ruuskanen & Parkatti, 1994). Limited physical activity may diminish the quality of life for residents of LTC.

Several investigators have explored the barriers to physical activity and restorative care⁶ within the LTC context (Benjamin, Edwards & Caswell, 2009, Benjamin et al., 2011, Chen, 2010; Galik et al., 2009; Resnick et al., 2006, 2008). Three main types of barriers are reported: individual (resident-related), organizational, and built (physical) environment. Barriers described at the individual level include factors such as poor health, fear of falling, past history of sedentary behaviour, lack of knowledge regarding the benefits of physical activity, anxiety and agitation, and sedative use. At the organizational level, barriers reported were funding and staffing constraints, the presence of pervasive institutional routines, the lack of tailored exercise programs, lack of nursing support, lack of time, and workloads demands. Barriers reported at the environmental level included the lack of designated space for physical activity, the presence of physical bottlenecks that reduce manoeuvrability, such as narrow and crowded hallways, and the lack of exercise equipment (Benjamin et al., 2009, 2011; Chen, 2010). In addition, a common barrier reported across most of the studies was the constraint of staffing due to factors such as: low staff:resident ratios, demands placed on staff to get their work done, and the provision of daily care by staff whose role and educational preparation did not include the provision of physical activity interventions for residents (Benjamin et al., 2009, 2011; Resnick et al., 2006, 2008).

The main purpose of this research was to gain a better understanding of how physical activity was socially organized to happen as it did. The focus of this research was on the work of PSWs and the factors that influence their work related to the promotion of physical activity in

¹ Within a LTC context, restorative care focuses on restoring or maintaining a resident's physical function so that the resident can maintain the highest level of function as possible (Resnick et al., 2008). It can include physical activities such as encouraging residents to wash their own face, self-propel their own wheelchairs, and go for a walk.

LTC. The method of inquiry that guided this research was institutional ethnography (IE), an approach that strives to uncover how things happen or how things work (Smith, D. E., 2006). It is based on sociologist Dorothy Smith's theory of the social organization of knowledge and is rooted in Marxist and feminist philosophy (Smith, D. E., 1987, 1990a, 1990b, 1999, 2001, 2005, 2006). Smith contends that people's daily experiences in local settings are shaped and organized, often unknowingly, by the actions of people outside of the local setting and that this organization is textually mediated (Campbell & Gregor, 2004). In contemporary societies, people's work often involves the use of texts such as reports, documents, and e-mails. The Nursing Home Act in Ontario (Government of Ontario, 2010) is an example of a text-based document that shapes and coordinates the way work happens in LTC homes.

Smith contends that all knowledge is socially organized. Some knowledge is dominant and authoritative, while other knowledge is subordinate (Campbell & Gregor, 2004). However, both forms of knowledge are at play in people's work lives. For example, according to the Ontario Ministry of Health and Long-Term Care (MOHLTC) standards (an authoritative knowledge source), residents must be offered two baths per week. However, through their experience, PSWs have learned (subordinate way of knowing) that it is faster to shower residents than to offer them baths. This alternative has become a usual care practice for some PSWs. Smith's work on the social organization of knowledge provides a framework that helps to uncover the instances in which authorized ways of knowing conflict with local knowledge. The main objectives of this study were to describe the everyday work of PSWs related to the promotion of physical activity of LTC residents and to uncover how this work was shaped and organized to happen as it did.

Methodology

Standpoint and Problematic

Standpoint and problematic are two key concepts that are used with the IE approach. Standpoint provides an entry point for the researcher. It is a particular location within the institutional order. It allows the researcher to discover how things work from people's everyday experiences rather than from objectified and authorized forms of knowledge (Smith, D. E., 2005). Typically, institutional ethnographers take the standpoint of people who are experiencing the situation or problem. For this study, I took the standpoint of PSWs because they provide the greatest proportion of direct resident care and could play a pivotal role in promoting residents to be more physically active.

The problematic is neither people's problems nor the research question (Campbell & Gregor, 2004). According to Smith, the problematic "is a territory to be discovered" (Smith, D. E., p. 410). It can be thought of as those moments when the official explanation of what is happening is at odds with the explanation provided by the people who are actually experiencing the situation (Rankin, Malinsky, Tate & Elena, 2010). In other words, the researcher can locate the problematic by looking for the instances in which the dominant form of knowing overrides and contradicts how the people who are actually experiencing the event talk about the experience. The territory that I wanted to explore in this research was the social organization of work related to the promotion of physical activity in LTC homes. My interest in this topic was generated by a practice issue that I had witnessed as a nurse in a LTC home: I noticed that the PSWs would wheel residents to the dining room rather than assisting them to walk because this was faster. Although I knew that this was not best practice, I felt powerless to change this practice.

Study Sites, Recruitment, and Eligibility

Two LTC homes in Eastern Ontario were invited to participate in this study. I chose LTC homes with more than 50 beds to ensure that I would have a sufficient pool of potential participants. I used my prior knowledge of LTC homes in this region to select two homes that I thought would be interested in participating. Since my interviews were to be conducted in English, I chose homes that I thought would have a sufficient potential pool of participants who were able to understand and communicate in English. Lastly, I chose study sites that were accessible by public transport.

The administrators at the two homes were asked to identify a clinical contact person such as a nurse or activity staff member to assist with the logistics of the study (for example, gaining access to the units). This study received reciprocal ethics approval from the University of Ottawa and approval from an affiliated ethics board using standard procedures of ethical conduct regarding informed consent, anonymity, and confidentiality.

I telephoned the LTC administrators to determine their interest and availability to be study sites, and both agreed. I was invited to attend various gatherings (such as the nurses' change of shift report and the residents' council meeting) for recruitment purposes. I also placed recruitment posters on the units asking people to contact me directly if they were interested in participating. Participants external to the study sites were recruited by telephone. I began data collection with my standpoint participants (PSWs), but as I gained clarity of the problematic with the preliminary data, I started to collect data from people other than PSWs, including nurse managers and MOHLTC representatives. To be eligible to participate, the participants had to be 18 years or older, able to understand and communicate in English, and capable of providing written informed consent.

Data Collection

Data collection methods included: (a) conducting participant observation of PSWs as they worked, (b) maintaining field notes, (c) conducting interviews using open-ended questions, and (d) identifying texts that the PSWs used in their work. Data collection involved an iterative process; details of this process are provided below.

Participant observations and field notes. During the observations, I accompanied the PSWs to their work areas (nurses' station, dining room, storage room, and tub room). The only room that the PSWs did not access regularly was the medication room. When possible, I sat in a location that gave me a full view of the geographical area to which the PSWs were assigned (for example, north corridor). During the observations, I paid particular attention to how residents were assisted or encouraged to mobilize and move their bodies. I noted anything in the work that seemed to frustrate the PSWs, paid attention to the pace and demands of their work, and observed how they negotiated these demands. The observations also helped me to see the activities and practices of the other staff, such as nursing supervisors.

Participant observations were conducted on all three shifts (day, evening, and night) at both study sites. Most of the observations were done during weekdays on the day and evening shifts. However, two periods of observations were conducted on the night shift and one observation period was held on a weekend. I limited my periods of observation to four hours to minimize disruptions to resident care. The ethics review board to which I submitted my proposal vetoed my plan to observe all types of PSW work or to assist with any direct or indirect resident care. Thus, I was not able to observe any care that was private, such as bathing, dressing, incontinence care, and toileting, which included most of the care provided in residents' rooms. Therefore, my observations were limited to common spaces.

I maintained detailed field notes during my participant observations, which included: (a) a description of the nature and pace of PSWs' daily work, (b) any comments they made, (c) who they interacted with, (d) texts they used or produced, (e) a description of the physical space, and (f) my personal reflections including follow-up questions I needed to ask.

Interviews. I began the interviews by asking the participants to explain what a typical day was like for them. I used probes when needed and asked questions related to their work including sources of information they used to do their work or make decisions about their work, and what made their work easy or difficult. Initial interviews were conducted with PSWs. Subsequently, I interviewed other people such as managers and MOHLTC representatives to gain further insights into how their work was connected with the work of PSWs. Examples of the questions that were asked included: (a) Can you tell me what a typical day is like for you?, (b) Can you tell me what makes your day run smoothly?, and (c) Can you tell me about the daily frustrations and challenges that happen in your work? I transcribed all of the interviews.

Collection of texts. To identify relevant texts, I paid attention to the texts that the participants used or produced during the participant observations, and I listened for mention of these texts in the interviews. As my study progressed, I gained clarity as to the specific work processes (threads) that I wanted to explore in more detail. These were the work processes related to meal service in the dining room and transferring residents (the movement of a resident from one surface to another [bed to chair] either by mechanical lift or by providing human assistance, such as a stand and pivot transfer). I chose these two work processes because they consumed a considerable amount of the PSWs' workday and because my initial hunch was that this work had some influence on residents' physical activity. I then looked for the texts that organized this work. Relevant texts that I examined and analyzed were the basic care flow sheet

and specific standards related to lifts, transfers and repositioning, and meal service located in the Long-Term Care Homes Program Manual (MOHLTC, 2007).

Data Analyses

As mentioned above, I came to focus on the dining room and transfer work of PSWs because during my initial observations I noticed that the PSWs spent a considerable portion of their day doing work related to these two work processes. In order to gain a deeper understanding of this work, I began to focus more of my observations and interview probes on this work. Therefore, I collected rich data on these two specific work processes and made these the focus of my analysis.

Data analysis involved an iterative strategy that involved reading and rereading my transcripts and field notes, asking questions of the data and examining linkages between the work practices of the PSWs and the work practices of others. As I read my transcripts and field notes, I asked the following questions: (a) What are the PSWs doing?, (b) How is their work connected to the work of other people?, (c) What is this work intended to produce?, and (d) What is it actually producing? When I could not answer these questions with my data, I returned to the study sites and asked for clarification during a formal interview or informal chat with the study participants.

I selected data excerpts from the transcripts and field notes that were relevant to the two work processes that I explored in detail, posted them on paper, and mapped the linkages that connected the work of the PSWs to the work of other people. Mapping provided a visual display of the linkages that connected peoples' work.

Analytical writing took place throughout the duration of this research. In the early stages of data collection, I read my transcripts and field notes, reflected on this data and then wrote an account of what I was seeing. I repeated this process building an increasingly deeper understanding of how the PSWs' work was shaped and organized and how their work was connected to the work of others. I also wrote vignettes that described a typical day for a PSW based on my observations.

Textual Analyses

To identify relevant texts, I paid attention to those that the participants used or produced that I observed and I also listened for mention of these texts in the interviews. As my study progressed, my analytical writing became centred on work related to the dining room and transfers and hence, I concentrated on retrieving and analyzing texts that seemed to organize this work. My analysis focused on how people engaged and used the texts. I used the following questions when doing my textual analyses (a) What is this text used for? (b) Who uses this text? (c) What does it accomplish? (d) What does it leave out? and (e) What happens to the text once it is completed?

The following is an illustrative example of how I went about doing a textual analysis. I was told by a manger that there were several MOHLTC standards related to how meals had to be served in dining room. I found these standards in the Long-Term Care Homes Program Manual (MOHLTC, 2007). One of these standards stipulated that meals had to be "served in an unhurried manner in a comfortable dining area equipped to meet the meal service requirements of residents" (MOHLTC, 2007, Meal Service Policy 1.24, p. 4). I reflected on what this standard was actually accomplishing using my observations and interview data and how it was affecting

the PSWs' work. For example, there was another standard stipulating that meals had to be served one course at a time. This meant that the PSWs had to serve the first course (such as soup), wait until the residents had finished this course, remove and stack the dirty dishes (while making a mental note of how much food was consumed), and then serve the next course of the meal. This placed additional demands on the PSWs' time, which meant that they had to work quickly to complete their work. I repeated this analytical process for several MOHLTC standards. The results of these analyses were then woven into my analytical writing and were used to support what I was seeing and hearing.

Study Rigour

To help ensure the rigour of my study, I extracted quotes from the participant's transcripts to support the claims that I was making; in keeping with the IE framework, I focused on the empirical excerpts – those quotes that revealed traces of the participants' material world, those aspects of things happening. I also maintained a detailed audit trail that included the storage of all data in a qualitative software program.

Although institutional ethnographers are not interested in establishing the transferability and generalizability of their data, they are interested in describing generalizing practices that cut across several settings (DeVault & McCoy, 2006). The enlistment of two study sites allowed me to discover the ruling relations that cut across both sites, including government standards and accountability practices that governed not only the sites where I was gathering data, but also other LTC sites where workplace practices are socially organized in similar ways.

Findings

Study Sites and Sample

The two study sites differed with respect to size and age: one site was located in a building more than 15 years old and had fewer than 100 LTC beds, while the other site was built less than 15 years ago, and had over 100 LTC beds. Despite these differences, the work of the PSWs was similar in the two LTC homes.

A total of 11 periods of observation were completed across the three shifts (six periods of observation on days, three on evenings, and two on nights) at the two sites, for a total of about 44 hours of observation. These observations included 19 participants (10 PSWs, six nurses, and three residents). Thirty-five interviews were completed. Twelve interviews were conducted with the 10 PSWs, with an average duration of 20 minutes (range 9.5 to 29.1 minutes). A total of 23 interviews were conducted with 21 other participants (four residents, five registered practical nurses [RPNs], two registered nurses, two nurse managers, two allied health care provider, one PSW educator, one LTC manager, three MOHLTC representatives and one representative from a Local Health Integration Network); the average duration of these interviews was 35 minutes (range 20 to 60 minutes).

Vignette: What do Personal Support Workers do in a Typical Day?

I begin by providing a vignette that describes a typical day for one PSW, whom I shall call Lorrie (not her real name). This information was collected during two periods of observation on two separate day shifts.

It is 7:15 am. Lorrie has just finished listening to the change of shift report given by the RPN. Typically, each PSW is assigned eight to 10 residents to care for by the RPN. Lorrie goes

to the storage room, restocks a linen cart, and then enters a resident's room. After assisting the resident to put on his/her shoes and pants, she goes to look for a Maxi-lift. She then places the lift canvas under the resident (she describes how she has learned to use her body weight to push 200-pound residents over by herself because it is often challenging to find a second person to help). She leaves the room to look for a second person to help with the mechanical lift since it is policy that two people must be present when doing a mechanical lift. The RPN offers to help her with the lift.

Four of Lorrie's residents require a mechanical lift, and the others require one or two people to assist with their transfers. Lorrie tries to complete morning care (washing, grooming, dressing, incontinence care/toileting, and transferring) by 8 am because she has to go to the dining room to serve breakfast. Today, there are three PSWs and two nurses in the dining room. Sometimes staff from other departments or volunteers assist in the dining room. The PSWs must serve one course at a time and remove the dishes from the table after each course. They are also expected to make a mental note of how much each resident has eaten so that this can be documented on the resident's nutritional record.

Breakfast is over by 8:50 am. Lorrie has two residents who require trays in their rooms. She explains that it is easier for her to provide breakfast to these two patients in bed because the residents are in rooms across the hall from one another. She leaves their doors open, which allows her to monitor the residents who are still lying in their beds. It is policy that all residents must be monitored for choking every two to three minutes when they are eating in their rooms. After the bed-bound residents have finished their meals, Lorrie goes for a 15-minute coffee break. When she returns, she completes two tub baths in about 45 minutes, empties her linen bags, and helps another PSW with a mechanical lift transfer. It is now 10:30 am, and she decides

to leave one resident in bed because she knows that she will not have enough time to transfer the resident from bed to wheelchair in preparation for lunch. She has to go for her own lunch break at 11 am so that she can return in time to help with the residents' lunch.

Lorrie returns at 11:30 am and transfers one resident out of bed into a chair using the mechanical lift. She then assists some residents with toileting and transports others by wheelchair to the dining room. The work processes that were followed at breakfast are repeated. Lunch takes one hour to complete. After lunch, she takes some residents in their wheelchairs to the lounge so that they can watch TV, and she takes others to their rooms. Although it is not part of her daily routine, she porters one of her residents who is able to mobilize independently by wheelchair to the ground floor because the resident was eager to meet her out-of-town visitors. Lorrie then serves the afternoon snack (for example, tea, coffee, juice, biscuits, or yogurt), which takes 20 minutes, tidies her linen cart, empties her soiled linen bags, and goes to the nurses' station to complete her paperwork. She is required to fill in several forms such as the daily basic care flow sheet, nutrition record, medication administration record, bowel movement record, and seven-day observation form for the Resident Assessment Instrument (RAI-MDS). Her paperwork can take up to 25 minutes to complete, and she must answer any resident call bells that ring during this time. At 2:45 pm, she goes to her residents' rooms to ensure the rooms are tidy and the residents are okay. She empties her supply cart and tells the RPN that her residents are fine, says goodbye to the other PSWs, and tells them she will see them tomorrow. Tomorrow will be a repeat of today.

This vignette is an illustrative example of a typical day for a PSW, which involves nonstop activities. Embedded in this information are numerous clues to support the analytical threads as to how the work of PSWs related to the promotion of physical activity was socially

organized. These threads include the physical care of residents related to lifts, transfers, and repositioning, and the work related to the dining room.

MOHLTC Standards Organizing Something “Good” to Happen

The LTC homes were highly regulated environments. One manager said that there were over 200 MOHLTC standards in Ontario applying to the care of the elderly in LTC homes. These are listed in the Long-Term Care Homes Program Manual (MOHLTC, 2007). Policies, rules, and regulations have been developed from these standards and are embedded into the PSWs’ daily routines. The intention of these standards is to organize the work of LTC providers so that something “good” happens for the residents. For example, in the past decade, new standards and policies related to meal service have been implemented in LTC homes in order to provide residents with pleasurable dining experiences, which placed additional demands on the PSWs. Given their heavy workloads, the PSWs sometimes wheeled residents to the dining room, because this was faster than assisting them to walk. This practice limited residents’ opportunities for physical activity.

During my observations, I noticed that the PSWs spent a large proportion of their day in the dining room serving meals and assisting residents to eat. They also spent a considerable amount of time transferring and transporting residents to and from the dining room. The 30-minute period before meals was especially hectic for the PSWs. For instance, in the morning the PSWs had one hour to do morning care for eight to 10 residents and then bring them to the dining room. Most of these residents needed some level of assistance to get to the dining room. To speed up the process, the PSWs sometimes wheeled residents to the dining room rather than assisting them to use their walkers. On the day shift, a PSW could spend two hours or more in

the dining room. In addition, one PSW had to pass out an afternoon snack, which took an additional 20 to 25 minutes.

Several standards shaped and organized this work. For instance, there is an MOHLTC standard stipulating that “residents shall be served meals in the dining room unless their needs are better met in another location, according to the residents’ plan of care” (MOHLTC, 2007, Programs and Services: Dietary Services: Meal Service Standard, P1.20, p. 4). Most of the people I interviewed supported the underlying rationale for this standard. For instance, a manager explained that for some residents, eating in the dining room was their only opportunity to socialize. However, I did not observe many instances when the residents actually talked to one another in the dining room. In fact, one resident said that there was no one at his/her table who could engage in a “lively discussion.” In most cases, the PSWs were busy serving the meal, which meant they had few opportunities to engage in social conversations with residents.

As previously mentioned, there is an MOHLTC standard that states: “To provide a pleasurable dining experience, meals shall be served in an unhurried manner in a comfortable dining area equipped to meet the meal service requirements of residents” (MOHLTC, 2007, Meal Service Standard, P1.24, p. 4). During my observations, I noticed that the dining rooms were decorated with plants and home furnishings. The PSWs, nurses, and managers explained that several modifications had been made to the dining rooms and meal service in order to create more of a home-like atmosphere and a better dining experience for the residents. One PSW provided further insights into how she understood these changes:

“They had one main dining room [talking about the past] . . . and the people who were capable of walking would go down for breakfast and lunch, and then on the unit they had people with less mobility to eat on the unit . . . But now . . . they [facility] want to get all of the people together and produce a different sort of dining with them. So it is a bit more formal for each floor . . . but they have

choices . . . Well they had choices before too, but now you have to show . . . they show you what your choice is so that you can select what you want. I think it is a bit more formal for the residents . . . They want it to be like a home situation like you can talk and whoever is serving . . . no loud talking . . . noise level should be at a minimal . . . So they [residents] can enjoy their meal and interact with each other. So I think it is very improved for the residents, and I think the atmosphere is pleasant and the tablecloths; well they did have tablecloths and placemats before, but everything is just nicer now.”

This statement did not match my observations of what was actually happening during meals.

The meal service in the dining room did not resemble the home-like situations with which I am familiar. Most older people living in their own homes eat at their kitchen tables, not in formal dining rooms. In addition, they typically are not served three-to-four-course meals three times per day. One nurse commented that the facility wanted to make the meal service like a “five-star restaurant.” Creating this ambience in the dining room was labour intensive, which meant that the PSWs had less time to assist and encourage residents with their physical activities.

Another standard requires LTC homes to offer the residents a choice of two main food courses. As mentioned by the PSW in the quote above, having a choice of two food options was not new. However, the PSWs now have to show the two food options to each resident, note his/her selection, and then retrieve the order from a small kitchenette area located in the dining room. This work consumes a lot of the PSWs’ time. An RPN questioned the value of this work because some residents did not understand that they were being offered a choice and could not make a selection. In these instances, the PSWs were advised to observe the resident for subtle hints that he/she was making a choice, such as gazing at one of the food plates. Although the residents were given some choice as to what they ate, they did not have a choice as to where, when, and with whom they dined, as meal hours were scheduled and tables were assigned.

A nurse manager explained that considerable emphasis was placed on the dining experiences because food was a “hot topic” among residents and families. Residents were encouraged to voice their concerns, likes, and dislikes about the food at different venues such as residents’ council meetings. Despite good intentions and all of the efforts to improve the dining experiences for residents, the consensus from nurses, managers, and residents was that the food was not very good and there was definitely room for improvement. For example, a resident complained that the meat was often processed, and another resident said that he/she looked forward to breakfast because it was the only meal “they could not spoil.” Despite good intentions to provide residents with pleasurable dining experiences, the quality of food was felt to be less than optimal.

There is another standard related to how meals are to be served: “Meals shall be served one course at a time, unless individual residents request otherwise” (MOHLTC, 2007, Meal Service Standards, P1.21, p. 4). The PSWs also had to remove the dishes after each course. Typically, there were three to four courses at each meal. A PSW provides further insights about her understanding of the work in the dining room:

“You have to serve them. Prepare the juice . . . the orange juice . . . and after you pick up the glasses, you start with the main course menu like porridge . . . You have to offer them a choice, they have two choices . . . After that you have to pick up the dishes . . . and scrub them, but sometimes we cannot, like if someone calls in sick for the day and we are down [staff] for the day.”

This statement illustrates the reality of the PSWs’ work in the dining room, a reality that does not match what everyone thinks is happening in the dining room. For instance, the official understanding of the meal service is such that it produces pleasant dining experiences for

residents, but in actuality the PSWs were rushed and sometimes could not complete their work, especially if a PSW called in sick and was not replaced.

How Was Physical Activity Socially Organized into the PSWs' Daily Work?

It became clear to me that the work demands on the PSWs meant that the promotion of physical activity was organized out of their daily work. However, when I asked the PSWs and their managers what the promotion of physical activity meant to them, more clues as to how this was organized surfaced. They felt that the promotion of physical activity was important but that it was not a PSW's role. They quickly pointed out that they had physiotherapists who did the "walking and the exercises."

When I asked the PSWs and the nurses to explain their understanding of how to promote physical activity, the most common response revolved around encouraging residents to do things for themselves like wash their face or comb their hair. Their understanding of how to promote physical activity was embedded in the rhetoric of doing for self. This idea was reinforced by the comments made by a PSW educator during an interview. This educator explained that the PSWs are taught to encourage residents to do for themselves, saying that this would help to promote resident "autonomy and independence." She/he emphasized that even simple activities such as buttoning one's blouse were important because they promoted residents' manual dexterity. However, she/he pointed out that what the PSWs learned "from the book" is not translated into practice because students "lose the ability of having time to promote mobility" when they enter clinical practice because the focus is on "getting their jobs done." Although this educator implied that promoting mobility was important, it was apparent that promoting physical activity was considered an add-on to "getting their jobs done", rather than being integral to their work. This

understanding was evident from my observations of and interviews with PSWs and nurses, who often completed the care for residents because it was faster. An RPN commented:

“Making them as independent as possible . . . letting them wash their hands and face if possible . . . or promoting them to walk . . . But in nursing, a lot of people say that it is easier and a faster way is just to do it for them, but they [PSWs] have to get their work done, and it’s got to be done in such a time, and they don’t believe in doing baths in the afternoon . . . So you see, you are trying to promote them [residents] to be independent, you are also taking away that little bit of independence that they had.”

The PSWs’ work focused on meeting the physical needs of the residents, with an emphasis on helping residents to complete their basic activities of daily living such as hygiene, transferring, and nutrition. It did not focus on promoting mobility or physical activity. I observed that the PSWs encouraged residents to do things for themselves if it could be done in a reasonable amount of time and would enable the PSWs to assist other residents with an activity of daily living. For example, I observed a PSW encouraging a resident to self-propel herself/himself to the dining room because it allowed the PSW more time to help other residents. However, in most cases, the PSWs compensated for the competing demands placed on their time, limiting opportunities for physical activity in daily care. They made these changes despite their belief that residents’ independence and autonomy were important.

The Separation of Physical Activity from Daily Care

The promotion of physical activity was seen as something separate from daily resident care. A PSW commented that most PSWs do not realize that helping a resident to walk can be considered as promoting physical activity. She/he explained: “The walking part, they [PSWs]

don't even realize that they are actually walking them as part of the activity; it's more of to get them from point A to point B."

I did not observe many instances when the PSWs assisted residents to walk in the hallways. One exception was when they guided blind residents to the dining room. When asked about the promotion of physical activity, some PSWs talked about formal exercise programs. However, these formal programs, which took place one to three times per week, were seen as something separate from daily resident care. One PSW explained:

"This morning he/she [physiotherapist assistant] had a big group in there [lounge area] and they were doing exercise with their hands and feet and moving their arms and their feet . . . but I mean that's like once or twice per week and that's it. And the PSWs just don't have the time. We just, we would love to do it, but we just don't have the time."

Thus, although several PSWs commented that they would like to assist residents with physical activity, they did not have the time. In most cases, this physical activity work was delegated to physiotherapists. The physiotherapy departments at the two study sites typically operated during normal business hours and not on weekends. Residents had to have a referral to be seen by a physiotherapist and were entitled to 100 visits from a physiotherapist per year under the Ontario Health Insurance Plan. I did not interview or observe the work processes of any of the physiotherapists. However, I did notice that a few residents hired their own private physiotherapists. One of the residents explained that he/she had hired a private physiotherapist for a short time because he/she had to learn to walk again after an illness and needed daily physiotherapy.

Data from the Price Waterhouse Coopers (2001) study provide further insights into the provision of physical therapies. According to this survey, 14% of LTC residents in Ontario are

deemed to have rehabilitation potential, but only 10% of those with rehabilitation potential received any physiotherapy. Furthermore, although 67% of LTC residents have restricted range of motion, only 27% of those in need received daily range of motion exercises.

My observations revealed that the normal, spontaneous daily movement that most elderly people living in the community engage in during the day was not part of the daily lives of LTC residents. Physical activity was viewed as an add-on program and not something that elderly people typically do each day. Most residents did not exercise on their own outside of their exercise classes. However, there were a few exceptions. For instance, one resident commented that he/she did hand weights on the weekends when the physiotherapy room was not open.

Ruling Knowledge about Rigid and Inflexible Routines: How the PSWs Organized Their Work

The PSWs' work was organized around several care routines such as toileting and bathing. One PSW told me that the care routines were "pretty much the same" in all of the LTC homes where she had worked. Some of the PSWs said that they followed the same routine each day because the residents did not like it when their care routines changed. Some of the nurses and RPNs made similar comments. Other PSWs said they had to follow their routines in order to "get their work done." They described how challenging their work became when their routines were disrupted. For instance, a PSW explained that "having to clean just one mess could cause my day to run poorly."

The routine nature of the PSWs' work was viewed as problematic. Some of the managers and nursing supervisors expressed frustration that the PSWs are "so task-orientated." A manager stated that the PSWs had their routines and that it was his/her impression that the PSWs would

“rush the residents through their meals” so that they could “move on to their next task.” In another case, an RPN said that, although PSWs were encouraged to go for a walk on their breaks in the summer to “de-stress” themselves, they rarely did so because they were focused on getting their care done.

Over the past decade, there have been efforts by the MOHLTC to standardize care in LTC homes. For instance, in 2005, the use of a standardized instrument, the RAI-MDS, was mandated in all LTC homes in Ontario, and on July 1, 2010, the new Long-Term Care Homes Act, 2007 was enacted. Despite the trend towards standardized care, the PSWs demonstrated or told me of instances when they circumvented some of the expected standardized work practices. For example, rather than using a standardised list of PSW duties, a full-time PSW said that she oriented casual PSWs to the unit by explaining her own routine to them because she knew that it “worked well.”

PSWs’ Work Related to Transfers, Lifts, and Repositioning

Transferring residents emerged as a major component of the PSWs’ work. All residents’ transfer needs were assessed upon admission by nursing or physiotherapy, and this information was entered into the individual resident’s care plan. PSWs were informed of the transfer needs of new residents during the change of shift report. Transfer pictograms were placed at the head of residents’ beds and were updated as needed. The policies related to lifts and transfers originated from a MOHLTC standard that stated: “When transferring or positioning a resident, staff shall use safe transferring and positioning techniques and equipment” (MOHLTC, 2007, Standard, B3.61, P. 21). This standard is intended to help ensure resident and worker safety.

Transferring was time-consuming for the PSWs because most of the residents required assistance with this activity. For instance, on a 32-bed unit, only eight residents could transfer independently. Of the remaining 24 residents, 12 needed mechanical lift transfers. On the day shift, this work was typically divided among three PSWs. A PSW explained: “I actually do five [mechanical] lifts, now she [other PSW] has four, and she [other PSW] has three.”

In addition to transfer work, the PSWs also had to reposition residents while in bed. Some of this repositioning required two workers. However, a PSW explained that she/he had to position transfer slings under residents’ bodies by herself/himself:

“But when you are putting on the sling, you have to push 200-pound bodies over, push the sling, push them back, and people [staff] want you to be ready so they are not helping you to move the body back and forth.”

The PSWs’ interpretation of mechanical lifts was that the repositioning of residents onto slings had to be done alone because of time constraints but that two workers would be present for the actual lifting. In the interest of saving time and preventing injuries to themselves, the PSWs sometimes reverted to the use of a mechanical lift even though the resident could walk or weight bear. One PSW explained:

“Some staff are not as motivated to promote it [physical activity] as others and some have had injuries so they are a little more reluctant to take a patient that is a heavier work case to get them to walk, move, or transfer. They will quickly go to the lift . . . whereas they [resident] could maybe walk a few steps with a walker.”

The main source of the PSWs’ official knowledge regarding lifts and transfers originates from their formal education and orientation to the LTC homes. When asked whether there were lessons in the curriculum devoted to the promotion of physical activity in the PSWs’ training, a former PSW educator commented:

“So you would have mobility, so you would have transfers . . . I would have gotten a physiotherapist to give them a little presentation on their role. Lifts and transfers . . . principles of body mechanics . . . How do you move residents . . . basic movement, sliding, rolling . . . getting a person who has fallen . . . it is basically how to move a patient safely. That’s about the only mobility to talk about . . . They are not physio assistants . . . so there is not a lot of emphasis there [promoting physical activity].”

Limitations

The work processes related to toileting/incontinence care were not included in this study since my plan to observe this work was vetoed by the ethic boards owing to its private nature. Typically, a considerable amount of bodily movement can happen during this work process. For instance, a PSW may assist a resident to walk from the bed to the toilet, or the PSW may supervise while the resident stands and pivots from the bed onto a commode chair. This work would be a fruitful area for future institutional ethnographic work.

Although I invited individuals such as family members and physiotherapists to participate in this research, they did not volunteer. There are several reasons why family members and physiotherapists may have decided not to participate. Recruitment strategies for family members involved the use of posters and recruitment efforts at family council meetings. The posters asked people to telephone the researcher if they were interested in participating. This strategy was not successful - I did not receive any calls.

I also provided information sessions at a family council meeting at both sites and asked people to call me by phone or to speak to me after the meeting if they were interested in participating. Although one person expressed interest, I was unable to reconnect with this person because I did not have adequate contact information. A spokesperson at a family council meeting did offer to help me with recruiting if my initial efforts were not successful. I did not

act on this offer because I assumed that my other recruitment efforts might work and I did not have ethical approval to elicit the help of this person. As my study progressed and I realized my other recruitment strategies were not working, I considered recruiting family members directly on the unit level. However, I saw very few family members on the units when I was visiting and did not have ethical approval to approach family members directly. I ran out of time to pursue the option of recruiting family members directly on the unit level through an ethics amendment or to attend other family council meetings.

With hindsight, other recruitment strategies for family members should have been used. For instance, in a previous study (Benjamin et al., 2011), a clinical contact person provided a letter of information to interested individuals and then gave research team members the names of potential participants. Information sessions at different social gatherings on weekends and in the evening when more family members were visiting may have aided recruitment.

In both study sites, the physiotherapy services were contracted out to private physiotherapy companies. Physiotherapists may not have volunteered due to lack of time for interviews given their many scheduled appointments with residents. The work of such people may have provided further insights into the social organization of physical activity work.

Discussion

Different Understandings of What was Happening

When I began my participant observations, I did not pay particular attention to the work in the dining room. This may partly be explained by the fact that I thought I knew what the PSWs actually did in the dining room based on my clinical practice. That is, a PSW's role was to assist residents with their meals. This could include tasks such as cutting a resident's food,

opening food containers, or feeding residents who were unable to feed themselves. However, I began to notice that the PSW also did many tasks similar to what a server would do in a restaurant.

The official understanding of the dining room work was that it produced pleasant dining experiences for residents. The PSWs' understanding of the work was different. They explained that this work was hectic and physically exhausting because there were many rules and regulations that they had to follow. Most of these rules were related to how the meals had to be served. When I examined this work more closely, I noticed that there was a contradiction between what people thought was happening and what was really happening. By following the links that connected this work to the work of other people, I realized that the MOHLTC standards did not unfold as they were intended to in actual practice. This finding highlights the value of having used an institutional ethnographic lens in order to discover what was actually happening in the daily experiences of PSWs and how this affected their ability to promote physical activity.

The Rhetoric of Doing for Self

The promotion of physical activity was embedded in the rhetoric of encouraging residents to do for self. A PSW educator in this study said that this philosophy of care is emphasized in the PSWs' training. For instance, the PSWs are taught that it is very important to encourage residents to assist with their care because this promotes their independence and autonomy. However, due to heavy workloads and the need to complete their work, PSWs often complete the task for the resident because this is faster.

This practice can have serious consequences for residents such as loss of dignity and independence, decreased sense of self-mastery and autonomy, and declines in physical functioning. Heavy workloads that do not allow PSWs ample time to encourage residents to do for self, are not health promoting or morally responsible. Every resident should be given opportunities to do things that will help them to maintain their sense of dignity and physical function.

The Separation of Physical Activity From Daily Care

The findings of this study clearly show that the promotion of physical activity is considered as something separate from daily care. The promotion of physical activity is seen as an add-on and a program separate from what elderly people do during the day. The promotion of physical activity is parcelled out and designated as a professional activity in the purview of physiotherapists.

Physiotherapy services were contracted out to private companies in the two study sites. A manager commented on the advantages of this arrangement for LTC operators. She/he said that when contracting out, the LTC home does not have to contend with the day-to-day operations; the only cost to the home is related to the provision of space for an exercise or physiotherapy room. Furthermore, she/he felt that the company provided excellent service, used the most current best practices to design their programs, and ensured that their staff were well qualified and engaged in ongoing continuing education.

However, contracting out may not always be in the best interest of residents. Private physiotherapy companies work during normal business hours and this means that residents must fit their exercise schedule into this timeframe. For instance, exercise rooms in LTC homes are

typically closed on the weekends and there are no physiotherapy staff to assist residents with their exercise. Current guidelines for healthy active living for seniors living in the community suggest that seniors should try to accumulate at least 2.5 hours of moderate-vigorous intensity aerobic activity per week (Public Health Agency of Canada, 2011). This equates to about 30 minutes of activity five days per week. However, exercise programs in LTC homes are typically provided only one to three times per week (Benjamin et al., 2011, Lazowski et al., 1999). Thus, evidence-informed guidelines for physical activity are not reflected in existing exercise and physiotherapy programs.

Regulated and Routinized Workplace

The PSWs were aware of many standards that had to be met. An environment that is highly routinized and regulated is not an environment that would embrace change related to the promotion of physical activity. A first step would be to gain a better understanding of what outcomes these regulations are actually producing. Using the analysis that an IE provides, it is apparent that the regulatory framework organizes contradictory practices that cannot enter into the accountability circuit being used to determine whether elderly residents are getting adequate care. If regulators could find a way to use the “good knowledge” PSWs have that provides insight into how their work proceeds, rather than the relying on the ideological knowledge of the regulatory and accountability frameworks, it would provide directions for real change — in the best interests of the residents. Within current systems, what the PSWs know is routinely “worked up” into the documentary understandings that are several steps removed from the realities of the PSWs’ daily practice. For instance, the PSWs complete a basic care flow sheet on each resident at the end of their shift. This flow sheet is a standardized form and the PSWs

initial the care that they provide. However, there is no space to mark in care that falls outside of the listed categories. Thus, this standardized form may not accurately capture what the PSWs know about the residents or reflect the full extent of actual care provided.

The Transfer Work of PSWs

Between 2004 and 2006, the MOHLTC committed about \$80 million to the Patient Lift Initiative, which covered costs for the installation of lifts and staff training (Institute for Work & Health, 2007). In addition, the lifting and transferring of residents is a key component of the PSWs' formal training course. There is no education related specifically to the promotion of physical activity because it is not seen as a PSW role. The use of mechanical lifts are intended to produce good outcomes for workers (e.g., reduced strain injuries) and residents (e.g., reduced skin injuries). However, the findings suggest that some PSWs were using lifts as a time-saver. This meant that residents were given fewer opportunities to move their bodies and assist during their transfers. This finding highlights the importance of gaining a better understanding of how standards and policies related to the lifting and transferring of residents are actually translated into practice and what outcomes these practices produce.

Implications for Practice and Policy

The purpose of an IE study is to explicate the social organization, laying the ground for alternate solutions to problems. Some people may think that the solution to improving the activity levels of residents is by adding more legislation, guidelines, role definitions, and education related to the promotion of physical activity. However, this study has shown that standards are taken up differently from the way they are written. Addressing this disjuncture

starts with the PSWs and LTC residents to determine how daily physical activity could be embedded into their work assignment and daily lives, respectively. There are several issues that require consideration when thinking about change.

Currently regulatory frameworks in LTC homes rely heavily on “standardizations” and the subsequent “facts” about what constitutes quality of care. This information is “worked up” in multiple documents such as audits, flowcharts, care plans, and so forth. For change to happen it is necessary to produce local solutions that take into consideration the specific context and the specific resident. As such, there is a need for regulators to begin moving away from their heavy reliance on standardizations and the ensuing facts about quality.

Adding new regulations to promote physical activity is not an optimal solution. This study has shown that every minute of the PSWs’ time is occupied, and they have very little slack in their heavy workloads. Each new regulation that is added requires the PSWs to decide what work can now be “left out” or what adjustments in care must be made in order to cope with the heavy demands on their time. This is exactly what happened with the dining room regulations. Other work that the PSWs did such as portering residents to the dining room (wheeling versus walking) was organized in relation to the dining room work. These regulatory practices overlook the capacities of the PSWs to provide care in such a “squeezed” timeframe. This underscores the importance of inviting PSWs to identify what types of resident assignments would facilitate their incorporation of physical activity promotion into daily care.

What this research has shown is that most of the managers looked “up” to the official or theorized explanations to understand and explain what was happening. There is a need to take a different approach — that is, to look “down” into the daily experiences of PSWs to discover and to understand what is actually happening. The work of PSWs on the ground needs to be

managed and supported within its rich contextual knowledge of what is needed, not without the supports and resources of interests in quality, but differently. There is also a need to build capacity among LTC home managers so that they look “down” into the daily experiences of workers (e.g., PSWs) rather than only looking “up” to the theorized explanations. This would help produce fertile ground for a different form of knowledge and alternative understanding of “evidence” that is based on people’s actual experiences.

Although this study provides a new view into what PSWs actually know and do, there were important details of what actually happened that were not captured. For instance, I was not ethically approved to observe work that was carried out “behind curtains.” However, from my own nursing experience I know that supporting people to toilet, bathe, and manage incontinence is complex and time-consuming. This seems unaccounted for in the way that PSWs’ work is understood to proceed. For instance, a manager felt that the PSWs did not always provide resident-focused care because they rushed the residents through their lunch. Her/his assessment of this rushing was that the PSWs’ aim was to finish their work 30 minutes before their shift ended. She/he implied that this was wasted time. The PSWs had a different explanation: They said that they had to work quickly because after lunch there were toileting routines and then they had to complete their paperwork, which took about 30 minutes. This manager did not appear to have a thorough understanding of what the PSWs actually did after they served lunch in the dining room or of the importance of 30 minutes of flexible time to complete their paperwork, or answer any call bells — in the event of “one mess.”

There is a need to supplement the current formal exercise and physiotherapy programs with a philosophy of care that will embed the promotion of physical activity into daily care. For instance, walking a resident to the dining room rather than wheeling the residents should be

afforded higher priority than ensuring that all baths are completed before 10 am. For this paradigm shift in thinking to happen, it will have to be organized into the daily work practices of PSWs. Lastly, rewards and incentives may help to facilitate this change in thinking and practice. For example, LTC homes that develop innovative ways of embedding the promotion of physical activity into daily care could be officially recognized within the LTC industry and provided opportunities to share their successes with other homes.

The new LTC Home Act (2007) stipulates that LTC homes have an organized interdisciplinary program with a restorative care philosophy (Government of Ontario, 2010). However, given the heavy workloads of staff in LTC homes, implementing this new legislation into practice will be challenging. One possible solution would be to embed this restorative work into daily care and to change staff perceptions so that they view the time used to complete their activities of daily living as windows of opportunity where physical activity can happen. For example, perceptions that baths are just “basic care” can be changed so that they are viewed as “therapeutic” windows of opportunities for residents to move their joints in soothing warm water.

Implication for Future Research

LTC homes are highly regulated and highly routinized work environments. Determining the impact of increased flexibility and less regulation on residents’ physical activity levels would be a fruitful area for future research. This could involve research questions such as what would be the impact on residents’ levels of physical activity if meal hours were more flexible (e.g., staggered meal sittings) and there was less formality and fewer regulations stipulating how meals are served.

Although this study focused on the promotion of physical activity, it would be interesting to look at other work processes such as toileting and incontinence care. Even though I did not ethnographically describe these duties, I know how time consuming the toileting and incontinence care routines can be. It is important that ethnographers document the complexity of this work and the individual knowledge PSWs rely on in order to provide this care with its necessary attention to detail. In the “official” accounts, this work is organized as though it were mundane and simple. This is unlikely the case. It is through studies such as this one that nurses and others can gain a better understanding of the work of PSWs. It would be valuable to gain a better understanding as to how the social organization of this work influences the promotion of physical activity.

The focus of this study was on the social organization of the promotion of physical activity within a LTC context. Currently, retirement homes in Ontario are not regulated by the government. However, plans to regulate this industry have been proposed. The social organization of work related to the promotion of physical activity of seniors living in these retirement homes pre- and post-regulation would be a useful area for study. Given population aging, retirement residences are important targets for health promotion related to physical activity and healthy lifestyles.

During this study, I heard and observed that different standards and policies took precedence over others. For example, the PSWs typically adhered to the policy related to having two staff to complete a mechanical lift. In contrast, some of the PSWs did the heavy preparatory work of placing residents onto slings alone. Gaining a better understanding of how some policies and standards take precedence over others is another area for future research.

In the past five years, several new initiatives such as implementation of the RAI-MDS system have been introduced into LTC homes in Ontario. It would be interesting to study how the RAI-MDS has influenced the care planning and resident care related to the promotion of physical activity in LTC homes. Lastly, future research is needed to better understand how standards and policies related to the visible work of PSWs (e.g., meal service) versus the invisible work of PSWs (e.g., work that happens behind closed doors such as toileting) are taken up and translated into practice.

Conclusion

Workers in LTC homes are trying to provide the best possible care for residents under challenging conditions. In my ethnographic observations, it was apparent that PSWs struggle to maintain genuine, caring relationships with the residents with whom they interact daily. The LTC setting is a highly regulated workplace for LTC staff. This seems at odds with the goals of the PSWs I observed. Although the intention of MOHLTC standards is to ensure that good care is provided to residents, we have shown that some of these standards actually disrupted the work of the PSWs. Owing to heavy workloads, the PSWs had to adapt some of their care practices in order to complete their work. This typically meant fewer opportunities for them to include physical activity in their daily care. An important first step in trying to find an optimal solution would be to talk to PSWs and residents in order to determine what type of assignments would allow the PSWs and residents to embed physical activity into their daily work and lives, respectively.

References

- Alessi, C. A., Martin, J. L., Webber, A. P., Cynthia, K. E., Harker, J. O., & Josephson, K. R. (2005). Randomized, controlled trial of a nonpharmacological intervention to improve abnormal sleep/wake patterns in nursing home residents. *Journal of the American Geriatrics Society, 53*, 803-810.
- Alessi, C. A., Yoon, E. J., Schnelle, J. F., Al-Samarrai, N. R., & Cruise, P. A. (1999). A randomized trial of a combined physical activity and environmental intervention in nursing home residents: Do sleep and agitation improve? *Journal of the American Geriatrics Society, 47*, 784-791.
- Bates-Jensen, B. M., Alessi, C. A., Cadogan, M., Levy-Storms, L., Jorge, J., Yoshii, J., . . . Schnelle, J. F. (2004). The Minimum Data Set bedfast quality indicator: differences among nursing homes. *Nursing Research, 53*(4), 260-272.
- Benjamin, K., Edwards, N., & Caswell, W. (2009). Factors influencing the physical activity of older adults in long-term care: Administrators perspectives. *Journal of Aging & Physical Activity, 17*, 181-195.
- Benjamin, K., Edwards, N., Guitard, P., Murray, M. A., Caswell, W., & Perrier, M. J. (2011). Factors that influence physical activity in long-term care. Perspectives of residents, staff, and significant others. *Canadian Journal on Aging, 30*(2), 1-12.
- Cameron, I. D., Murray, G. R., Gillespie, L. D., Robertson, M. C., Hill, K. D., Cumming, R. G., Kerse, N. (2010). *Interventions for preventing falls in older people in nursing care facilities and hospitals. Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD005465.doi: 10.1002/14651858.CD005465.pub2.

- Campbell, M., & Gregor, F. (2004). *Mapping social relations: A primer in institutional ethnography*. Aurora, ON: Garamond Press.
- Chen, Y. M. (2010). Perceived barriers to physical activity among older adults residing in long-term care institutions. *Journal of Clinical Nursing, 19*, 432-439.
- DeVault, M. L., & McCoy, L. (2006). Institutional ethnography: Using interviews to investigate ruling relations. In D.E. Smith (Ed.), *Institutional ethnography as practice* (pp. 15-44). Lanham, MD: Rowan & Littlefield Publishers.
- Fiatarone, M. A., O'Neill, E. F., Ryan, N. D., Clements, K. M., Solares, G. R., Nelson, M. E., . . . Evans, W. J. (1994). Exercise training and nutritional supplementation for physical frailty in very elderly people. *New England Journal of Medicine, 330*, 1769-1775.
- Galik, E. M., Resnick, B., & Pretzer-Abhoff, I. (2009). 'Knowing what makes them tick': motivating cognitively impaired older adults to participate in restorative care. *International Journal of Nursing Practice, 15*, 48-55.
- Gillespie, L.D., Robertson, M.C., Gillespie, W., J., Lamb, S. E., Gates, S., Cumming, R. G., & Rowe, B.H. (2009). Interventions for preventing falls in older people living in the community. *Cochrane Database of Systematic Reviews: Reviews 2009 Issue 2* (pp.1-210). John Wiley & Sons, Ltd Chichester, UK. doi:10.1002/14651858.CD007146.pub2
- Government of Ontario. (2010). Long-term care homes act, 2007. Retrieved January 10, 2011, from http://www.e-laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10079_e.htm
- Ice, G. (2002). Daily life in a nursing home: Has it changed in 25 years? *Journal of Aging Studies, 16*(4), 345-359.

- Institute for Work & Health. (2007). Ontario's Patient Lift initiative: early findings. *At Work*, Issue 48, Spring 2007. Retrieved April 25, 2011, from <http://www.iwh.on.ca/at-work/48/patient-lift-initiative>
- Lazowski, D. A., Ecclestone, N. A., Myers, A. M., Paterson, D. H., Tudor-Locke, C., Fitzgerald, C., . . . Cunningham, D. A. (1999). A randomized outcome evaluation of group exercise programs in long-term care institutions. *Journals of Gerontology Series A-Biological Sciences & Medical Sciences*, 54, M621-M628.
- MacRae, P., Schnelle, J., Simmons, S., & Ouslander, J. (1996). Physical activity levels of ambulatory nursing home residents. *Journal of Aging and Physical Activity*, 4(3), 264-278.
- Ministry of Health and Long-Term Care of Ontario. (2007). *Long-term care homes program manual* (rev. ed.). Retrieved December 3, 2009, from http://www.health.gov.on.ca/english/providers/pub/manuals/ltc_homes/ltc_homes_mn.html
- Norris, M. A., Walton, R. E., Patterson, C. J., Feightner, J. W., & the Canadian Task Force on Preventive Health Care. (2003). *Prevention of falls in long-term care facilities: Systematic review and recommendations*. Retrieved June 3, 2007, from http://www.ctfphc.org/Full_Text/CTF_FallsPrevn_TR_Jun03.pdf
- Ouslander, J. G., Griffiths, P. C., McConnell, E., Riolo, L., Kutner, M., & Schnelle, J. (2005a). Functional incidental training: A randomized, controlled, crossover trial in Veterans Affairs nursing homes. *Journal of the American Geriatrics Society*, 53, 1091-1100.

- Price Waterhouse Coopers (2001). Report of a study to review levels of service and response to need in a sample of Ontario long term care homes and selected comparators. Retrieved Sept.25, 2006, from <http://www.oanhss.org/staticcontent/staticpages/frameset.html>
- Public Health Agency of Canada (2011). Physical activity tips for older adults (65 years and older). Retrieved October 25, 2011 from <http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/pa-ap/08paap-eng.php>.
- Rankin, J. M., Malinsky, L., Tate, B., & Elena, L. (2010). Contesting our taken-for-granted understanding of student evaluation: Insights from a team of institutional ethnographers. *Journal of Nursing Education, 49*, 333-339.
- Resnick, B., Petzer-Aboff, I., Galik, E., Russ, K., Cayo, J., Simpson, M., & Zimmerman, S. (2008). Barriers and benefits to implementing a restorative care intervention in nursing homes. *Journal of the American Medical Directors Association, 9*, 102-108.
- Resnick, B., Simpson, M., Galik, E., Bercovitz, A., Gruber-Baldini, A. L., Zimmerman, S., & Magaziner, J. (2006). Making a difference: nursing assistants' perspectives of restorative care nursing. *Rehabilitation Nursing, 31*, 78-86.
- Ruuskanen, J. M., & Parkatti, T. (1994). Physical activity and related factors among nursing home residents. *Journal of the American Geriatrics Society, 42*, 987-991.
- Smith, D. E. (1987). *The everyday world as problematic a feminist sociology*. Boston, MA: Northeastern University Press.
- Smith, D. E. (1990a). *The conceptual practices of power: A feminist sociology of knowledge*. Boston, MA: Northeastern University Press.

- Smith, D. E. (1990b). *Texts, facts, and femininity: Exploring the relations of ruling*. London, England: Routledge.
- Smith, D. E. (1999). *Writing the social: Critique, theory, and investigations*. Toronto, ON: University of Toronto Press.
- Smith, D. E. (2001). Texts and the ontology of organizations and institutions. *Studies in Culture Organizations and Societies*, 7, 159-198.
- Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. Walnut Creek, CA: AltaMira Press.
- Smith, D. E. (2006). *Institutional ethnography as practice*. Lanham, MD: Rowman & Littlefield.

Chapter 4:

Integrated Discussion and Conclusion

This chapter presents further insights from study findings, integrating these findings with those reported in Chapter 3. In order to set the context, the key findings reported in Chapter 3 are reviewed and other emerging threads (accounts) are identified. A discussion is then presented of two emerging threads: work environments and the standardization of care. Finally, the limitations of this study; contributions to new knowledge; study rigour, and implications for practice, policy and future research are considered.

Key Findings and Emerging Threads

In the previous chapter, the social organization of PSWs' work related to meal service in the dining room and to resident transfers was explored. Despite the intent of the Ministry of Health and Long-Term Care (MOHLTC) standards to produce something "good" for residents, some of these standards actually disrupted the work of PSWs, which, in turn, reduced opportunities for them to promote physical activity. Physical activity was seen as an add-on, a program that happened a few times per week; it was parcelled out as a professional activity in the purview of physiotherapists. Furthermore, standards were taken-up differently from the way they are written. That is, standards "happen" in a way that is contradictory to the way they are thought to be happening within the authorized views of long-term care.

There were several other threads that I observed and heard about during my fieldwork that I did not explore in depth. This is common for an institutional ethnographic (IE) study because it is impossible to explore all the work processes within the time constraints of a study.

These unexplored threads may be fruitful areas for future research. Two of these threads are highlighted in this chapter; work environments and the standardization of care.

Work Environments

There has been considerable discussion about the importance of suitable work environments for health care workers within the authorizing discourses of official and theorized explanations (Armstrong & Daly, 2004, Armstrong et al., 2009; Brown, 2009; Cohen, Stuenkel, & Nguyen, 2009; Cummings et al., 2010; Kramer, Schmalenberg, & Maguire, 2010; Registered Nurses' Association of Ontario [RNAO], 2007; Shamian & El-Jardali, 2007; Smith, M., 2004; Wagner et al., 2010). The rhetoric that is used to describe this work in these dominant discourses is "creating healthy work environments." Despite strategies to create healthy workplaces such as staff recognition programs, leadership-training programs, workplace-bullying programs, and the implementation of the Registered Nurses' Association of Ontario Best Practices Guidelines, it will be argued that the work environment of PSWs in the LTC setting is not conducive to health promotion related to physical activity.

Although many factors have been identified as contributing to healthy workplaces, (e.g., adequate staffing levels, teamwork, staff autonomy and recognition, and empowerment) (Armstrong et al., 2009; Clark, 2009; Cornett & O'Rourke, 2009), my discussion focuses specifically on factors that emerged from the IE study findings. These factors are: (a) workload and staffing levels, (b) working short-staffed and pace of work, and (c) stress and physical and emotional exhaustion.

Workloads and staffing levels. The consensus within the authorizing discourses is that workloads in the LTC setting are heavy (Armstrong & Daly, 2004; Armstrong et al., 2009;

Canadian Health Association, 2009; Canadian Union of Public Employees [CUPE], 2008; Smith, M., 2004; RNAO, 2007; Sharkey, 2008). Inadequate staffing levels have been reported as one of the contributing factors for heavy workloads in the LTC setting.

Provincial data suggest that understaffing is common in LTC homes in Ontario (Price Waterhouse Coopers, 2001). The current recommendation is for 4.55 hours of direct care per LTC resident per day. However, in Ontario, residents in LTC homes receive on average 2.6 to 3.8 hours of paid staff hours per day (Armstrong et al., 2009). As these estimates include paid sick days and paid vacation, the number of actual hours worked may be overestimated. There is also evidence of differences in staffing levels according to ownership, with higher staffing levels in non-profit homes than in for-profit homes (MacGregor et al., 2005).

There are no mandated minimum staffing requirement levels in Ontario. The Registered Nurses' Association of Ontario has lobbied the MOHLTC to legislate and fund a minimum of 3.5 hours of nursing and personal care per day for each LTC resident (RNAO, 2009). However, this recommendation has yet to be acted upon. Considering factors such as funding constraints and recruitment and retention problems in LTC homes, it is likely that inadequate staffing in these homes will continue to adversely affect the integration of physical activity into the daily lives of their residents.

In this study, the PSWs also talked about their heavy workloads. Several said that their workloads had increased considerably in the past 10 years because residents entering LTC homes are older and more dependent with greater care needs. However, they commented that there had not been a corresponding increase in the number of staff. To cope with their heavy workloads, and when given the choice between care options, the PSWs typically opted for the care option that was faster to complete. This study revealed that the PSWs' heavy workloads contributed to

less physical activity opportunities for residents. Fundamentally, it was both the heavy workloads and the way the work was socially organized that contributed to less physical activity.

Working short-staffed and pace of work. Working short-staffed is a common occurrence in the LTC setting (Armstrong & Daly, 2004; Canadian Healthcare Association, 2009; CUPE, 2009; Sharkey, 2008; Smith, M., 2004). For example, in Armstrong et al. (2009) Canadian study of long-term residential care, 46.2% of direct care workers reported working short-staffed almost every day and some of them made personal sacrifices such as missing scheduled breaks.

Similarly, in this study, some of the PSWs made personal sacrifices to cope with the demands of their jobs. Some of them explained how difficult it was to “get off” of the unit for their breaks because of their heavy workloads and the need to have at least one staff member to cover the unit at all times. Break times were assigned by the nurse, and the PSWs had little flexibility in changing their break times. Other PSWs stayed past their shift to finish their paperwork, and they typically did not receive any financial compensation for this. One PSW said that it was very difficult to do the work in the dining room when they were “down” one PSW. Having to work short-staffed, missing breaks and staying overtime is not an ideal environment for the promotion of physical activity among residents.

The pace of work in LTC is another topic that has received some attention. These discussions suggest that the pace of work in LTC homes is nonstop and hectic (Armstrong & Daly, 2004; Benjamin et al., 2011; Canadian Healthcare Association, 2009; Smith, M., 2004). Armstrong et al. (2009) noted that direct care workers in their study described the pace of work as being “on a treadmill” and “almost like Speedy Gonzales shooting all over the place” (p. 61).

Similarly, in this study, PSWs described their work as “hectic,” “nonstop,” “very fast,” “rushed,” and “exhausting.” They said that they did not have a “minute to spare” and that just one minor disruption could make their day run poorly. The 30 minutes before meals was especially busy for them, for they had to porter most of the residents to the dining room. A nonstop work pace may also contribute to stress and physical and mental exhaustion, which, in turn, may produce less than optimal conditions for the promotion of physical activity for residents.

Stress and physical and mental exhaustion. There has been considerable discussion in the authorizing discourses related to stress and physical and mental exhaustion among health care workers (Abrahamson, Sutor, & Pillimer, 2009; Armstrong & Daly, 2004; Hsu et al., 2007; Lapane & Hughes, 2007; Smith, M., 2004). Reports of physical and mental exhaustion among staff are relatively common in LTC homes. The majority (57.8%) of direct care workers sampled in Armstrong et al. study (2009) reported that they finished their day feeling physically exhausted all or most of the time. Furthermore, 43% reported that they always or almost always finished the day mentally exhausted

Some of the PSWs in this study described how their jobs exhausted them, both physically and mentally. For example, a PSW explained that the heavy physical work and work-related stress made some of her/his colleagues “sick.” She/he expressed a desire to retire before it was “too late” but felt that this was financially impossible. PSWs spent a considerable amount of their day pushing heavy geriatric wheelchairs up and down long corridors and handling heavy linen and garbage bags. Some of the PSWs reported that they were physically exhausted or “dead” at the end of their shifts.

Another PSW explained that it was very challenging to do paperwork at the end of her/his shift because she/he was very tired, both mentally and physically. However, the PSWs did this paperwork because this was policy and the MOHLTC could come in at anytime to “check the books” and monitor care. Workers who are physically and emotionally exhausted are less likely to embrace physical activity promotion. Potential consequences of heavy workloads, inadequate staffing levels, and job-related stress include the inability of staff to meet the care needs of residents and/or to leave care undone.

The PSWs described other stressful situations in their daily work. For instance, a PSW described how stressful it was to care for residents who were verbally abusive. She/he explained that despite the fact that some of the residents said very hurtful things, the PSWs were expected to carry on and care for the resident as if nothing had transpired. A resident commented that some of the PSWs had to endure racial insults from some of the residents. Other authors have reported that verbal abuse from residents and/or their families is common in LTC homes and can take the form of yelling, racial insults, and sexist comments (Banerjee et al., 2008; Gates, Fitzwater, & Succop, 2005; Levin, Hewitt, Misner, & Reynolds, 2003; Zeller et al., 2009).

Meeting the needs of residents and gaps in care. The Price Waterhouse Coopers Survey (2001), which looked at the level of service provided in response to the care needs of residents living in LTC homes in Europe, the USA, and Canada, revealed a gap between care needs and service provided. Some of the findings of this survey are especially relevant to the topic of physical activity. For example, although 67% of residents in LTC homes in Ontario were noted to have restricted range of motion (ROM), only 33% of these residents received any ROM exercises, and among those who received ROM exercises, only 24% had it daily. Moreover, 68% of the residents surveyed in LTC homes in Ontario did not receive any nursing

rehabilitation, and only 10% of residents with rehabilitation potential received any physiotherapy or occupational therapy (Price Waterhouse Coopers, 2001). Similarly, Armstrong et al., (2009) reported that nearly half (48%) of their sampled direct care workers reported that toileting routine were frequently left undone. These are examples of care practices that are a consequence of heavy workloads and staffing constraints (Armstrong & Daly, 2004; Smith, M., 2004; Price Waterhouse Coopers, 2001) and these further reduce opportunities for physical activity promotion.

Most of the PSWs in this study did not talk directly about leaving their work undone. However, some PSWs talked about having to make adjustments in their care because of their heavy workloads. For example, some of the PSWs had to leave residents in bed in the morning because they ran out of time and had to go and serve breakfast in the dining room at a specified time. Without adequate resources and supports in the LTC setting, it is unlikely that the promotion of physical activity will be afforded a higher priority.

Standardization of Care

Another thread that I observed and heard about concerned work related to standardization of care. This is the process whereby standards (such as those of the MOHLTC) or standardized instruments (e.g., the Resident Assessment Instrument Minimum Data Set –RAI-MDS) are implemented in the clinical setting in order to promote consistent and evidence-based care across settings.

In recent years, there has been an increased emphasis on standardization of care in Ontario's LTC system. This can partly be explained by the growing belief among the public and government that hospitals and other health care organizations must be more fiscally responsible

with taxpayers' dollars (Matthews & Closson, 2009). Thus, standards are organized by an underlying interest in economic rationality.

Resident Assessment Instrument Minimum Data Set. Both study sites were in the final stages of implementing the mandated RAI-MDS, which was first introduced in LTC homes in Ontario in 2005. The RAI-MDS is a computerized multidisciplinary resident assessment tool that contains over 450 items. The official explanation of this tool is that it will help to identify a resident's health status, needs, preferences, and strengths, as well as the root causes of his/her problems, and it will be used for care and resource planning. Although I did not explore the work related to the RAI-MDS in depth, I did observe the PSWs, registered practical nurses, and registered nurses participating in this work process. These new documentary practices are accompanied by additional demands on staff time. Many of the nurses and the PSWs commented that having to do the additional paperwork and data entry associated with the RAI-MDS increased their workloads. The registered practical nurses could not help the PSWs at the bedside when they were entering data into the computers. On the days when data entry occurred, the workload of PSWs increase. Nonetheless, the nurses were optimistic about the longer-term benefits of the RAI-MDS tool as it would allow them to "really get to know the residents and their needs."

The PSWs did not express views similar to those of the nurses. When the PSWs spoke about the new form they had to complete for the RAI-MDS, they observed that the amount of paperwork seemed to be increasing each year. Most of the PSWs felt that they had too much paperwork to do. Similar findings have been reported by others. For instance, Armstrong et al., (2009), reported that 23.1% of direct care workers surveyed in their study strongly agreed that too much time is taken up with meaningless paperwork.

Other aspects of the required RAI-MDS system also surfaced. Nurses and PSWs commonly stated that the information entered was important because this data was “tied to funding”. They were hopeful that the use of the RAI-MDS would ultimately translate into more funding for staff. Nurses also believed that use of this tool would improve resident care including physical activity because it could capture declines in mobility and physical function.

Although the RAI-MDS does contain indicators related to activities other than formal therapies, such as “walking in the hallway”, it is unclear whether this tool will help identify declines in residents’ mobility and physical strength that may occur over a short period since the RAI-MDS assessments are typically done only quarterly. Oftentimes, it is the PSW who first notices minor declines in a resident’s physical abilities during daily care, but the authorized (official) view supersedes the knowledge of the PSWs, and there is no way to accommodate this within this textual tool. The potential for the RAI-MDS to steer the focus of direct care workers’ attention towards quarterly assessments of mobility that are part of the authorized data collection system and to implicitly suggest that day-to-day clinical observations are less important requires ongoing attention.

Problems with standardized approaches to care. In this study, the demands of having to do the paperwork (e.g., RAI-MDS) related to standardized approaches to care meant that the PSWs had less time to provide direct care for residents. Since the standardized forms that the PSWs complete each shift (e.g., basic flow care sheet) contain objectified data, they may not truly reflect the care that is actually provided. A more careful examination of what this paperwork actually accomplishes is needed.

Despite intentions to improve the quality of resident care by regulating patterns of work and measuring outcomes, Rankin (2003) has observed that such approaches are flawed. For

instance, Rankin analysed a standard patient satisfaction survey that she helped her aunt complete after a hospital stay. Rankin found the survey to be lacking. For example, there was no place to write in what they actually knew had happened and wanted to communicate about the hospitalization experiences, and the aunt was forced to summarize multiple experiences into single responses. Rankin commented:

“Patient satisfaction surveys are one way of building an objectified account, externally validated as indicative of quality. This approach to knowledge contains a fatal flaw—the experiencing subjects (the patient and her family) are dropped from the account, while organizational categories and relevancies are inserted. The resulting account supersedes all others, subordinating ‘what actually happened’ as a patient would have known it to happen. There is a profound danger in this approach . . . The objectified account may tell one story, but that story may not match anybody’s experience, let alone offer any useful insight into how that experience happens or what should be done about it.” (Rankin, 2003, pp. 64-65)

This quote invites us to rethink some of the issues related to the growing trend towards standardization of care. Flow sheets, audits, assessment sheets, patient satisfaction surveys, and so forth provide an objectified account of what is happening. However, they do not provide an account of what is really happening in practice. The danger in these approaches is that decisions about resident care, funding, staffing, and so on are based on these objectified accounts.

The manner in which standardization processes are implemented also has consequences for the work of PSWs. Although standardized approaches are intended to improve efficiency and resident care, they arose as contradictory in this study. For instance, there is a standard that all residents must eat in the dining room and that all meals must be served in an unhurried manner. Prior to this change, dietary staff served meals. The additional tasks associated with providing “pleasurable dining experiences” for residents have placed considerable demands on the PSWs’ time, which means that they have fewer opportunities to assist residents with their

physical activities. There is something within the ideological frameworks being inserted into the standardization of LTC homes to produce mealtimes as a “dining experience” that, when examined for what is happening, seems rather peculiar.

An alternative explanation as to what is happening is that when official standards (e.g., mandated use of the RAI-MDS) and the accompanying standardized processes (e.g., the RAI-MDS assessment form) converge with the approaches that PSWs are using to cope and manage with their workloads demands (i.e., routinized care), they do so in deeply contradictory ways. As the authorized accounts, which are ideological in origin, are inserted into the work processes, they introduce the ruling relations into the LTC work setting. This process goes on invisibly and as it “should” happen, even though the people in the setting will know the peculiarities as they experience them in their daily work.

Limitations to Analysis: Threads (Accounts) not Followed

My interview data revealed that an enormous amount of time is invested in toileting/incontinence work. As with the dining room work, this was intricately related to the time and opportunity to support physical activity. For instance, routines were built into the PSWs’ workday as to when a resident had to be toileted or incontinence care provided, and when to dispose of soiled linen and incontinence products. A considerable amount of bodily movement and physical activity can occur during toileting/incontinence care routines. I did not have access to direct observation of this work, which may have provided other insights as to the social organization of the work related to physical activity.

The physiotherapy departments and the physiotherapists had a contracted relationship with the LTC organizations. Physiotherapy plays a critical role in the LTC setting by helping

residents to maintain their mobility and function. However, I was unable to interview physiotherapists, and thus the social organization of their work as it intersects with what I discovered going on in the work of PSWs was not available for a full analysis.

Study Rigour

In conventional qualitative research, a broad set of criteria can be used to evaluate the trustworthiness or rigour of a study. For example, Lincoln and Guba (1985) suggest that the trustworthiness of a study can be established by evaluating the credibility, transferability, dependability, and confirmability of the study. Issues of trustworthiness and rigour are important for IE researchers. In IE, rigour is closely linked to the “ontological shift” (Smith, D.E., 2005, p. 4) that requires the researcher to stay firmly focused on “things happening” rather than seeking out theorized explanations as to how things happen. Hence, IE researchers use a somewhat different approach than other qualitative researchers to build rigour into their studies.

I began my study by observing and interviewing PSWs whom I positioned as the “expert knowers” (Smith, D.E., 2005) of their everyday work. I maintained detailed field notes that provided rich descriptions of what was actually happening and I talked to people from within and external to the LTC setting to gain a deeper understanding of the practices that I had observed.

Next, I supported any claims with empirical evidence. I used evidence (e.g. salient quotes, observational data) that helped the reader to see the ruling relations in the data. For example, a manager’s comment that there were standards that organized the meal service in the dining room allowed the reader to see the ruling relations related to this work practice. Hence, from an IE perspective, I developed a compelling analyses of the features of PSWs work and

produced a warrantable argument that is supported by empirical data, providing credibility to the claims I have made.

IE researchers are interested in discovering generalizing practices that cut across several settings (DeVault & McCoy, 2006). According to Campbell and Gregor (2004), “Generalizability in institutional ethnography relies on discovery and demonstration of how ruling relations exist in and across many local settings, organizing the experiences informants talk about” (Campbell & Gregor, 2004, p. 89). The relevancy of IE does not come from a claim that local settings are similar but from the ability of this method to uncover features of ruling relations cutting across many settings (DeVault & McCoy, 2006).

I enlisted two study sites to determine if there were generalizing practices that cut across these two settings. Despite the fact that my two study sites differed considerably with respect to factors such as age and size, I discovered that the work processes were similar in the two homes and created similar issues related to the promotion of physical activity. As I moved away from the local setting, I uncovered the broad regulatory framework (e.g., standards, policies), that people in the LTC setting were activating. Since all LTC homes in Ontario are governed by the same provincial standards and policies, similar work processes may be unfolding in other LTC settings in this province.

A potential threat to the rigour of the study is my position as a nurse. In Ontario, registered nurses supervise the work of PSWs. This professional role may have influenced how the PSWs behaved during my periods of observation and how they responded to my questions during the interviews. For instance, a PSW may have decided to encourage a resident to self-propel his/her own wheelchair or to assist them to walk to the dining room because I was “watching”.

I also entered this study with prior knowledge and several years of experience as a registered nurse and researcher in LTC. I had familiarity with the LTC setting and with the work of nurses and PSWs in this setting. I E does not prohibit researchers from relying on their knowledge to deepen their understanding. However, my prior experiences and knowledge could have influenced my observations and the findings of this study. For instance, I may have assumed that I knew what the PSWs actually did and what troubles and challenges they face in their work.

To safeguard against this and to help ensure the rigor of this study, I relied on the PSWs to be “expert knowers” (Smith, D.E., 2005) of their work processes, because I could not assume that I knew how their work actually unfolded. I tried to take the standpoint of PSWs, which meant that when I was drawn to the often compelling official explanations of how their work happened (e.g. pleasant dining experiences), I would look to my data to see how the PSWs actually described what was happening (e.g. dining work is hectic, difficult to complete when short staffed).

It is a recognized ethnographic assumption that the presence of the researcher tends to become less intrusive over time and the practices of the participants revert to their “normal” behaviour (Wall, 2008). This fact and the establishment of rapport with my participants may partly explain why they were not hesitant to disclose the fact that some of the PSWs were using mechanical lifts to transfer residents rather than doing stand and pivot transfers.

An ontological assumption of ruling relations is that they are constituted outside (external) of people’s daily experiences (Smith, D. E., 2005). If the PSWs worked to meet my expectations as a nurse (e.g. ensuring that there were two people present when doing a

mechanical lift), this work would still provide valuable data regarding the ruling relations that shaped and organized their work.

Another strategy that I used to help ensure the rigor of this study is that I rendered everything that I heard or saw as fundamentally mysterious (Smith, D. E., 1987; Rankin et al., 2010). This helped me to not lose sight of those taken-for-granted things that happen in the LTC setting. For instance, heavy assignments are a common (taken-for-granted) daily experience for PSWs. This topic did surface during my interviews, but rather than taking this for granted, I followed this up by asking probing questions about the assignment of residents to PSWs such as: Who makes the assignment? How often are these assignments changed?

Contributions of This Study to the Development of New Knowledge

This research has contributed to the development of new knowledge in several ways. To the best of my awareness, it is the only study that has focused on the social organization of the work of direct caregivers in LTC homes using an IE lens to establish how physical activity is organized to happen as it does. Furthermore, this method of inquiry allowed the researcher the opportunity to look beyond the local setting to the broader institutional complex (LTC health care system) to uncover the ruling relations (activities and practices) that shaped and controlled the work of PSWs related to the promotion of physical activity. Examining people's actions beyond the local setting distinguishes this method of inquiry from a more conventional ethnographic research approach.

This research adds new knowledge regarding how mandated standards actually unfold in the normal day-to-day practice of PSWs in LTC homes and how these standards shape and coordinate the work related to the promotion of physical activity. This study revealed that some

of the MOHLTC standards, which were intended to produce good outcomes for residents, were actually disrupting the work of PSWs so that physical activity was being organized out of their daily care.

This research contributes new knowledge by broadening our understanding of PSWs' work within a LTC context. PSWs are an important segment of the LTC workforce, providing much of the day-to-day care for residents. This study has illuminated critical aspects of their work related to meal service in the dining room and to transferring and repositioning residents. These findings are especially useful for nurses who supervise their work because it provides them with a better understanding of what the PSWs actually "do" and how MOHLTC standards actually unfold in the LTC setting. This study has explicated how the work of PSWs is connected to the work processes within the workplace and to the development, implementation, and enforcement of standards by those within and outside their LTC settings.

In terms of the contribution my thesis makes to nursing knowledge specifically, nursing has embraced Barbara Carper's (1978) pivotal work on the fundamental patterns of knowing in nursing. These four patterns of knowing are: empirical knowledge (the science of nursing); esthetic knowledge (the art of nursing); personal knowledge, and ethical knowledge (Carper, 1978; McEwen, 2011). These patterns of knowing are interdependent; as a whole, they are the basis for nursing practice (McEwen, 2011). This typology was used to guide my thinking to determine what specific types of nursing knowledge (e.g. empirical, esthetic, personal, and ethical) this study added to the body of nursing knowledge.

This study has contributed to nursing knowledge by providing empirical, factual and descriptive information regarding the work and the work environments of PSWs, the uptake and implementation of MOHLTC standards into the daily practice of PSWs, the textual organization of work in the LTC system; and how the promotion of physical activity for frail elderly people living in long-term care homes was formulated and delivered.

This study adds to a growing body of knowledge regarding gerontological nursing care (e.g., Buettner & Kolanowski, 2003; Kolanowski, Buettner, Litaker, & Yu, 2006; Forbes et al., 2008; Schoenfelder & Rubenstein, 2004; Williams & Tappen, 2008). Specifically, this study extends previous nursing research on physical activity by focusing on the ways in which the social organization of PSWs' work in LTC homes influences the promotion of physical activity and the quality of care provided.

Creating healthy work environments is a major concern for the nursing profession because toxic work environments can have severe repercussions for staff, residents, and for the LTC organization (e.g. more sick time, difficult recruitment and retention, and workplace bullying). Some of the PSWs in this study described their work as hectic and mentally and physically exhausting. Nurses can use this knowledge to lobby for improvements in the workplace and new policies to create healthier work environments. Nurses have a key role to play in identifying challenging work environments and working with others to try and improve them.

In Ontario, registered nurses typically supervise PSWs. This study provided a rich description of what a typical day is like for a PSW. This knowledge can help improve nursing care planning. It can also guide nurses in preparing PSWs' work assignments.

This study has contributed to nursing knowledge by informing nurses of the need to examine existing standards and policies with a critical eye. These policies and procedures may

become so entrenched into practice that their impact on residents is neither questioned nor evaluated.

Health promotion is a critical role and responsibility for nurses. Yet, some of the PSWs and nurses in this study viewed the promotion of physical activity as being outside of the PSW role. If the promotion of physical activity is to be embedded into daily care, nurses will have to advocate for change so that these perceptions can be altered.

Finally, study findings contribute to nursing knowledge regarding interprofessional collaboration. Compared to other health care settings, the LTC setting tends to be more hierarchical and this may discourage effective team communication and collaboration. Nurses can play a key role in fostering good inter-professional teamwork that helps ensure the provision of physical activity and better quality care.

Implications for Practice and Policy

Embedding Physical Activity into Daily Care

The findings of this study have several implications for nursing practice and policy. Given the workloads of PSWs, it may seem obvious that bringing in other people to promote physical activity among residents and parcelling out this work to one specific category of worker (e.g., physiotherapists) would be an optimal solution. However, funding constraints in LTC are a key limitation to these approaches, and the fundamental question of how physical activity can be better integrated into the work processes of daily care remains. For instance, how can we understand how physical strength can be maintained within an understanding of how it could happen *inside* the work practices of washing, toileting, eating, and so forth? How could the efforts and intentions of PSWs be afforded more legitimacy in the workplace? It is the PSWs (and

residents) themselves who can best advise on how this integration might occur and how routines for the provision of direct care might be adjusted to incorporate physical activity.

Many of the opportunities for residents to move their bodies were overridden by other aspects related to the smooth operation of the LTC setting including the need to meet standards (e.g. providing pleasant dining experiences for residents). These standards did not readily allow physical activity to be embedded in the daily work practices of PSWs. Hence, increasing physical activity is not primarily about providing more education, more training, or asking the PSWs to work differently (e.g. be more flexible regarding their bath schedules). It may mean looking at both Ministry and organizational standards and policies related to the dining room or how physical activity has been formulated as a “program.” For instance, this may involve nurses working with PSWs to see how their assignments could be modified so that the promotion of physical activity is afforded greater priority in their daily care. It may also involve working with people from the Ministry to determine how standards and organizational policies related to the dining room could be more flexible and less formal so that the PSWs would have more time to assist residents with their physical activities. In this study, the promotion of physical activity was viewed as an “add-on” and something that happened within the context of a “program” one to three times per week. This mindset is likely to be reinforced since, as mentioned previously in this thesis, the new Long-Term Care Act (2007), enacted on July 1, 2010, requires all LTC homes to have an interdisciplinary *program* based on a restorative philosophy of care in place (Government of Ontario, 2010). A paradigm shift of thinking will be needed so that physical activity is not seen as a program, but rather as an aspect of daily living for residents, which is embedded in daily care.

Enacting More Legislation, Standards, and Policies

Simply adding more legislation, standards, or policies to promote physical activity is not an optimal solution. This study indicates that some of the MOHLTC standards did not get operationalized in the way they were written and their intent was not fully realized in actual practice. Some of the policies were clearly disrupting the work of PSWs. For instance, there was a policy that all residents should be encouraged to eat in the dining room, which meant that the PSWs sometimes had to modify their care (e.g. leave a resident in bed because of lack of time to perform a mechanical lift) in order to comply with this policy. Since PSWs have very little slack in their workday, more legislation may further squeeze their work routines, forcing them to leave out some other aspect of care as a means of coping with additional demands.

A solution would be to go and talk to PSWs and residents to determine what type of assignments would allow the promotion of physical activity to be embedded in daily care. In turn, this information could be used to inform the development of legislation, standards and policies related to the promotion of physical activity that may “work.” in a work environment that is highly regulated, poorly resourced (material and human resources) and involves heavy care. Furthermore, when evaluating the outcomes of new legislation related to the promotion of physical activity, there is a need to consider ethnographic and other more naturalistic approaches rather than relying primarily on standardized objectified accounts. The value-added of using an IE approach is that it can uncover the contradictions and disjunctures between what is thought to be happening within the authorized views of long-term care and what is actually happening in clinical practice.

Meeting the Physical Activity Needs of Residents: How are We Doing?

At first glance, the availability of exercise classes up to three times per week and an allotment of up to 100 visits of physiotherapy per resident per year appears generous. However, the results of a needs assessment of 27 LTC homes in Ontario revealed that only 10–15% of residents actually attended the exercise classes (Lazowski et al., 1999). Similarly, results of the Price Waterhouse Coopers survey found that only 8% of LTC residents in Ontario received any physiotherapy. These findings suggest that, despite what appears to be a generous allotment for physical activity, there is something preventing residents from utilizing these services.

There are several possible factors that prevent residents from utilizing existing services. In a study by Benjamin et al., (2011), staff commented that residents sometimes opted out of their scheduled exercise class when it conflicted with other activities such as their bath day. Second, unlike their community counterparts, frail seniors who live in LTC homes have restricted access to exercise equipment and areas for physical activity (Benjamin et al., 2009, 2011; Lazowski et al., 1999). Third, many residents need some level of assistance to get to their classes and/or help with their activities, precluding the option of substituting missed classes with the use of personal equipment or exercising on their own. Furthermore, lack of space for physical activity may act as an impediment to the promotion of physical activity. In a study conducted in Ottawa, Ontario, only two of nine LTC homes had a designated exercise or physiotherapy room, and these spaces were described as too small and crowded (Benjamin et al., 2009, 2011). Lastly, it is not uncommon for the health status of frail elderly people living in LTC homes to fluctuate from day to day. Temporary illnesses may prevent residents from attending scheduled exercise classes.

In this study, some residents commented that there was a general lack of access to exercise spaces, equipment, and services. Some residents felt that they needed daily exercises. To compensate for the lack of equipment and services, some residents purchased their own exercise equipment (e.g., hand weights) and hired their own private physiotherapist if they could afford to do so. However, equitable access to these alternatives is problematic. If daily physical activity is to become a reality in LTC homes, access to physical spaces (e.g., walking spaces) is essential, and alternatives to the human resource scarcity in LTC settings will need to be considered.

The knowledge gained from this study can help nurses to better understand where they can intervene and advocate for residents. Nurses can work with PSWs to advocate for less rigid and more flexible care routines that would allow PSWs to take advantage of opportunities to encourage physical activities. For instance, more flexible meal schedules (e.g. staggered meal sittings) or the involvement of more volunteers may help to reduce the “rush” of trying to get all of the residents to the dining room in a short time frame. Nurses could also work with the PSWs to review their work processes that may be amendable to change.

Providing scheduled exercise or physiotherapy sessions is important but does not adequately address needs for physical activity. Frail residents need daily physical activity as opposed to activity only one to three times per week. Many residents suffer from restricted ROM due to conditions such as arthritis and stroke. In fact, according to the Price Waterhouse Coopers survey (2001), LTC homes in Ontario had the highest number of residents with restricted ROM (67%) compared to other LTC homes in Canada, the USA, and Europe.

An exercise program provided one to three times per week for 30–45 minutes does not allow residents to meet the current physical activity recommendations for older adults. Although

there are no specific guidelines for frail seniors living in nursing homes, the Public Health Agency of Canada (2011) recommends that seniors should try to accumulate 2.5 hours of moderate to vigorous aerobic type of activity per week. This would equate to about 30 minutes of exercise five days per week. Seniors can accumulate this time through shorter exercise intervals. Achieving these small daily “physical activity breaks” may be more feasible and doable for deconditioned and frail elderly people living in LTC homes. For example, many residents spend a considerable amount of time sitting in their wheelchairs. LTC staff and family members could cue residents during these sedentary periods to do range of motion and/or strengthening exercises to help maintain flexibility and function. This might also help combat boredom, an issue of concern raised by residents in family members in a previous study of physical activity among residents in LTC (Benjamin et al., 2011).

Viewing physical activity as a program is problematic because residents may develop a mindset whereby they refuse to do any activity unless it is structured as a formal program provided by physiotherapists. In fact, a PSW in this study complained that she could not get some of her residents to “move” because they viewed the provision of exercise as a physiotherapist’s role. Furthermore, when residents in this study talked about physical activity it was always in the context of scheduled exercise programs provided by the physiotherapy department.

If the promotion of *daily* physical activity is to become a reality in the LTC setting, then all health care providers will have to work together to achieve this goal. Some of the major barriers to effective interprofessional collaboration involve communication issues and lack of awareness and understanding of different professional roles and responsibilities (Conn, Lingard, Reeves, Miller, Russell, & Zwarenstein, 2009; Farahani, Sahragard, Carroll, & Mohammadi,

2011; Hall, 2005; Weller, Barrow, & Gasquoine, 2011). Our current knowledge on interprofessional collaboration and education (Reeves et al., 2009; Zwarenstein, Goldman & Reeves, 2009) can be used to help develop physical activity interventions within LTC homes. For example, interprofessional problem solving workshops with mentorship have been used to better understand how the use of data and feedback influences change in LTC settings in Ontario (Murray, Higuchi, Edwards, Greenough & Hoogevan, (2011, in press). Another LTC study developed and pilot tested an eLearning resource to help address the challenges associated with providing continuing education in the LTC setting such as heavy workloads, inadequate staffing and shift work (Halabisky, et al., 2010). Nurses were identified as key leaders and hence described as ideal knowledge brokers for the interprofessional team (Halabisky, et al., 2010). Participants enjoyed the flexibility of the training resource and acquired new skills and knowledge, which they were able to use in their practice (Halabisky, et al., 2010).

In summary, the provision of physical activity programs remains important in LTC homes. However, even if more funding was provided for regularly scheduled, formal exercise programs, an approach that relies entirely on their delivery is unlikely to be sufficient to meet the physical activity needs of residents. The next section discusses the pragmatics of potential supports and resources related to the promotion of physical activity in LTC homes.

Resources and Supports

Volunteers

In a study that looked at the barriers to and facilitators of physical activity in nine LTC homes in Ontario, Canada, administrators reported that they relied heavily on volunteers to help porter residents to their physical activities and to assist residents in the various programs

(Benjamin et al., 2009). However, bringing in trained volunteers to deliver exercise programs may not provide a viable long-term solution. For instance, a manager in this study explained that it is becoming increasingly difficult to recruit volunteers “because the younger generation do not volunteer as often as their parents.” A PSW explained that the supply of volunteers to help out with the meals is never sufficient partly due to the fact that volunteers are aging, and they may not show up because of illness.

In 2007, 36% of volunteers in Canada were 65 years of age or older (Statistics Canada, 2009), and the number of volunteers in Canada is declining (Canadian Healthcare Association, 2009; Statistics Canada, 2009). According to Statistics Canada (2009), the volunteer rate in Ontario dropped from 50% in 2004 to 47% in 2007. Although there will be a considerable increase in the number of seniors as the baby boomers age, this cohort has different social characteristics than the current cohort, which is likely to influence their volunteer behaviours (Canadian Healthcare Association, 2009). Given the anticipated overall decline in the number of volunteers in Canada, reliance on volunteers to assist with the physical activity programs may not be realistic.

Use of “Champions”

Another strategy that may be useful to help embed physical activity into the daily work of PSWs is the use of “champions.” Champions can be thought of as people who support and market an innovation (Greenlough, Robert, Bate, MacFarlane, & Kyriakidou, 2005); they are sometimes called “change agents” (Greenlough et al., 2005; Ploeg et al., 2010). The use of champions has been promoted in nursing to help with the introduction, implementation, and maintenance of change such as the use of best-practice guidelines (Campbell, 2008; Ploeg et al.,

2010; Ploeg, Davis, Edwards, Gifford, & Miller, 2007). Overall, these studies found that the use of champions was a key facilitator in the implementation of best practice guidelines (Ploeg et al., 2007) and improved compliance with an ICU sepsis screening protocol (Campbell, 2008). According to Ploeg et al., (2010), champions influence the use of best practice guidelines most readily by disseminating information during mentoring and education sessions, by being persuasive leaders at team meetings and by their ability to tailor implementation strategies to best suit the organizational context.

During my fieldwork, I noticed that there was a formal system whereby PSWs were designated as champions related to a specific work process. These champions acted as resource person and mentor for the other PSWs. The use of champions to help embed the promotion of physical activity into the PSWs daily care is a potential strategy warranting further exploration.

Implications for Future Research

In this study, physiotherapists and physiotherapy assistants were the main providers of exercise and physical therapies. I was not able to observe or interview these individuals in this study. It would be enlightening to study the social organization of their work and how it relates to the work of PSWs and other workers. Future research on the social organization of physiotherapy work and how it affects the daily promotion of physical activity for residents would be useful.

Currently, there are no mandated minimum staffing requirement levels for LTC settings in Ontario. It would be very useful to gain a better understanding regarding how staffing decisions are made and what factors shape and organize this work. Using an IE lens to uncover the social organization of “staffing work” in LTC is a fruitful area for future research.

More research conducted outside of the authorizing discourses (such as this one, using an IE lens) is required to examine how the workplace can be made more reasonable for PSWs. In a work environment where PSWs are rushed and physically and mentally exhausted, and where knowledge of their work is sometimes subordinated, health promotion related to physical activity is unlikely to be embraced.

Rigid routines are pervasive in the LTC setting. It would be interesting to determine how greater flexibility could be built into the PSWs' daily care routine and how this increased flexibility would influence outcomes for residents and workers.

The intent and focus of this study was not explicitly on issues related to race, gender, or class. I did not follow-up the one thread (account) related to race provided by a resident (i.e. a resident making racial slurs to the PSWs). Issues related to race, gender and class did not figure explicitly in the PSWs' interviews or in my observations of their work. Nonetheless, IE researchers do realize that these issues do contribute to what happens in LTC settings, as has been noted by other authors (e.g., Armstrong et al. 2009; Diamond, 1992, 2006).

In this study, most of the PSWs and nurses were women and some were also visible minorities. The PSWs' work consisted predominately of women's work (e.g. servitude, caring, domestic), rather than work related to the promotion of physical activity. Armstrong et al., (2009) also noted the abundance of women's work provided by PSWs.

In this study, some of the PSWs talked about how mentally and physically exhausted they were at the end of their shift. This may partly be related to the fact that some of the PSWs had double roles (e.g., PSW, mother, and wife) and burdens (e.g., work and families responsibilities). In addition, due to the challenges of finding full-time employment with benefits as noted by other authors (Armstrong et al., 2009), some of the PSWs may have worked in more than one

LTC home to supplement their hours and earnings. PSWs who are physically and mentally exhausted are less likely to practice self-care behaviours (e.g. getting enough rest and exercising) or to embrace the promotion of physical activity for residents.

There is a definite hierarchy of power in LTC homes and PSWs are typically positioned at the bottom of this hierarchy. One could speculate that this social positioning may affect the PSWs' willingness to "push" for more built in supports that could facilitate the promotion of physical activity for residents. This positioning may also impact negatively on their beliefs regarding how their opinions are listened to and valued as have been noted by other authors. For instance, in Armstrong et al. study (2009), a PSW with over 10 years of experience refused to offer any recommendations on how to improve care because she/he did not believe that PSWs had a voice. In addition, many of them believed that there would be a significant improvement in working conditions and quality of resident care "if" their voices were heard and their knowledge taken into account when policies were developed. This underscores the importance of asking PSWs about the best ways to incorporate physical activity into their daily care.

Certain types of work in the LTC setting have been genderized. Future research could examine how the work of PSWs in LTC homes has been socially organized to be predominately womens' work and how this, in turn, influences the promotion of physical activity for residents.

Bodily care such as toileting and incontinence care is an example of "women's work" that could not be directly observed in this study. It was apparent that PSWs spent a considerable portion of their day toileting and providing incontinence care. Ouslander and colleagues (2005a) implemented a combined exercise and incontinence care program in LTC homes, which was delivered by members of the research team every two hours during the day. Those authors concluded that it would be difficult to implement this intervention in clinical practice owing to

current staffing constraints (Ouslander et al., 2005a; Ouslander, Griffiths, McConnell, & Schnelle, 2005b). It seems to me that during this segment of care, it would be pragmatic to encourage and assist residents with their physical activities. The social organization of toileting/incontinence care in the LTC setting, the gendered aspects of toileting work and how these intersect to influence the promotion of physical activity warrants future research. This would help to inform future intervention studies that combine toileting routines and physical activity and take gendered roles into account. Lastly, enacting more legislation related to the promotion of physical activity alone is not likely optimal. Thus, such legislative changes need to be accompanied by studies that will determine the impact of new legislation to ensure that the best interests of the residents are served. Future studies comparing jurisdictions that have and do not have legislation related to the promotion of physical activity are warranted.

Conclusion

This study began with the assumption that the work of PSWs is socially organized by ruling relations that extend beyond their everyday experiences. This research made visible the disjuncture between the official explanations of what is happening related to the work of PSWs and the explanations provided by the PSWs who were actually experiencing the daily work. Researchers are thus required to go beyond what can be known in the local setting, because a full understanding necessitates that the researcher gain an understanding about how work is socially organized in ways that cannot be fully understood from inside its accomplishment.

This study revealed that some of the MOHLTC standards disrupted the work of PSWs in such a manner that physical activity was left out of their daily care and was parceled out as a professional activity outside of the PSWs' role and daily lives of residents. These findings

provide a critical starting point for considering what changes may promote daily physical activity.

An important first step would be to consult with PSWs and residents in order to establish work assignments that would allow physical activity to be integrated into the daily work of PSWs. The knowledge gained through these consultations is essential for nurses who wish to advocate for sustainable change so that the daily promotion of physical activity becomes a reality in the daily lives of LTC residents. If physical activity is to be embedded into daily care, nurses will also need to advocate for additional supports and resources such as training support, more reasonable work assignments, and improved staffing levels. Although the focus of this study was work related to the promotion of physical activity, the findings have implications not only for the direct promotion of physical activity but also for other aspects of care.

Appendix 1
Statement of Contributions

Statement of Contributions

I conceptualized and led this research as part of the requirements for completion of the degree in Doctorate in Philosophy at the University of Ottawa. I assumed responsibility for this research and led it through the different stages of research design, ethics approval, participant recruitment, data collection, transcription, data analysis, and analytical writing. I was also responsible for writing each chapter of the thesis and the manuscripts contained in this thesis.

I was supervised by my thesis committee, which included the following members: Dr. Nancy Edwards (thesis supervisor), Faculty of Nursing, University of Ottawa, Dr. Frances Legault, Faculty of Nursing, University of Ottawa, Dr. Jenny Ploeg, Faculty of Nursing, McMaster University, and Dr. Janet Rankin, Faculty of Nursing, University of Calgary. Committee members provided consultation throughout the research study, participated in data analyses and interpretation and contributed to the intellectual content in the thesis, as well as the manuscripts.

Appendix 2

Master List of References

NB: A master reference list is included in Appendix 2. This list includes the references from all chapters in the thesis.

References

- Abrahamson, K., Sutor, J., & Pillemer, K. (2009). Conflict between nursing home staff and residents' families: does it increase burnout?. *Journal of Aging & Health, 21(6)*, 895-912.
- Alessi, C. A., Martin, J. L., Webber, A. P., Cynthia, K. E., Harker, J. O., & Josephson, K. R. (2005). Randomized, controlled trial of a nonpharmacological intervention to improve abnormal sleep/wake patterns in nursing home residents. *Journal of the American Geriatrics Society, 53*, 803-810.
- Alessi, C. A., Yoon, E. J., Schnelle, J. F., Al-Samarrai, N. R., & Cruise, P. A. (1999). A randomized trial of a combined physical activity and environmental intervention in nursing home residents: Do sleep and agitation improve? *Journal of the American Geriatrics Society, 47*, 784-791.
- Angus, J. (2001). The material and social predicaments of home: Women's experiences after aortocoronary bypass surgery. *Canadian Journal of Nursing Research, 33*, 27-42.
- Armstrong, P., Banerjee A., Szebehely, M., Armstrong, H., Daly, T., & Lafrance, S. (2009). *They Deserve Better: The long-term care experience in Canada and Scandinavia*. Ottawa, Ontario: Canadian Centre for Policy Alternatives.
- Armstrong, P., & Daly, T. (2004). *There are not enough hands: Conditions in Ontario's long-term care facilities* Canadian Union Public Employees (CUPE). Retrieved from <http://cupe.ca/updir/CUPELTC-ReportEng1.pdf>.
- Banerjee, A., Daly, T., Armstrong, H., Armstrong, P., Lafrance, S. & Szebehely, M. (2008). Out of control violence against personal support workers in long-term care. Toronto: York University.

- Bates-Jensen, B. M., Alessi, C. A., Al-Samarrai, N. R., & Schnelle, J. F. (2003). The effects of an exercise and incontinence intervention on skin health outcomes in nursing home residents. *Journal of the American Geriatrics Society, 51*, 348-355.
- Bates-Jensen, B. M., Alessi, C. A., Cadogan, M., Levy-Storms, L., Jorge, J., Yoshii, J., . . . Schnelle, J. F. (2004). The Minimum Data Set bedfast quality indicator: differences among nursing homes. *Nursing Research, 53*(4), 260-272.
- Baum, J. A. C. (1999). Rise of chain nursing homes in Ontario, 1971-1996. *Social Forces, 78*, 543-583.
- Beck, C. T. (2009). Critiquing qualitative research. *AORN Journal, 90*, 543-554.
- Bell, M. & Goss, A. J. (2001). Recognition, assessment and treatment of depression in geriatric nursing home residents. *Clinical Excellence for Nurse Practitioners, 5*, 26-36.
- Benjamin, K., Edwards, N., & Caswell, W. (2009). Factors influencing the physical activity of older adults in long-term care: Administrators perspectives. *Journal of Aging & Physical Activity, 17*, 181-195.
- Benjamin, K., Edwards, N., Guitard, P., Murray, M.A., Caswell, W., & Perrier, M. J. (2011). Factors that influence physical activity in long-term care. Perspectives of residents, staff, and significant others. *Canadian Journal on Aging, 30*(2), 1-12.
- Berta, W., Laporte, A., Zarnett, D., Valdmanis, V., & Anderson, G. (2006). A pan-Canadian perspective on institutional long-term care. *Health Policy, 79*, 175-194.
- Buettner, L., Kolanowski, A. (2003). Practice guidelines for recreation therapy in the care of persons with dementia. *Geriatric Nursing, 24*(1), 17-22.

- Blackham, J., Garry, J. P., Cummings, D. M., Russell, R. G., & Dealleaume, L. (2008). Does regular exercise reduce the pain and stiffness of osteoarthritis? *Journal of Family Practice, 57*, 476-477.
- Bossen, A. (2010). The importance of getting back to nature for people with dementia. *Journal of Gerontological Nursing, 36*, 17-22.
- Brown, C. J., (2009). Self-renewal in nursing leadership: the lived experience of caring for self. *Journal of Holistic Nursing, 27*, 75-78.
- Cameron, I. D., Murray, G. R., Gillespie, L. D., Robertson, M. C., Hill, K. D., Cumming, R. G., Kerse, N. (2010). *Interventions for preventing falls in older people in nursing care facilities and hospitals. Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD005465.doi: 10.1002/14651858.CD005465.pub2.
- Campbell, J. (2008). The effect of nurse champions on compliance with Keystone Intensive Care Unit Sepsis-screening protocol.[Erratum appears in Crit Care Nurs Q. 2009 Apr-Jun;32(2),158] *Critical Care Nursing Quarterly, 31(3)*, 251-69.
- Campbell, M. (2003). Dorothy Smith and knowing the world we live in. *Journal of Sociology and Social Welfare, 30(1)*, 3-22.
- Campbell, M., & Gregor, F. (2004). *Mapping social relations: A primer in institutional ethnography*. Aurora, ON, Canada: Garamond Press.
- Canadian Center for Activity and Aging (2011). Home page. Retrieved from <http://www.uwo.ca/actage/index.html>
- Canadian Healthcare Association (2009). *New Directions for Facility-Based Long Term Care*. Ottawa: Author. Retrieved May 01, 2011 from http://www.cha.ca/documents/CHA_LTC_9-22-09_eng.pdf

- Canadian Institute for Health Information (CIHI)(2009-2010). Contingency Care Reporting System (CCRS) Profile of residents in continuing care facilities 2009-2010. Retrieved from http://www.cihi.ca/CIHI-ext-portal/xls/internet/STAT_PROFILE_RES_9-10_EN.XLS
- Canadian Union of Public Employees (CUPE, Ontario) (2008). *Submission to the review of staffing and care standards for long-term care homes*. Retrieved April 1st 2011 from http://www.cupe.on.ca/aux_file.php?aux_file_id=725Ottawa, ON: Author
- Carper, B. (1978), Fundamenta; patterns of knowing in nursing. *ANS Adv Nursing Sci.*, *1(1)*, 13-23.
- Chen, Y. M. (2010). Perceived barriers to physical activity among older adults residing in long-term care institutions. *Journal of Clinical Nursing*, *19*, 432-439.
- Clark, P. R. (2009). Teamwork: building healthier workplaces and providing safer patient care. *Critical Care Nursing Quarterly*, *32*, 221-231.
- Coffield, C. D. (2002). Welfare reform in Indiana: The political economy of restricting access to education and training. *Journal of Family and Economic Issues*, *23*, 261-284.
- Cohen, J., Stuenkel, D., & Nguyen, Q. (2009). Providing a healthy work environment for nurses: the influence on retention. *Journal of Nursing Care Quality*, *24(4)*, 308-315.
- Cornett, P. A. & O'Rourke, M. W. (2009). Building organizational capacity for a healthy work environment through role-based professional practice. *Critical Care Nursing Quarterly*, *32*, 208-220.
- Conn, L. G., Lingard, L., Reeves, S., Miller, K. L., Russell, A., & Zwarenstein, M. (2009). Communication channels in general internal medicine: a description of baseline patterns for improved interprofessional collaboration. *Qualitative Health Research*, *19*, 943-953.

- Cummings, G. G., MacGregor, T., Davey, M., Lee, H., Wong, C. A., Lo, E.,...Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: a systematic review. *International Journal of Nursing Studies*, 47(3), 363-385.
- de Carvalho, B. A. & Filho, W. J. (2004). Effect of an exercise program on functional performance of institutionalized elderly. *Journal of Rehabilitation Research and Development*, 41, 659-668
- Dechamps, A., Diolez, P., Thiaudiere, E., Tulon, A., Onifade, C., Vuong, T.,...Bourdell-Marchasson, I. (2010). Effects of exercise programs to prevent decline in health-related quality of life in highly deconditioned institutionalized elderly persons: a randomized controlled trial. *Archives of Internal Medicine*, 170, 162-169.
- de Ruiter, H.-P. (2008). *To lift or not to lift: An institutional ethnography of patient handling practices* (unpublished doctoral dissertation). University of Minnesota.
- DeVault, M. L., & McCoy, L. (2006). Institutional ethnography: Using interviews to investigate ruling relations. In D.E. Smith (Ed.), *Institutional ethnography as practice* (pp. 15-44). Lanham, MD: Rowan & Littlefield Publishers.
- Diamond, T. (1992). *Making gray gold*. Chicago, IL: University of Chicago Press.
- Diamond, T. (2006). "Where did you get the fur coat, Fern?": participant observation in institutional ethnography. In D. E. Smith (Ed.), *Institutional ethnography as practice* (pp. 45-63). Lanham, MD: Rowman & Littlefield.
- Evert, L. (2008). *Mother knows breast: An examination of breastfeeding knowledge and experiences* (master's thesis). University of Regina, SK, Canada.

- Farahani, M. A., Sahragard, R., Carroll, J. K., & Mohammadi, E. (2011). Communication barriers to patient education in cardiac inpatient care: a qualitative study of multiple perspectives. *International Journal of Nursing Practice, 17*, 322-328.
- Fiatarone, M. A., O'Neill, E. F., Ryan, N. D., Clements, K. M., Solares, G. R., Nelson, M. E., . . . Evans, W. J. (1994). Exercise training and nutritional supplementation for physical frailty in very elderly people. *New England Journal of Medicine, 330*, 1769-1775.
- Focht, B. C. (2006). Effectiveness of exercise interventions in reducing pain symptoms among older adults with knee osteoarthritis: a review. *Journal of Aging & Physical Activity, 14*, 212-235.
- Forbes, D., Forbes S., Morgan, D. G., Markle-Reid, M., Wood, J., & Culum, I. (2008). Physical activity programs for persons with dementia. Cochrane Database of Systematic Reviews: Reviews 2008 Issue 3 John Wiley & Sons, Ltd Chichester, UK doi: 10.1002/14651858.CD006489.pub2YR: 2008.
- Galik, E. M., Resnick, B., & Pretzer-Aboff, I. (2009). 'Knowing what makes them tick': motivating cognitively impaired older adults to participate in restorative care. *International Journal of Nursing Practice, 15*, 48-55.
- Gates, D., Fitzwater, E., & Succop, P. (2005). Reducing assaults against nursing home caregivers. *Nursing Research, 54*, 119-127
- Gillespie, L.D., Robertson, M.C., Gillespie, W., J., Lamb, S. E., Gates, S., Cumming, R. G., & Rowe, B.H. (2009). Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews: Reviews 2009 Issue 2 (pp.1-210). John Wiley & Sons, Ltd Chichester, UK. doi: 10.1002/14651858.CD007146.pub2

- Goodman, P. (2008). "It's just Black, White, or Hispanic?": An observational study of racializing moves in California's segregated prison reception centers. *Law & Society Review, 42*, 735-770.
- Gossett, A., Mirza, M., Barnds, A. K., & Feidt, D. (2009). Beyond access: a case study on the intersection between accessibility, sustainability, and universal design. *Disability & Rehabilitation Assistive Technology, 4*, 439-450.
- Government of Ontario and the Ontario Community Support Association (OCSA) (2009). *The History and Development of the Personal Support Worker and Personal Attendant Programs in Ontario*. Retrieved on April 1, 2011 from http://www.ocsa.on.ca/userfiles/PSW_History.pdf
- Government of Ontario. (2010). Long-term care homes act, 2007. Retrieved January 10, 2011, from http://www.e-laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10079_e.htm
- Grahame, K. M. (2003). "For the family": Asian immigrant women's triple day. *Journal of Sociology & Social Welfare, 30*, 65-90.
- Green, C. J., & Moehr, J. R. (2003). Decision support for governing boards of integrated delivery networks: Explicating versus eliciting knowledge. *AMIA Annual Symposium Proceedings, 854*.
- Green, L. W., Richard, L., & Potvin, L. (1996). Ecological foundations of health promotion. *American Journal of Health Promotion, 10*, 270-281.
- Greenlough, T. Robert, G., Bate, P. Mac Farlane, F. & Kyriakidou, O. (2005). Diffusion of innovations in health services organizations: A systematic reviews of interventions , Medical Maldden, MA: Blackwell.

- Halabisky, B., Humbert, J., Stodel, Emma J., MacDonald, C. J., Chambers, L.W., Doucette, S.,... Conklin, J. (2010). eLearning, knowledge brokering, and nursing: strengthening collaborative practice in long-term care, *Informatics Nursing*, 28(5), 264-273.
- Hall, P. (2005) Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*, (May 2005) Supplement 1: 188-196. Retrieved October 25, 2011 from http://www.cihc.ca/library/bitstream/10296/385/1/Hall_CultureBarriers_May2005.pdf
- Hamilton, P., Mathur, S., Gemeinhardt, G., Eschiti, V., & Campbell, M. (2010). Expanding what we know about off-peak mortality in hospitals. *Journal of Nursing Administration*, 40, 124-128.
- Harrison, D. (2006). The role of military culture in military organizations' responses to woman abuse in military families. *The Sociological Review*, 54, 546-574.
- Higgins, I., Madjar, I., & Walton, J.A. (2004). Chronic pain in elderly nursing home residents: The need for nursing leadership, *Journal of Nursing Management*, 12, 167-173
- Hsu, H.C., Kung, Y.W., Huang, H.C. Ho, P.Y. Lin, Y.Y., & Chen, W.S. (2007). Work stress among nursing home care attendants in Taiwan: a questionnaire survey. *International Journal of Nursing Studies*, 44(5), 736-46.
- Ice, G. (2002). Daily life in a nursing home: Has it changed in 25 years? *Journal of Aging Studies*, 16(4), 345-359.

- Institute for Work & Health. (2007). Ontario's Patient Lift initiative: early findings. *At Work*, Issue 48, Spring 2007. Retrieved April 25, 2011, from <http://www.iwh.on.ca/at-work/48/patient-lift-initiative>
- Jongenelis, K., Pot, A. M., Eisses, A. M., Beekman, A. T., Kluiters, H., & Ribbe, M. W. (2004). Prevalence and risk indicators of depression in elderly nursing home patients: the AGED study. *Journal of Affective Disorders*, 83, 135-142.
- Kolanowski, A., Buettner, L., Litaker, M., & Yu, F. (2006). Factors that relate to activity engagement in nursing home residents. *American Journal of Alzheimer's Disease & Other Dementias*, 2(1), 15-22.
- Koontz, A. M., Brindle, E. D., Kankipati, P., Feathers, D., & Cooper, R. A. (2010). Design features that affect the maneuverability of wheelchairs and scooters. *Archives of Physical Medicine & Rehabilitation*, 91, 759-764.
- Kramer, M., Schmalenberg, C. & Maguire P. (2010). Nine structures and leadership practices essential for a magnetic (healthy) work environment. *Nursing Administration Quarterly*, 34(1), 4-17.
- Lapane, K.L., & Hughes, C.M. (2007). Considering the employee point of view: perceptions of job satisfaction and stress among nursing staff in nursing homes. *Journal of the American Medical Directors Association*, 8(1), 8-13
- Lazowski, D. A., Ecclestone, N. A., Myers, A. M., Paterson, D. H., Tudor-Locke, C., Fitzgerald, C., . . . Cunningham, D. A. (1999). A randomized outcome evaluation of group exercise programs in long-term care institutions. *Journals of Gerontology Series A-Biological Sciences & Medical Sciences*, 54, M621-M628.

- Levin, C. A., Wei, W., Akincigil, A., Lucas, J. A., Bilder, S., & Crystal, S. (2007). Prevalence and treatment of diagnosed depression among elderly nursing home residents in Ohio. *Journal of the American Medical Directors Association, 8*, 585-594.
- Levin, P. F., Hewitt, J. B., Misner, S. T., & Reynolds, S. (2003). Assault of long-term care personnel. *Journal of Gerontological Nursing, 29*, 28-35.
- Limoges, J. (2010). An exploration of ruling relations and how they organize and regulate nursing education in the high-fidelity patient simulation laboratory. *Nursing Inquiry, 17*, 58-64.
- Lincoln, Y. S., & Guba, E. G., (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.
- Loeb, J. L. (1999). Pain management in long-term care. *American Journal of Nursing, 99*, 48-52.
- Luken, P. C., & Vaughan, S. (2003). Living alone in old age: Institutionalized discourse and women's knowledge. *Sociological Quarterly, 44*, 109-131.
- Luken, P. C., & Vaughan, S. (2006). Standardizing childrearing through housing. *Social Problems, 53*, 299-331.
- MacKinnon, K. (2006). Living with the threat of preterm labour: Women's work of keeping the baby in. *JOGNN: Journal of Obstetric, Gynecologic, and Neonatal Nursing, 36(6)*, 700-708.
- MacRae, P., Schnelle, J., Simmons, S., & Ouslander, J. (1996). Physical activity levels of ambulatory nursing home residents. *Journal of Aging and Physical Activity, 4(3)*, 264-278.

- Matthews, D. & Closson, T. (2009). Remarks By The Honourable Deb Matthews Minister of Health and Long-Term Care and Tom Closson, President & CEO of the Ontario Hospital Association. In. Retrieved on May 01, 2011 from http://www.health.gov.on.ca/en/news/speech/2009/sp_20091118.aspx
- Marx, K., & Engels, F. (1976). *The German ideology*. Moscow: Progress
- McCoy, L. (2005). HIV-positive patients and the doctor-patient relationship: Perspectives from the margins. *Qualitative Health Research*, 15, 791-806.
- Mc Ewen, M, (2011). Philosophy, science and nursing. In M. Mc Ewen & E.M. Wills (Eds). *Theoretical Basis for Nursing*. (pp 17-19). Philadelphia, WoltersKluwer/Lippincot Willians & Wilkins.
- McGibbon, E. A. (2004). *Reformulating the nature of stress in nurses' work in pediatric intensive care: An institutional ethnography* (unpublished doctoral dissertation). University of Toronto, ON, Canada.
- McGregor, M. J., Cohen, M., McGrail, K., Broemeling, A. M., Adler, R. N., Schulzer, M.(2005). Staffing levels in not-for-profit and for-profit long-term care facilities: does type of ownership matter? *CMAJ Canadian Medical Association Journal*, 172, 645-64
- Ministry of Health and Long-Term Care (MOHLTC) of Ontario (2008). *Senior's Care: Long-Term Care*.
http://www.health.gov.on.ca/english/public/program/ltc/15_facilities.html.
- Ministry of Health and Long-Term Care of Ontario. (2007). *Long-term care homes program manual* (rev. ed.). Retrieved December 3, 2009, from http://www.health.gov.on.ca/english/providers/pub/manuals/ltc_homes/ltc_homes_mn.html.

- Ministry of Health and Long-Term Care, H. P. R. A. C. (2006). *Regulation of health professions in Ontario: New directions*. Retrieved online in Sept. 25, 200 from http://www.health.gov.on.ca/english/public/pub/ministry_reports/personal_support_workers/personal_support_workers.html.
- Murray, M. A., Higuchi-Smith, K. A., Edwards, N., Greenough, M., & Hoogeveen, K. (2011, in press). Practice change in long-term care facilities in Ontario: Views of managers and staff. *Geriatric Nursing*.
- Norris, M.A., Walton, R.E., Patterson, C.J., Feightner, J.W., & The Canadian Task Force on Preventative Health care (2003). *Prevention of falls in long-term care facilities: Systematic review and recommendations*. Retrieved June 3, 2007, from http://www.ctfphc.org/Full_Text/CTF_FallsPrevn_TR_Jun03.pdf
- Ontario Community Support Association (OCSA) (2009). *Personal Support Worker Training Backgrounder*. Retrieved on April 1st, 2011 from www.ocsa.on.ca/.../PSW%20Backgrounder%20short%20version.pdf -
- Ouslander, J. G., Griffiths, P. C., McConnell, E., Riolo, L., Kutner, M., & Schnelle, J. (2005a). Functional incidental training: A randomized, controlled, crossover trial in Veterans Affairs nursing homes. *Journal of the American Geriatrics Society*, 53, 1091-1100.
- Ouslander, J. G., Griffiths, P., McConnell, E., Riolo, L., & Schnelle, J. (2005b). Functional Incidental Training: applicability and feasibility in the Veterans Affairs nursing home patient population. *Journal of the American Medical Directors Association*, 6, 121-127.
- Paterson, B. L., Osborne, M., & Gregory, D. (2004). How different can you be and still survive? Homogeneity and difference in clinical nursing education. *International Journal of Nursing Education Scholarship*, 1(1), 1-13.

Personal Support Network of Ontario. Frequently asked questions: How much do PSW earn?

Retrieved on April 11, 2011 from <http://www.psno.ca/faq.php#howEarn>

Ploeg, J., Davies, B., Edwards, N., Gifford, W., & Miller, P.E. (2007). Factors influencing best-practice guideline implementation: lessons learned from administrators, nursing staff, and project leaders. *Worldviews on Evidence- Based Nursing*, 4(4), 210-9.

Ploeg, J., Skelly, J., Rowan, M., Edwards, N., Davies, B., Grinspun, D., ... Downton, A. (2010). The role of nursing best practice champions in diffusing practice guidelines: a mixed methods study. *Worldviews on Evidence-Based Nursing*, 7(4), 238-51.

Price Waterhouse Coopers. (2001). *Report of a study to review levels of service and response to need in a sample of Ontario long-term care homes and selected comparators*. Retrieved September 25, 2006, from <http://www.oanhss.org/staticcontent/staticpages/frameset.html>

Public Health Agency of Canada. Physical activity: Tips to get active. Retrieved April 21, 2011 from <http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/pa-ap/08paap-eng.php>.

Quance, M. (2007). *The social organization of nurses' labour pain work* (unpublished doctoral dissertation). University of Calgary, AB, Canada.

Rankin, J. M. (2003). 'Patient satisfaction': Knowledge for ruling hospital reform: An institutional ethnography. *Nursing Inquiry*, 10, 57-65.

Rankin, J. M. (2004). *How nurses practise health care reform: An institutional ethnography* (unpublished doctoral dissertation). University of Victoria, BC, Canada.

Rankin, J., & Campbell, M. J. (2006). *Managing to nurse*. Toronto, ON, Canada: University of Toronto Press.

- Rankin, J. M., Malinsky, L., Tate, B., & Elena, L. (2010). Contesting our taken-for-granted understanding of student evaluation: Insights from a team of institutional ethnographers. *Journal of Nursing Education, 49*, 333-339.
- Rantakokko, M., Iwarsson, S., Kauppinen, M., Leinonen, R., Heikkinen, E., & Rantanen, T. (2010). Quality of life and barriers in the urban outdoor environment in old age. *Journal of the American Geriatrics Society, 58*, 2154-2159.
- Reeves, S., Zwarenstein, M., Goldman, J., Barr, H., Freeth, D., Koppel, I. & Hammick, M. (2010). The effectiveness of interprofessional education: key findings from a new systematic review. *Journal of Interprofessional Care, 24(3)*, 230-241
- Registered Nurses' Association of Ontario (RNAO) (2001). Submission to the Senate Committee on Social Affairs, Science and Technology re: the Canada Health Act. Retrieved on January 5, 2011 from http://www.rnao.org/Storage/12/705_kirby_recommendations.pdf
- Registered Nursing Association of Ontario (RNAO) (2007). *Staffing and Care Standards for Long-Term Care Homes; Submission to the Ministry of Health and Long-Term Care.*
- Registered Nurses' Association of Ontario (RNAO) (2009). *RNAO Response to the Minister of Health and Long-Term Care on: Part 2 of the Draft Regulation under the Long-Term Care Homes Act, 2007. Summary of Recommendations.* Retrieved April 1, 2011 from <http://www.rnao.org/Page.asp?PageID=122&ContentID=2943&SiteNodeID=390>
- Resnick, B., Petzer-Aboff, I., Galik, E., Russ, K., Cayo, J., Simpson, M., & Zimmerman, S. (2008). Barriers and benefits to implementing a restorative care intervention in nursing homes. *Journal of the American Medical Directors Association, 9*, 102-108.

- Resnick, B., Simpson, M., Galik, E., Bercovitz, A., Gruber-Baldini, A. L., Zimmerman, S., & Magaziner, J. (2006). Making a difference: nursing assistants' perspectives of restorative care nursing. *Rehabilitation Nursing, 31*, 78-86.
- Richard, L., Potvin, L., Kishchuk, N., Prlic, H., & Green, L. W. (1996). Assessment of the integration of the ecological approach in health promotion programs. *American Journal of Health Promotion, 10*, 318-328
- Rose, D. J. & Hernandez, D. (2010). The role of exercise in fall prevention for older adults. *Clinics in Geriatric Medicine, 26*, 607-63
- Ruuskanen, J. M., & Parkatti, T. (1994). Physical activity and related factors among nursing home residents. *Journal of the American Geriatrics Society, 42*, 987-991.
- Sallis, F., & Owen, N. (1997). *Health behavior and health education: Theory, research and practice* (2nd ed.). San Francisco, CA: Jossey-Bass, 403-424.
- Sallis, J. F., Cervero, R. B., Ascher, W., Henderson, K. A., Kraft, M. K., & Kerr, J. (2006). An ecological approach to creating active living communities. *Annual Review of Public Health, 27*, 297-322.
- Schnelle, J. F., Alessi, C. A., Simmons, S. F., Al Samarrai, N. R., Beck, J. C., & Ouslander, J. G. (2002). Translating clinical research into practice: a randomized controlled trial of exercise and incontinence care with nursing home residents. *Journal of the American Geriatric Society, 50(9)*, 1476-1483.
- Schnelle, J. F., Kapur, K., Alessi, C., Osterweil, D., Beck, J. G., Al-Samarrai, N. R., & Ouslander, J.G. (2003). Does an exercise and incontinence intervention save healthcare costs in a nursing home population? *Journal of the American Geriatrics Society, 51*, 161-168.

- Schoenfelder, D. P. & Rubenstein, L. M. (2004). An exercise program to improve fall-related outcomes in elderly nursing home residents. *Applied Nursing Research, 17*, 21-31.
- Schutzer, K. A., & Graves, B. S. (2004). Barriers and motivations to exercise in older adults. *Preventive Medicine, 39*, 1056-1061.
- Seniors Health Research Transfer Network (SHRTN) (2009). Activity and Aging Community of Practice. Recommended Practice Guidelines for Outcome-Focused Physical Activity Programming in Long-Term Care Homes. Retrieved from <http://beta.shrtn.on.ca/resources/254>.
- Shamian, J., & El-Jardali, F. (2007). Healthy Workplaces for Health Workers in Canada: Knowledge Transfer and Uptake in Policy and Practice. *Healthcare Papers, 7*, 6-25.
- Sharkey, S. (2008). *People Caring for People. Impacting the Quality of Life and Care of Residents of Long-Term Care Homes*. A report of the independent review of staff and care standards for long-term care homes in Ontario. Retrieved May 1st 2011 from <http://www.health.gov.on.ca>.
- Sharma, N. (2001). On being not Canadian: The social organization of “migrant workers” in Canada. *Canadian Review of Sociology and Anthropology, 38*, 415-439.
- Simmons, S. F., Ferrell, B. A., & Schnelle, J. F. (2002). Effects of a controlled exercise trial on pain in nursing home residents. *Clinical Journal of Pain, 18*, 380-385.
- Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*. Boston, MA: Northeastern University Press.
- Smith, D. E. (1990a). *Texts, facts, and femininity: Exploring the relations of ruling*. London, UK: Routledge.

- Smith, D. E. (1990b). *The conceptual practices of power: A feminist sociology of knowledge*. Boston, MA: Northeastern University Press.
- Smith, D. E. (1999). *Writing the social: Critique, theory, and investigations*. Toronto, ON, Canada: University of Toronto Press.
- Smith, D. E. (2001). Texts and the ontology of organizations and institutions. *Studies in Cultures, Organizations and Societies*, 7, 159-198.
- Smith, D. E. (2004). Ideology, science and social relations: A reinterpretation of Marx's epistemology. *European Journal of Social Theory*, 7, 445-462.
- Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. Walnut Creek, CA: AltaMira Press.
- Smith, D. E. (2006). *Institutional ethnography as practice*. Lanham, MD: Rowman & Littlefield.
- Smith, M. (2004). *Commitment to care: A plan for long-term care in Ontario*.
http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_04/mohltc_rep04.html [On-line].
- Statistics Canada (2009). Caring Canadians, involved Canadians: Highlights from the 2007 Canada survey of giving, volunteering and participating. Cat # 71-542-X pp1-91.
Retrieved May 1, 2011 from
http://www.givingandvolunteering.ca/files/giving/en/csgvp_highlights_2007.pdf
- Townsend, E. A. (1992). Institutional ethnography: Explicating the social organization of professional health practices intending client empowerment. *Canadian Journal of Public Health*, 83, S58-S61.

- Townsend, E., Langille, L., & Ripley, D. (2003). Professional tensions in client-centered practice: Using institutional ethnography to generate understanding and transformation. *American Journal of Occupational Therapy, 57*, 17-28.
- Townsend, E., Sheffield, S. L., Stadnyk, R., & Beagan, B. (2006). Effects of workplace policy on continuing professional development: The case of occupational therapy in Nova Scotia, Canada. *Canadian Journal of Occupational Therapy – Revue canadienne d'ergothérapie, 73*, 98-108.
- Wagner, J.I., Cummings, G., Smith, D.L., Olson, J., Anderson, L. & Warren, S. (2010). The relationship between structural empowerment and psychological empowerment for nurses: a systematic review. *Journal of Nursing Management, 18(4)*, 448-62.
- Wall, C. (2009). Working in fields as fieldwork. Khaskar, participant observation and the tamorka as way to access local knowledge in rural Uzbekistan. In C. R. L. Wall, & P. P. Mollinga, (Eds). *In Fieldwork in Difficult Environments: Methodology as Boundary Work in Development Research*, pp. 137-159, Zurich, LIT.
- Webster, F. (2009). *The social organization of best practice for acute stroke: An institutional ethnography* (unpublished doctoral dissertation). University of Toronto, ON, Canada.
- Weeks, L. E., Profit, S., Campbell, B., Graham, H., Chircop, A., & Sheppard-LeMoine, D. (2008). Participation in physical activity: influences reported by seniors in the community and in long-term care facilities. *Journal of Gerontological Nursing, 34*, 36-43.
- Weller, J. M., Barrow, M., & Gasquoine, S. (2011). Interprofessional collaboration among junior doctors and nurses in the hospital setting. *Medical Education, 45*, 478-487.

- Wilcox, S., Der Ananian, A. C., Abbott, J., Vrazel, J., Ramsey, C., Sharpe, P. A., & Brady, T. (2006). Perceived exercise barriers, enablers, and benefits among exercising and nonexercising adults with arthritis: Results from a qualitative study. *Arthritis & Rheumatism, 55*, 616-627.
- Williams, C. L., & Tappen, R. M. (2008). Exercise training for depressed older adults with Alzheimer's disease. *Aging & Mental Health, 12*, 72-80.
- Zeller, A., Hahn, S., Needham, I., Kok, G., Dassen, T., & Halfens, R. J. (2009). Aggressive behavior of nursing home residents toward caregivers: a systematic literature review. *Geriatric Nursing, 30*, 174-18.
- Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews* 2009, Issue 3. Art. No.: CD000072. doi:10.1002/14651858.CD000072.pub2.

Appendix 3: Recruitment

Letter of Information

Recruitment Poster

Telephone Script

Letter of Information

Project title: The Social Organization of Personal Support Work in Long-Term Care (LTC) and the Promotion of Physical Activity for Residents: An Institutional Ethnography

My name is Kathleen Benjamin. I am conducting this research as part of my doctoral studies in nursing at the University of Ottawa. Dr. Nancy Edwards from the School of Nursing at the University of Ottawa is supervising this study.

What is this all about?

Despite the benefits of physical activity, many residents living in long-term care homes are relatively inactive. Personal Support Workers (PSWs) are important caregivers in LTC settings. Many factors influence how the day-to-day work of PSWs is organized. Some of these influencing factors are internal to the LTC setting and others are external. The ways in which PSWs work is organized may influence the promotion of physical activity for residents in LTC.

The purposes of this study are to understand how the work of PSWs is socially organized and to determine how the social organization of their work influences the promotion of physical activity for LTC residents. The study is guided by the theory and methodology of Institutional Ethnography which proposes that the everyday lives (work) of people are organized socially by factors that lie outside of their everyday lives and that text-based materials (e.g. standards, policies, etc.) are involved in this organization.

Data will be collected by observing PSWs as they go about their typical day, paying particular attention to how they initiate, facilitate, encourage and/or assist residents to be physically active. Following the observations, interviews will be conducted with some people from inside (e.g. staff member, resident, family member, volunteer) and outside of the LTC setting (e.g. policy

analyst for the Ministry). Data will also be collected through document review (e.g. standards of care). This study will be conducted in two LTC facilities in xxxx Ontario.

What do I need to do?

First, I will observe the PSWs as they go about their typical day paying attention to what they do related to the promotion of physical activity for residents (e.g. transport a resident to their exercise class) and their social relations with other staff, residents, families, and volunteers. I will be conducting seven periods of observations on all three shifts in each facility. Each period of observation will last about four hours. I will just be observing and writing notes. Based on the findings of my observations, I will be inviting some people in the LTC setting to an interview that will last 30-45 minutes.

Participation is voluntary and you can agree to participate in the observations or in an interview, or both. You can refuse to participate and withdraw from the study at any time. There is a possibility that I may need to interview some participants a second time.

What good/harm will this do to me?

The observations may make you feel self-conscious. You may ask me to leave the area at any time for any reason. I will not observe any interactions that are private in nature (e.g. bathing a resident).

During the interview, I will be asking you questions about the work processes of PSWs related to the promotion of physical activity. You may feel uncomfortable sharing your thoughts. You will be encouraged to say only what you feel comfortable saying. Although you may not personally benefit from this study, the findings of this study will help to inform institutional policies and procedures, which in turn could lead to changes in practice.

Is this confidential?

All information you provide or any health information that I hear during my observations will be kept confidential. Your name and the name of your facility will not be recorded with your responses or identified in any way. You and your organization will be assigned a unique ID number. Only ID numbers and pseudonyms will appear on my field notes. Your name will not appear with any of your quotes

Audio-recordings of the interview will be stored on the password protected computer in the researcher's locked office. One backup CD of the interview will be made and stored in a locked filing cabinet in the researcher's office. One year following transcription, the audio recordings will be deleted from the researcher's computer and the CD will be destroyed (cut and disposed).

All paper data will be kept in a locked filing cabinet in a secure office belonging to the researcher. The paper and computer data (e.g. transcripts) will be destroyed ten years after completion of the thesis (cut and shredded). If you decide to withdraw from the study, I will ask you for permission to use your data.

What if I have more questions? Who do I call?

You may contact Kathleen Benjamin at XX or e-mail or fax XX. For ethical concerns you may contact the Chair of the Research Ethics Board at XX

Recruitment Poster
Volunteers Needed for a Study on xxx

Title: Social Organization of Personal Support Work in Long-Term Care (LTC) and the Promotion of Physical Activity for Residents: An Institutional Ethnography .

Kathleen Benjamin, PhD student in nursing, University of Ottawa, will explore how work in the LTC setting is organized and how this organization affects the promotion of physical activity for residents. Findings of this study will help to inform institutional policies and procedures related to the promotion of physical activity for residents.

Who is needed?

- Personal Support Workers (PSWs), and any staff member (e.g. RN, RPN, Activity Staff, Physiotherapist, Housekeeper etc.)
- Residents, family members, and volunteers.
- People who are able to speak and understand English.

What will you need to do?

I will observe PSWs as they go about their typical day on xxx looking at how they initiate, facilitate, encourage and/or assist residents to be physically active. I will also observe their interactions with residents, families, volunteers and other staff members related to the promotion of physical activity. To do so, I will need written consent from any person who will be observed.

Observations will occur on all three shifts during xxxx and xxxx. I will just be observing and writing notes. You may ask me to leave the area at any time, for any reason. Next, based on the findings from the observations, I will invite some people to an interview.

For further information or to volunteer to be in the study please contact Kathleen at XX-or email XX

Telephone Script to Recruit People from Outside of the Long Term Care Setting

Hello _____ (name).

My name is _____ I am a doctoral student in Nursing at the University of Ottawa.

Is this a good time to speak to you? Yes _____ → proceed No _____ → call back
time _____

- I am doing a research study as part of my doctoral program that will examine the social, work, and organizational factors that influences the work of Personal Support Workers (PSWs) related to physical activity for residents.
- You have been identified as someone one who has knowledge about the topic of interest. I am inviting you to participate in this study.
- Your participation would involve a 30-45 audiotaped face-to-face or phone interviews. You will be asked questions regarding the work practices and social organization of the PSW's work in the LTC setting related to the physical activity of LTC residents.
- Your participation is voluntary and you can withdraw for the study at any time. Everything that you tell me will be held confidential.
- Are you interested in participating? If No → Thank- you for your time. Goodbye
If Yes → proceed
- I would like to send you an information sheet and a consent form. Could I have your e-mail, fax or mailing address _____
- Could you please return a signed copy of the consent to me by fax/post and keep one copy for yourself.
- I will then e-mail or phone you to schedule a time for the interviews.

Do you have any question? Yes No

Thank- you

Appendix 4: Consents

Consent: Interview: Personal Support Workers (PSW)

Consent: Interview: (staff, resident, family member, volunteer)

Consent: Participant observation: personal support workers

Consent: Participant observation: (staff, resident, family member, or volunteer)

Consent: Interview: (participants recruited from outside of the long-term care facilities)

Form letter: Permission to access, copy and reprint text(s)

Consent: Interview: Personal Support Workers (PSW)

Project title:

The Social Organization of Personal Support Work in Long-Term Care and the Promotion of Physical Activity for Residents: An Institutional Ethnography

My name is Kathleen Benjamin. I am conducting this research as part of my doctoral studies in nursing at the University of Ottawa. Dr. Nancy Edwards from the School of Nursing at the University of Ottawa is supervising this study.

What is this all about?

Despite the benefits of physical activity, many residents living in long-term care homes are relatively inactive. Personal Support Workers (PSWs) are important caregivers in LTC settings. Many factors influence how the day-to-day work of PSWs is organized. Some of these influencing factors are internal to the LTC setting and others are external. The ways in which PSWs work is organized may influence the promotion of physical activity for residents in LTC. The purposes of this study are to understand how the work of PSWs is socially organized and to determine how the social organization of their work influences the promotion of physical activity for LTC residents. The study is guided by the theory and methodology of Institutional Ethnography which proposes that the everyday lives (work) of people are organized socially by factors that lie outside of their everyday lives and that text-based materials (e.g. standards, policies, etc.) are involved in this organization.

Data will be collected by observing PSWs as they go about their typical day, paying particular attention to how they initiate, facilitate, encourage and/or assist residents to be physically active. Following the observations, interviews will be conducted with some people from inside (e.g. staff member, resident, family member, volunteer) and outside of the LTC setting (e.g. policy analyst for the Ministry). Data will also be collected through document review (e.g. standards of care). This study will be conducted in two LTC facilities in xxxx Ontario.

What do I need to do?

I am inviting you to participate in an interview. I will be asking you questions about your work processes. Interviews will be audio-taped, last 30-45 minutes and will be conducted in a private space in your facility. Your participation is voluntary. You can refuse to participate or withdraw from the study at any time, for any reason. Your non-participation will not affect your employment status. Your employer is aware that the interviews will be conducted during normal working hours. There is a possibility that I may need to interview you a second time.

What good/harm will this do to me?

You may feel uncomfortable sharing your thoughts during an interview. You will be encouraged to say only what you feel comfortable saying. Although you may not personally benefit from this study, the findings of this study will help to inform institutional policies and procedures, which in turn could lead to changes in practice.

Is this confidential?

All information you provide or any health information that I hear during my observations will be kept confidential. Your name and the name of your facility will not be recorded with your responses or identified in any way. You and your organization will be assigned a unique ID number. Only ID numbers and pseudonyms will appear on my field notes. Your name will not appear with any of your quotes.

Audio-recordings of the interviews will be stored on the password protected computer in the researcher's locked office. One backup CD of the interviews will be made and stored in a locked filing cabinet in the researcher's office. One year following transcription, the audio recordings will be deleted from the researcher's computer and the CD will be destroyed (cut and disposed).

All paper data will be kept in a locked filing cabinet in a secure office belonging to the researcher. The paper and computer data (e.g. transcripts) will be destroyed ten years after completion of the thesis (cut and shredded). If you decide to withdraw from the study, I will ask you for permission to use your data.

What if I have more questions? Who do I call?

You may contact Kathleen Benjamin at XX or e-mail fax XX. For ethical concerns, you may contact the Chair of the Research Ethics Board at XX

Are you willing to participate in an interview?

Yes No

May I tape-record your interview?

Yes No

May I use direct quotes from you, without your name, for the purposes of research and educational publications?

Yes No

Participant's Signature

Date

Researcher's Signature

Date

Please sign two copies of the consent form so that I can give you a copy.

OR

The consent has been read to me by _____ in the presence of
_____ (witness's name)

I _____ (participant's name) consent to participate in the proposed research
project

Researcher's Signature

Date

Participant's Signature

Date

Witness's Signature

Date

Consent: Interview (staff, resident, family member, volunteer)**Project title:**

The Social Organization of Personal Support Work in Long-Term Care and the Promotion of Physical Activity for Residents: An Institutional Ethnography

My name is Kathleen Benjamin. I am conducting this research as part of my doctoral studies in nursing at the University of Ottawa. Dr. Nancy Edwards from the School of Nursing at the University of Ottawa is supervising this study.

What is this all about?

Despite the benefits of physical activity, many residents living in long-term care homes are relatively inactive. Personal Support Workers (PSWs) are important caregivers in LTC settings. Many factors influence how the day-to-day work of PSWs is organized. Some of these influencing factors are internal to the LTC setting and others are external. The ways in which PSWs work is organized may influence the promotion of physical activity for residents in LTC. The purposes of this study are to understand how the work of PSWs is socially organized and to determine how the social organization of their work influences the promotion of physical activity for LTC residents. The study is guided by the theory and methodology of Institutional Ethnography which proposes that the everyday lives (work) of people are organized socially by factors that lie outside of their everyday lives and that text-based materials (e.g. standards, policies, etc.) are involved in this organization.

Data will be collected by observing PSWs as they go about their typical day, paying particular attention to how they initiate, facilitate, encourage and/or assist residents to be physically active. Following the observations, interviews will be conducted with some people from inside (e.g. staff member, resident, family member, volunteer) and outside of the LTC setting (e.g. policy analyst for the Ministry). Data will also be collected through document review (e.g. standards of care). This study will be conducted in two LTC facilities in xxxx Ontario.

What do I need to do?

I am inviting you to participate in an interview. I will be asking questions about the work processes of PSWs related to the promotion of physical activity. Interviews will be audio-taped, last 30-45 minutes and will be conducted in a private space in your facility. Your participation is voluntary. You can refuse to participate or withdraw from the study at any time, for any reason.

If you are a staff member, your non-participation will not affect your employment status. Your employer is aware that the interviews will be conducted during normal working hours. There is a possibility that I may need to interview you a second time.

What good/harm will this do to me?

You may feel uncomfortable sharing your thoughts during an interview. You will be encouraged to say only what you feel comfortable saying. Although you may not personally benefit from this study, the findings of this study will help to inform institutional policies and procedures, which in turn could lead to changes in practice.

Is this confidential?

All information you provide or any health information that I hear during my observations will be kept confidential. Your name and the name of your facility will not be recorded with your responses or identified in any way. You and your organization will be assigned a unique ID number. Only ID numbers and pseudonyms will appear on my field notes. Your name will not appear with any of your quotes

Audio-recordings of the interviews will be stored on the password protected computer in the researcher's locked office. One backup CD of the interviews will be made and stored in a locked filing cabinet in the researcher's office. One year following transcription, the audio recordings will be deleted from the researcher's computer and the CD will be destroyed (cut and disposed).

All paper data will be kept in a locked filing cabinet in a secure office belonging to the researcher. The paper and computer data (e.g. transcripts) will be destroyed ten years after

completion of the thesis (cut and shredded). If you decide to withdraw from the study, I will ask you for permission to use your data.

What if I have more questions? Who do I call?

You may contact Kathleen Benjamin at XX or e-mail or fax XX. For ethical concerns, you may contact the Chair of the Research Ethics Board at XX

Are you willing to participate in an interview?

Yes No

May I tape-record your interview?

Yes No

May I use direct quotes from you, without your name, for the purposes of research and educational publications?

Yes No

Participant's Signature

Date

Researcher's Signature

Date

Please sign two copies of the consent form so that I can give you a copy.

OR

The consent has been read to me by _____ in the presence of
_____ (witness's name)

I _____ (participant's name) consent to participate in the proposed research
project

Researcher's Signature

Date

Participant's Signature

Date

Witness's Signature

Date

Consent: Participant Observation: Personal Support Workers

Project title:

The Social Organization of Personal Support Work in Long-Term Care and the Promotion of Physical Activity for Residents: An Institutional Ethnography

My name is Kathleen Benjamin. I am conducting this research as part of my doctoral studies in nursing at the University of Ottawa. Dr. Nancy Edwards from the School of Nursing at the University of Ottawa is supervising this study.

What is this all about?

Despite the benefits of physical activity, many residents living in long-term care homes are relatively inactive. Personal Support Workers (PSWs) are important caregivers in LTC settings. Many factors influence how the day-to-day work of PSWs is organized. Some of these influencing factors are internal to the LTC setting and others are external. The ways in which PSWs work is organized may influence the promotion of physical activity for residents in LTC. The purposes of this study are to understand how the work of PSWs is socially organized and to determine how the social organization of their work influences the promotion of physical activity for LTC residents. The study is guided by the theory and methodology of Institutional Ethnography which proposes that the everyday lives (work) of people are organized socially by factors that lie outside of their everyday lives and that text-based materials (e.g. standards, policies, etc.) are involved in this organization.

Data will be collected by observing PSWs as they go about their typical day, paying particular attention to how they initiate, facilitate, encourage and/or assist residents to be physically active. Following the observations, interviews will be conducted with some people from inside (e.g. staff member, resident, family member, volunteer) and outside of the LTC setting (e.g. policy analyst for the Ministry). Data will also be collected through document review (e.g. standards of care). This study will be conducted in two LTC facilities in xxxx Ontario.

What do I need to do?

I will observe the PSWs as they go about their typical day paying attention to what they do related to the promotion of physical activity for residents (e.g. transport residents to their exercise calls) and their social relations with other staff, residents, families, and volunteers. I will be conducting seven periods of observations on all three shifts in each facility.

Your participation is voluntary. You can refuse to participate or withdraw from the study at any time, for any reason. Your non-participation will not affect your employment status. Your employer is aware that these observations will be conducted during normal working hours.

What good/harm will this do to me?

The observations may make you feel self-conscious. You may ask me to leave the area at any time, for any reason. I will not observe any of your social interactions that are private (e.g. bathing) in nature. Although you may not personally benefit from this study, the findings of this study will help to inform institutional policies and procedures, which in turn could lead to changes in practice.

Is this confidential?

All information you provide or any health information that I hear during my observations will be kept confidential. Your name and the name of your facility will not be recorded with your responses or identified in any way. You and your organization will be assigned a unique ID number. Only ID numbers and pseudonyms will appear on my field notes. Your name will not appear with any of your quotes

All paper data will be kept in a locked filing cabinet in a secure office belonging to the researcher. The paper and any computer data (e.g. field notes) will be destroyed ten years after completion of the thesis (cut and shredded). If you decide to withdraw from the study, I will ask you for permission to use your data. The researcher is also a Registered Nurse who is bound by the professional standards and code of ethics that govern the nursing profession, which includes the reporting elder abuse.

What if I have more questions? Who do I call?

You may contact Kathleen Benjamin at XX or e-mail or fax XX. For ethical concerns, you may contact the Chair of the Research Ethics Board at XX

Are you willing to participate in the observations?

Yes No

May I write down what I see and hear in my field notes?

Yes No

May I use your direct quotes without your name from you for the purpose of research and educational publications?

Yes No

Participant's Signature

Date

Researcher's Signature

Date

Please sign two copies of the consent form so that I can give you a copy.

OR

The consent has been read to me by _____ in the presence of _____ (witness's name)

I _____ (participant's name) consent to participate in the proposed research project

Researcher's Signature

Date

Participant's Signature

Date

Witness's Signature

Date

Participant Observation: (Staff, Resident, Family Member, or Volunteer)

Project Title: The Social Organization of Personal Support Work in Long-Term Care and the Promotion of Physical Activity for Residents: An Institutional Ethnography

My name is Kathleen Benjamin. I am conducting this research as part of my doctoral studies in nursing at the University of Ottawa. Dr. Nancy Edwards from the School of Nursing at the University of Ottawa is supervising this study.

What is this all about?

Despite the benefits of physical activity, many residents living in long-term care homes are relatively inactive. Personal Support Workers (PSWs) are important caregivers in LTC settings. Many factors influence how the day-to-day work of PSWs is organized. Some of these influencing factors are internal to the LTC setting and others are external. The ways in which PSWs work is organized may influence the promotion of physical activity for residents in LTC.

The purposes of this study are to understand how the work of PSWs is socially organized and to determine how the social organization of their work influences the promotion of physical activity for LTC residents. The study is guided by the theory and methodology of Institutional Ethnography which proposes that the everyday lives (work) of people are organized socially by factors that lie outside of their everyday lives and that text-based materials (e.g. standards, policies, etc.) are involved in this organization.

Data will be collected by observing PSWs as they go about their typical day, paying particular attention to how they initiate, facilitate, encourage and/or assist residents to be physically active. Following the observations, interviews will be conducted with some people from inside (e.g. staff member, resident, family member, volunteer) and outside of the LTC setting (e.g. policy analyst for the Ministry). Data will also be collected through document review (e.g. standards of care). This study will be conducted in two LTC facilities in xxxx Ontario.

What do I need to do?

I will observe the PSWs as they go about their typical day paying attention to what they do related to the promotion of physical activity for residents (e.g. transport residents to their exercise calls) and their social relations with other staff, residents, families, and volunteers. I will be conducting seven periods of observations on all three shifts in each facility. Each period of observation will last about four hours. I will just be observing and writing notes.

Your participation is voluntary. You can refuse to participate or withdraw from the study at any time, for any reason. If you are a staff member, your non-participation will not affect your employment status. Your employer is aware that these observations will occur during normal working hours.

What good/harm will this do to me?

The observations may make you feel self-conscious. You may ask me to leave the area at any time for any reason. I will not observe any interactions that are private (e.g. bathing) in nature. Although you may not personally benefit from this study, the findings of this study will help to inform institutional policies and procedures, which in turn could lead to changes in practice.

Is this Confidential?

All information you provide or any health information that I hear during my observations will be kept confidential. Your name and the name of your facility will not be recorded with your responses or identified in any way. You and your organization will be assigned a unique ID number. Only ID numbers and pseudonyms will appear on my field notes. Your name will not appear with any of your quotes

Audio-recordings of the interviews be stored on the password protected computer in the researcher's locked office. One backup CD of the interviews will be made and stored in a locked filing cabinet in the researcher's office. One year following transcription, the audio recordings will be deleted from the researcher's computer and the CD will be destroyed (cut and disposed).

All paper data will be kept in a locked filing cabinet in a secure office belonging to the researcher. The paper and computer data (e.g. transcripts) will be destroyed ten years after completion of the thesis (cut and shredded). If you decide to withdraw from the study, I will ask you for permission to use your data. The researcher is also a Registered Nurse who is bound by the professional standards and code of ethics that govern the nursing profession, which includes the reporting elder abuse

What if I have more questions? Who do I call?

You may contact Kathleen Benjamin at XX or e-mail or fax XX. For ethical concerns, you may contact the Chair of the Research Ethics Board at XX

Are you willing to participate in the observations?

Yes No

May I write down what I see and hear in my field notes?

Yes No

May I use your direct quotes without your name from you for the purpose of research and educational publications?

Yes No

Participant's Signature

Date

Researcher's Signature

Date

Please sign two copies of the consent form so that I can give you a copy.

OR

The consent has been read to me by _____ in the presence of _____
(witness's name)

I _____ (participant's name) consent to participate in the proposed research
project

Researcher's Signature

Date

Participant's Signature

Date

Witness's Signature

Date

Consent: Interview (Participants Recruited From Outside of the Long-Term Facilities)

Project title: The Social Organization of Personal Support Work in Long-Term Care and the Promotion of Physical Activity for Residents: An Institutional Ethnography

My name is Kathleen Benjamin. I am conducting this research as part of my doctoral studies in nursing at the University of Ottawa. Dr. Nancy Edwards from the School of Nursing at the University of Ottawa is supervising this study.

What is this all about?

Despite the benefits of physical activity, many residents living in long-term care homes are relatively inactive. Personal Support Workers (PSWs) are important caregivers in LTC settings. Many factors influence how the day-to-day work of PSWs is organized. Some of these influencing factors are internal to the LTC setting and others are external. The ways in which PSWs work is organized may influence the promotion of physical activity for residents in LTC.

The purposes of this study are to understand how the work of PSWs is socially organized and to determine how the social organization of their work influences the promotion of physical activity for LTC residents. The study is guided by the theory and methodology of Institutional Ethnography which proposes that the everyday lives (work) of people are organized socially by factors that lie outside of their everyday lives and that text-based materials (e.g. standards, policies, etc.) are involved in this organization.

Data will be collected by observing PSWs as they go about their typical day, paying particular attention to how they initiate, facilitate, encourage and/or assist residents to be physically active. Following the observations, interviews will be conducted with some people from inside (e.g. staff member, resident, family member, volunteer) and outside of the LTC setting (e.g. policy analyst for the Ministry). Data will also be collected through document review (e.g. standards of care). This study will be conducted in two LTC facilities in xxxx Ontario.

What do I need to do?

I am inviting you to participate in an interview. I will be asking questions about the organization of the work of PSWs related to the promotion of physical activity (assisting a resident to go for a walk). Interviews will be audio-taped, last 30-45 minutes. Based on your preference, interviews will be conducted by phone or face-to-face in your office. Your participation is voluntary. You can refuse to participate or withdraw from the study at any time, for any reason. There is a possibility that I may need to interview you a second time.

What good/harm will this do to me?

You may feel uncomfortable sharing your thoughts during an interview. You will be encouraged to say only what you feel comfortable saying. Although you may not personally benefit from this study, the findings of this study will help to inform institutional policies and procedures, which in turn could lead to changes in practice.

Is this confidential?

All information you provide or any health information that I hear during my observations will be kept confidential. Your name and the name of your facility will not be recorded with your responses or identified in any way. You and your organization will be assigned a unique ID number. Only ID numbers and pseudonyms will appear on my field notes. Your name will not appear with any of your quotes

Audio-recordings of the interviews will be stored on the password protected computer in the researcher's locked office. One backup CD of the interviews will be made and stored in a locked filing cabinet in the researcher's office. One year following transcription, the audio recordings will be deleted from the researcher's computer and the CD will be destroyed (cut and disposed). All paper data will be kept in a locked filing cabinet in a secure office belonging to the researcher. The paper and computer data (e.g. transcripts) will be destroyed ten years after completion of the thesis (cut and shredded). If you decide to withdraw from the study, I will ask you for permission to use your data.

What if I have more questions? Who do I call?

You may contact Kathleen Benjamin at XX or e-mail fax XX. For ethical concerns, you may contact the Chair of the Research Ethics Board at XX

Are you willing to participate in an interviews?

Yes No

May I tape-record your interview?

Yes No

May I use direct quotes from you, without your name, for the purposes of research and educational publications?

Yes No

Participant's Signature

Date

Researcher's Signature

Date

Please sign two copies of the consent form so that I can give you a copy.

Form Letter: Permission to Access, Copy and Reprint Text(s)

Project Title: The Social Organization of Personal Support Work in Long-Term Care (LTC) and the Promotion of Physical Activity for Residents: An Institutional Ethnography

Name

Location

Date

Re: Text (Name)

Dear

I am a doctoral student in nursing at the University of Ottawa. As part of my thesis, I will be doing textual analyses of documents that appear to be organizing the work of personal support workers related to the physical activity of residents in long-term care.

I am writing to you to ask you for permission to access and copy the institutional text(s) titled: _____.

Should my analyses reveal this is a relevant document for my thesis, I would also like your permission to insert a copy of this text in my thesis and in future publications and presentations. Any identifying information (e.g. name of facility) will not appear (whitened out).

Please do not hesitate to contact me at XX if you have any questions or concerns. Could you please sign this form below and return it to me by fax @ (XX or mail. For ethical concerns, you may contact the Chair of the Research Ethics Board at XX

Thank-you for your consideration

Kathleen Benjamin PhD (c).

- I grant the researcher permission to access and copy the text(s) listed above.
- I grant the researcher permission to insert a copy of the text (s) noted above into her thesis and other future publications and/or presentations.

Signature of Administrator/Other

Date

Appendix 5

Interview Questions and Contact Form

Contact Form: Field Notes during Participant Observations

Examples of Interview Questions

1. Can you tell me about your typical day describing what you do from the start to the end of your shift?
2. How do you decide whether to walk or wheel a resident to the dining room?
3. Can you tell me what makes your shift runs smoothly? Can you tell me about the daily frustrations and challenges that happen in your work?
4. I noticed that you and other PSWs fill in this flowchart. Can you tell me more about this form?
5. Can you suggest other people that I should speak to or other documents that I should be looking at?

Contact Form: Field Notes During Participant Observations

Pseudonym: __ ID number __ Facility __ Contact date ____ Duration of observation ____

1. What were my key observations?
2. Summary of information obtained and gaps
 - What do PSWs do related to the promotion of physical activity? (i.e. initiate, facilitate, assist, and/or encourage residents with their physical activities)
 - How do PSWs decide to do what they do?
 - What text(s) (e.g. posters, polices) do PSWs interact with or create during their typical day related to the promotion of physical activity?
 - Who does the PSWs interact with related to the promotion of physical activity? (e.g. nurse, physio)?
 - What was the language used, tone, context of the conversations?
 - What challenges did PSWs encounter in promoting physical activity?
 - What made it easy for PSWs to promote physical activity?
3. What stands out from the observation period?
4. Potential questions arising from the observations?
5. Potential texts to obtain?

Appendix 6: Manuscript # 3:**Barriers to Physical Activity and Restorative Care for Residents in Long-Term Care Homes: A Review of the Literature****Authors:**

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Abstract

Despite the benefits of physical activity, residents in long-term care (LTC) homes are relatively sedentary. A better understanding of the barriers to physical activity is pivotal to the successful implementation and sustainability of physical activity programs. This paper is a review of the literature related to the barriers to physical activity and restorative care in LTC homes. Five studies were included in this review following a database search. Barriers reported across the five studies occurred at the resident (e.g., health status, lack of motivation), environmental (lack of space for physical activity), and organizational level (staffing and funding constraints). The LTC health care system is complex, and there are several layers of influence that may be affecting the physical activity of older people living in LTC homes. Future studies need to examine this complexity and the multiple levels of influence that act as barriers to physical activity.

Keywords: physical activity, exercise, restorative care, barriers, nursing homes, long-term care, homes for the aged

Barriers to Physical Activity and Restorative Care for Residents in Long-Term Care Homes: A Review of the Literature

According to the Canadian Institute for Health Information, in 2009–2010 there were 130,649 older people living in residential care in Canada. Given the aging population, this number is expected to increase significantly over the next two decades. Various reports have called for improvements in the quality of life for these residents of long-term care (LTC) (Armstrong & Daly, 2004; Canadian Healthcare Association, 2009; Smith, M., 2004). However, common conditions among these older adults such as falls, physical frailty, chronic pain, and depression can reduce their quality of life. Despite evidence that physical activity can reduce or help to improve these conditions (Cameron et al., 2009; de Carvalho & Filho, 2004; Dechamps et al., 2010; Gillespie et al., 2009; Norris, Walton, Patterson, Feightner & the Canadian Task Force on Preventive Health, 2003; Ouslander et al., 2005a; Rose & Hernandez, 2010; Schnelle et al., 2002; Simmons, Ferrell, & Schnelle, 2002; Williams & Tappen, 2008), many LTC residents are relatively inactive (Bates-Jenson et al., 2004; Ruuskanen et al., 1994). This suggests that there exist important underlying barriers to physical activity in LTC settings. The main objective of this paper is to present an overview of the literature related to the barriers to physical activity and restorative care within LTC homes. A better understanding of barriers within a LTC context is pivotal to the successful implementation and sustainability of physical activity strategies aimed at increasing the physical activity levels of residents living in LTC homes.

Search Strategy

An English-language search of MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), AgeLine, and SPORTdiscus (1996–2011) was conducted using the keywords: barriers, physical activity, exercise, restorative care, long-term care, nursing homes,

and homes for the aged, singly and in combination. The terms *home for the aged* and *nursing home* are sometimes used to denote a LTC home. In addition to the terms physical activity and exercise, the keyword *restorative care* was used because this type of care encourages residents to engage in movement and physical activity such as rolling from side to side in bed to change their position, self-propelling their own wheelchair, weight bearing during a patient transfer, or walking in the hallways.

Sixteen articles were identified, and the abstracts of these articles were reviewed using the following inclusion criteria: (a) the research was conducted entirely in a LTC home, home for the aged, or in a nursing home; and (b) the study examined the barriers to physical activity, exercise, or restorative care. The full article was retrieved when eligibility could not be determined from the abstract content.

Twelve articles were eliminated. Seven of these twelve were excluded because they were not conducted exclusively in a LTC setting. Among these seven, four were community-based, two were in low level residential care facilities, and one had a mixed sample of participants over 40 years of age who were recruited from home, hospital and nursing home settings. The remaining five articles were excluded because they did not examine the barriers to physical activity, exercise, or restorative care.

The reference lists of the four articles were reviewed, and one additional article was identified (Resnick et al., 2006). A total of five studies (six articles) were included in this review: those by Benjamin, Edwards, & Caswell (2009), Benjamin et al. (2011), Chen (2010), Galik, Resnick, & Pretzer-Aboff (2009), and Resnick et al. (2006, 2008).

The barriers were initially grouped into three main categories: resident-related (e.g., health status, lack of motivation), organizational (e.g., staffing and funding constraints), and

environmental (e.g., lack of space for physical activity, uneven walking surfaces). A similar typology was used by Chen (2010). Subsequently, a fourth category called *intersecting barriers* was created. This category included examples of barriers that intersected at two or more levels. We assessed the trustworthiness of the five studies included in this review using a tool that was developed by Polit and Beck (Beck, 2009).

Findings

The characteristics of the five studies are presented in Table 1. Although the two articles by Resnick et al. (2006, 2008) were based on the same restorative care study, they were treated as separate studies because they included different samples and were written by different authors. However, the two articles by Benjamin et al. (2009, 2011) reported different findings of one multicomponent study that examined the perceptions of administrators, staff, residents, and residents' families regarding the promotion of physical activity in LTC homes.

All the studies were qualitative in design, and most were exploratory in nature. Data were collected during audiotaped interviews or focus groups, using interview guides. Sample sizes across the studies ranged from seven to 152 participants and included staff members, residents, and significant others. Two studies focused on barriers to physical activity and three on barriers to restorative care. Three studies were conducted in the USA, one in Canada, and one in Taiwan. In only one study (Benjamin et al., 2011) did the authors report using a conceptual model (socioecological), and in two articles the investigators suggested that a sociological model be used to guide future research (Benjamin et al., 2011; Resnick et al., 2008). All of the investigators reported strategies that were used to ensure the trustworthiness of the research (for example, truthfulness, credibility, dependability, and transferability).

Barriers

Resident-related. Resident-related barriers to physical activity and restorative care were reported by staff, residents, and/or significant others across the five studies. Poor health status was a common barrier reported by staff and residents (Benjamin et al., 2009, 2011; Chen, 2010; Galik et al., 2009; Resnick et al., 2006, 2008). For instance, residents reported that poor health and physical limitations such as heart disease, arthritis, stroke, limited mobility, and lack of energy acted as barriers to their participation in regular physical activity (Chen, 2010). Nursing assistants reported that residents or their families were not interested in encouraging restorative care activities such as toileting because these activities were thought to cause pain or shortness of breath for residents (Resnick et al., 2006). In the study by Benjamin et al. (2009), administrators indicated that residents admitted to LTC in the previous five years were older and sicker, which meant that many needed assistance with their physical activities or exercise programs.

Another barrier to restorative care, reported by nursing assistants in the study by Galik et al. (2009), was resident anxiety and agitation. To prevent behavioural outbursts, the nursing assistants encouraged sedentary activities or tried to distract residents so that the assistants could get their care done as quickly as possible. The use of sedative medications was reported as a barrier to restorative care because it reduced residents' interest and ability to participate in activities (Galik et al., 2009; Resnick et al., 2008).

Fear of falling and injury was identified as a barrier to physical activity and restorative care in three studies (Chen, 2010; Galik et al., 2009; Resnick et al., 2006). Nursing assistants were fearful that they or the resident could be injured during activities such as walking or transferring (Galik et al., 2009; Resnick et al., 2006). Residents in the study by Chen (2010)

reported a fear of falling due to poor eyesight and balance, and they were concerned that engaging in physical activity was just too “risky” for them.

A past history of a sedentary lifestyle was another barrier to engagement in regular physical activity (Chen, 2010). For instance, some residents explained they never got into the habit of exercise or never thought about physical activity. Other residents felt they did not need to engage in physical activity because they felt “good” or believed that they had worked hard most of their lives and now it was time to rest.

Organizational. Barriers at the organizational level were reported across all studies by staff, residents, and residents’ significant others. Two major barriers were funding and staffing constraints. For instance, administrators commented that due to inadequate staffing levels, there were often not enough staff to transport residents to their activities (Benjamin et al., 2009). Funding cutbacks resulted in loss of physiotherapy and recreational staff, and fewer exercise opportunities for residents (Benjamin et al., 2009). Another barrier mentioned by administrators and staff members was a general lack of time to incorporate physical activity into the residents’ daily routine (Benjamin et al., 2009, 2011). Nursing assistants reported that they felt pressure to get their work done, which acted as a barrier to the provision of restorative care (Resnick et al., 2008). Lack of communication and support among staff were also seen as impediments to the provision of restorative care (Galik et al., 2009; Resnick et al., 2008).

Barriers related to the type and delivery of physical activity programs were reported by staff, residents, and residents’ significant others (Benjamin et al., 2009, 2011; Chen, 2010). Some residents found the exercise classes boring and not challenging enough, while others did not like the group format of the classes (Benjamin et al., 2011, Chen, 2010). The lack of tailored programs was attributed in part to a failure to include residents in the planning of activities. In

the study by Chen et al. (2010), residents reported that they were rarely consulted about their exercise preferences. Lastly, a major theme reported by Benjamin et al. (2009) was the presence of rigid care routines, which interfered with physical activity. For example, bath days were scheduled, and residents would often opt out of attending an exercise class if this meant that they would miss their bath.

Environmental. Environmental barriers in both indoor and outdoor spaces were reported by staff members, residents, and residents' significant others in two studies (Benjamin et al., 2009, 2011; Chen, 2010). In both of these studies, administrators and residents described the limited living space and the lack of designated spaces for exercise as impediments to physical activity. Administrators described difficulties storing regular equipment like wheelchairs and large reclining chairs (Benjamin et al., 2009). Multipurpose rooms such as dining rooms were often used for exercise classes, which meant that staff had to rearrange the furniture before and after the classes (Benjamin et al., 2009). A general lack of exercise equipment and/or the lack of suitable spaces where it could be installed were also concerns. For instance, an administrator explained that the home was having difficulty trying to find a suitable room to install parallel bars because of limited space (Benjamin et al., 2009). The administrator said that the dining room had been considered but that this was not a pragmatic solution because parallel bars would not be aesthetically pleasing in a dining room (Benjamin et al., 2009). Residents' offers to donate exercise equipment such as treadmills were refused because of lack of space (Benjamin et al., 2011).

Other barriers in the indoor environment included lack of circular design of the nursing unit (which helps promote walking), uneven flooring, and step ramps (Benjamin et al., 2009). Finally, Benjamin et al. (2011) reported that the ambience in the LTC homes hindered physical

activity. For instance, some residents and staff felt that their facility was too quiet and thus not stimulating for physical activity.

Some outdoor environmental barriers to physical activity were also reported, but less frequent references were made to outdoor than indoor barriers. In the study by Benjamin et al. (2011), staff reported that a steep outdoor ramp that led to a patio area was not safe for residents to use. In the publication by Benjamin et al. (2009), an administrator explained that some of the residents could not use an outdoor greenhouse because the entrance was difficult for them to manoeuvre. Lastly, in the study by Chen (2010), a resident commented that there were no suitable outdoor walking paths.

Intersecting barriers. In one study, researchers examined the interrelationships among barriers at multiple levels (Benjamin et al., 2009, 2011). They noted that when barriers at the environmental level (e.g. lack of sufficient elevators to accommodate large pieces of equipment such as wheelchairs, motorized scooters and geriatric-chairs) intersected with barriers at the organizational level (e.g. not enough staff to take residents to the ground floor lounge to attend bingo), this further reduced opportunities for physical activity (Benjamin et al., 2009).

Discussion and Implications for Practice and Future Research

This review illuminates the barriers to physical activity and restorative care in LTC settings that can occur at multiple levels. A common resident-related barrier was poor health and the presence of chronic illness such as arthritis, chronic pain, and heart disease. Interestingly, Chen (2010) has suggested that barriers to physical activity may also act as motivators for residents to be more physically active. For instance, it is well recognized that exercise can help to decrease pain for older adults with arthritis (Blackham, Garry, Cummings, Russell, &

Dealleaume, 2008; Focht, 2006; Wilcox et al., 2006). Thus, some residents with arthritis may be motivated to begin an exercise program with the hope that it will help to reduce their pain and disability. Therefore, it is important that the resident's health status be considered when designing physical activity interventions. Providing exercises that the residents can accomplish and tolerate can act as a motivator.

There was some diversity in the location where the studies were conducted, with three undertaken in the USA, one in Canada, and one in Taiwan. LTC homes differ across countries with respect to resident characteristics, funding and staffing levels, and available services (e.g., exercise, restorative care, and physiotherapy). For example, according to a Price Waterhouse Coopers survey (2001), residents in nursing homes in the USA were more likely to receive rehabilitation services such as physiotherapy than those in LTC homes in Ontario. This is most likely due to differences in payment systems between Canada and the USA for rehabilitation services (Price Waterhouse Coopers, 2001). Between-country and within-country differences need to be considered when planning the design and implementation of physical activity programs

In this review, studies were included that examined barriers to physical activity and/or restorative care. No environmental barriers were reported in the three studies that focused on restorative care (Galik et al., 2009; Resnick et al., 2006, 2008), although environmental barriers were prominent in the two other studies (Benjamin et al., 2009, 2011; Chen, 2010). One possible explanation for this difference is that restorative care is typically provided at the residents' bedside (e.g., stand and pivot transfer from bed to wheelchair) or on the unit level (e.g., self-propelling a wheelchair en route to the dining room), while physical activity typically takes place

within a broader environmental context (e.g., outdoor walking , weight training in the main floor exercise room).

Our understanding of how barriers at multiple levels exert their influence on the physical activity of residents in the LTC setting is limited. This is partly related to the fact that multi-level barriers to physical activity are not consistently assessed. Only one study examined the intersection of barriers at multiple system levels (Benjamin et al., 2009, 2011). While this study examined factors at the individual, interpersonal, organizational, and environmental levels, it excluded factors at the policy level such as legislation and standards. Socioecological models stress the important of examining factors and their nestedness across system levels (Green, Richard, & Potvin, 1996; Richard, Potvin, Kishchuk, Prlic, & Green, 1996; Sallis & Owen, 1997; Sallis et al., 2006). The consistent use of socioecological models in future research on barriers to physical activity in LTC would help to advance this field of research.

In order to determine how similar the barriers reported in this review were to barriers described by those who have conducted physical activity studies in LTC, we searched for randomized controlled trials on this topic. We reviewed 24 randomized controlled trials on exercise/physical activity in the LTC setting that had been published during the past 10 years. Three of these studies included a discussion of barriers (Bates-Jensen, Alessi, Al-Samarrai, & Schnelle, 2003; Lazowski et al., 1999; Schnelle et al., 2002). Two studies discussed barriers related to staffing and funding constraints (Bates et al., 2003; Schnelle et al., 2002); the authors concluded that increases in staffing and funding would be needed to implement their interventions in practice. In these two studies, research staff provided a combined exercise and toileting routine every two hours on the day shift, five days per week; the routine was described as labour intensive.

In the study by Lazowski et al. (1999), trained nursing home staff provided the exercise intervention three times per week for 45 minutes. Challenges reported in this intervention study were: lack of designated spaces for exercise classes, time conflicts (e.g., resident had a hairdressing appointment), and the need to make modifications when working with different LTC homes and very frail residents (Lazowski et al., (1999). Prior to implementing this intervention, Lazowski et al. (1999) conducted a needs assessment of 27 LTC homes in the London, Ontario region. Based on this needs assessment, barriers reported included: funding constraints for exercise equipment and staff, safety concerns, lack of exercise training among staff, difficulty motivating residents, and the challenge of providing exercise programs to residents who were diverse in physical and cognitive status. In future, researchers conducting intervention studies need to make explicit the barriers they encounter when trying to implement their interventions.

The structural design of LTC homes can create environmental barriers. For instance, in Ontario, LTC homes built before the 1980s tend to have less living and common space because they were designed for older people who were relatively independent and mobile. In future studies, it would be useful for authors to indicate the age of the LTC buildings and the structural features of those buildings (Benjamin et al., 2009). Furthermore, when planning new LTC homes, consideration must be given to ensuring adequate space for physical activities. In most cases, overcoming the barriers in the physical environment will require a coordinated effort among health care workers, administrators, architects, builders, engineers, and designers.

A growing body of literature describes barriers to accessibility related to architectural features in areas such as homes, offices, and parks and other public places (Bossen, 2010; Gossett, Mirza, Barnds, & Feidt, 2009; Koontz, Brindle, Kankipati, Feathers, & Cooper, 2010;

Rantakokko et al., 2010). This parallel literature could be used to inform future studies of environmental barriers to physical activity in LTC homes.

The development of a typology of barriers that could be systematically assessed in all studies addressing physical activity in LTC would be useful. This might encourage researchers to consider barriers in the design of the physical activity interventions, potentially enhancing their effectiveness and sustainability.

Personal support workers provide the greatest proportion of direct care to residents in LTC homes in Ontario and are thus well situated to play a pivotal role in assisting and encouraging residents to be more physically active. However, our understanding of their work related to the promotion of physical activity is limited. Future studies need to examine how their work is shaped and organized by factors that extend beyond their local experiences such as policies, standards, and legislation.

Lastly, there is a need to move away from the notion that physical activity is an individually oriented intervention. A multiple intervention approach that takes into consideration the multiple layers of influence will be needed to ensure a systems change. This will involve innovative strategies to offset some of the ongoing system issues that plague the LTC system such as chronic understaffing.

Limitations

This review was limited to an English-language search of published articles. No hand searching or internet searches were done, and we did not contact experts in the field to inquire about unpublished work. Thus, some research in this field may have been missed.

Conclusion

Understanding barriers to physical activity in the LTC setting is critical for the appropriate design of physical activity programs for residents. This review indicates that barriers operate at multiple levels. Thus, a socioecological framework would be useful to guide future research on how these barriers intersect and how they can be addressed through intervention programs. Furthermore, new knowledge regarding the challenges of implementing physical activity interventions in LTC homes should be considered when designing physical activity programs in this setting.

References

- Armstrong, P., & Daly, T. (2004). *There are not enough hands: Conditions in Ontario's long-term care facilities* Canadian Union Public Employees (CUPE). Retrieved from <http://cupe.ca/updir/CUPELTC-ReportEng1.pdf>.
- Bates-Jensen, B. M., Alessi, C. A., Cadogan, M., Levy-Storms, L., Jorge, J., Yoshii, J., . . . Schnelle, J. F. (2004). The Minimum Data Set bedfast quality indicator: Differences among nursing homes. *Nursing Research, 53*(4), 260-272.
- Bates-Jensen, B. M., Alessi, C. A., Al-Samarrai, N. R., & Schnelle, J. F. (2003). The effects of an exercise and incontinence intervention on skin health outcomes in nursing home residents. *Journal of the American Geriatrics Society, 51*, 348-355.
- Beck, C. T. (2009). Critiquing qualitative research. *AORN Journal, 90*, 543-554.
- Benjamin, K., Edwards, N., & Caswell, W. (2009). Factors influencing the physical activity of older adults in long-term care: Administrators perspectives. *Journal of Aging & Physical Activity, 17*, 181-195.
- Benjamin, K., Edwards, N., Guitard, P., Murray, M.A., Caswell, W., & Perrier, M. J. (2011). Factors that influence physical activity in long-term care. Perspectives of residents, staff, and significant others. *Canadian Journal on Aging, 30*(2), 1-12.
- Blackham, J., Garry, J. P., Cummings, D. M., Russell, R. G., & Dealleaume, L. (2008). Does regular exercise reduce the pain and stiffness of osteoarthritis? *Journal of Family Practice, 57*, 476-477.
- Bossen, A. (2010). The importance of getting back to nature for people with dementia. *Journal of Gerontological Nursing, 36*, 17-22.

- Cameron, I. D., Murray, G. R., Gillespie, L. D., Robertson, M. C., Hill, K. D., Cumming, R. G., & Kerse, N. (2010). *Interventions for preventing falls in older people in nursing care facilities and hospitals. Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD005465. doi: 10.1002/14651858.CD005465.pub2
- Canadian Healthcare Association (2009). *New Directions for Facility-Based Long Term Care. Ottawa: Author*. Retrieved May 01, 2011 from http://www.cha.ca/documents/CHA_LTC_9-22-09_eng.pdf
- Chen, Y. M. (2010). Perceived barriers to physical activity among older adults residing in long-term care institutions. *Journal of Clinical Nursing*, 19, 432-439.
- de Carvalho, B. A., & Filho, W. J. (2004). Effect of an exercise program on functional performance of institutionalized elderly. *Journal of Rehabilitation Research and Development*, 41, 659-668.
- Dechamps, A., Diolez, P., Thiaudière, E., Tulon, A., Onifade, C., Vuong, T., . . . Bourdel-Marchasson, I. (2010). Effects of exercise programs to prevent decline in health-related quality of life in highly deconditioned institutionalized elderly persons: A randomized controlled trial. *Archives of Internal Medicine*, 170, 162-169.
- Focht, B. C. (2006). Effectiveness of exercise interventions in reducing pain symptoms among older adults with knee osteoarthritis: A review. *Journal of Aging & Physical Activity*, 14, 212-235.
- Galik, E. M., Resnick, B., & Pretzer-Aboff, I. (2009). 'Knowing what makes them tick': Motivating cognitively impaired older adults to participate in restorative care. *International Journal of Nursing Practice*, 15, 48-55.

- Gillespie, L.D., Robertson, M.C., Gillespie, W., J., Lamb, S. E., Gates, S., Cumming, R. G., & Rowe, B.H. (2009). *Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD007146. doi: 10.1002/14651858.CD007146.pub2
- Gossett, A., Mirza, M., Barnds, A. K., & Feidt, D. (2009). Beyond access: A case study on the intersection between accessibility, sustainability, and universal design. *Disability & Rehabilitation Assistive Technology*, 4, 439-450.
- Green, L. W., Richard, L., & Potvin, L. (1996). Ecological foundations of health promotion. *American Journal of Health Promotion*, 10, 270-281.
- Koontz, A. M., Brindle, E. D., Kankipati, P., Feathers, D., & Cooper, R. A. (2010). Design features that affect the maneuverability of wheelchairs and scooters. *Archives of Physical Medicine & Rehabilitation*, 91, 759-764.
- Lazowski, D. A., Ecclestone, N. A., Myers, A. M., Paterson, D. H., Tudor-Locke, C., Fitzgerald, C., . . . Cunningham, D. A. (1999). A randomized outcome evaluation of group exercise programs in long-term care institutions. *Journals of Gerontology Series A-Biological Sciences & Medical Sciences*, 54, M621-M628.
- Norris, M.A., Walton, R.E., Patterson, C.J., Feightner, J.W., & The Canadian Task Force on Preventative Health care (2003). *Prevention of falls in long-term care facilities: Systematic review and recommendations*. Retrieved June 3, 2007, from http://www.ctfphc.org/Full_Text/CTF_FallsPrevn_TR_Jun03.pdf
- Ouslander, J. G., Griffiths, P. C., McConnell, E., Riolo, L., Kutner, M., & Schnelle, J. (2005a). Functional incidental training: A randomized, controlled, crossover trial in Veterans Affairs nursing homes. *Journal of the American Geriatrics Society*, 53, 1091-1100.

- Price Waterhouse Coopers. (2001). *Report of a study to review levels of service and response to need in a sample of Ontario long term care homes and selected comparators*. Retrieved September 25, 2006, from <http://www.oanhss.org/staticcontent/staticpages/frameset.html>
- Rantakokko, M., Iwarsson, S., Kauppinen, M., Leinonen, R., Heikkinen, E., & Rantanen, T. (2010). Quality of life and barriers in the urban outdoor environment in old age. *Journal of the American Geriatrics Society, 58*, 2154-2159.
- Resnick, B., Petzer-Aboff, I., Galik, E., Russ, K., Cayo, J., Simpson, M., & Zimmerman, S. (2008). Barriers and benefits to implementing a restorative care intervention in nursing homes. *Journal of the American Medical Directors Association, 9*, 102-108.
- Resnick, B., Simpson, M., Galik, E., Bercovitz, A., Gruber-Baldini, A. L., Zimmerman, S., & Magaziner, J. (2006). Making a difference: Nursing assistants' perspectives of restorative care nursing. *Rehabilitation Nursing, 31*, 78-86.
- Richard, L., Potvin, L., Kishchuk, N., Prlic, H., & Green, L. W. (1996). Assessment of the integration of the ecological approach in health promotion programs. *American Journal of Health Promotion, 10*, 318-328.
- Rose, D. J., & Hernandez, D. (2010). The role of exercise in fall prevention for older adults. *Clinics in Geriatric Medicine, 26*, 607-631.
- Ruuskanen, J. M., & Parkatti, T. (1994). Physical activity and related factors among nursing home residents. *Journal of the American Geriatrics Society, 42*, 987-991.
- Sallis, J. F., Cervero, R. B., Ascher, W., Henderson, K. A., Kraft, M. K., & Kerr, J. (2006). An ecological approach to creating active living communities. *Annual Review of Public Health, 27*, 297-322.

- Sallis, F., & Owen, N. (1997). *Health behaviour and health education: Theory, research and practice*. (2nd ed.) San Francisco, CA: Jossey-Bass, pp. 403-424.
- Schnelle, J. F., Alessi, C. A., Simmons, S. F., Al-Samarrai, N. R., Beck, J. C., & Ouslander, J. G. (2002). Translating clinical research into practice: A randomized controlled trial of exercise and incontinence care with nursing home residents. *Journal of the American Geriatrics Society*, 50(9), 1476-1483.
- Simmons, S. F., Ferrell, B. A., & Schnelle, J. F. (2002). Effects of a controlled exercise trial on pain in nursing home residents. *Clinical Journal of Pain*, 18, 380-385.
- Smith, M. (2004). *Commitment to care: A plan for long-term care in Ontario*.
http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_04/mohltc_rep04.html [On-line].
- Wilcox, S., Der Ananian, A. C., Abbott, J., Vrazel, J., Ramsey, C., Sharpe, P. A., & Brady, T. (2006). Perceived exercise barriers, enablers, and benefits among exercising and nonexercising adults with arthritis: Results from a qualitative study. *Arthritis & Rheumatism*, 55, 616-627.
- Williams, C. L., & Tappen, R. M. (2008). Exercise training for depressed older adults with Alzheimer's disease. *Aging & Mental Health*, 12, 72-80.

Table1: Barriers to Physical Activity and Restorative Care in Long-Term Care (LTC) Homes

Investigator and Country	Design and Sample	Methods	Barriers			Comments
			Resident-Related	Organizational	Environmental	
Benjamin et al. (2011), Ontario, Canada	Qualitative exploratory study focusing on physical activity 62 staff, 48 residents, 42 significant others 9 LTC homes	26 focus group sessions Interview guide Audiotaped Thematic analyses	Health issues (e.g., stroke, paralysis, inability to mobilize)	Inadequate support for physical activity (e.g., lack of funding) Presence of rigid institutional routines Care practices highly structured	Lack of space because of increase in storage needs owing to increase in equipment such as wheelchairs and lifts Lack of a designated room for physiotherapy Physical bottlenecks (e.g., narrow hallways, limited number of elevators, steep ramps), lack of exercise equipment	3 main themes: (a) inadequate support for physical activity, (b) rigid institutional routines, and (c) constraints in physical environment Authors described measures to ensure rigour and trustworthiness. Overall rating suggests that results appear to be trustworthy (Beck, 2009). Authors stated socioecological framework used
Benjamin et al. (2009), Ontario, Canada	Qualitative exploratory study focusing on physical activity 9 administrators 9 LTC homes	Audiotaped walkabout interviews ^a Content analyses	Residents' condition more medically complex; needed more help to get to exercise classes and to participate in classes	Lack of staff, funding cutbacks (i.e., physiotherapy and recreational services) Staff attitudes (e.g., did not see value of exercise for bedridden residents with contractures)	Ramps, uneven flooring, heavy doors, lack of circular design on units Lack of space because of increased equipment storage needs (e.g., wheelchairs, walkers)	Authors described measures to ensure rigour and trustworthiness. Rating of study suggests that results appear to be trustworthy (Beck, 2009)

Table1: Barriers to Physical Activity and Restorative Care in Long-Term Care (LTC) Homes

Investigator and Country	Design and Sample	Methods	Barriers			Comments
			Resident-Related	Organizational	Environmental	
Chen (2010), Taiwan (middle region)	Qualitative exploratory study focusing on physical activity 90 residents from 6 nursing homes	Interviews Audiotaped Content analyses	Physical health/frailty (e.g., arthritis) Uncomfortable symptoms following activity (e.g., muscle soreness), limited mobility Fear of falling, injury or falling again (second most frequent barrier reported); activity seen as too risky owing to poor eyesight or balance Past history of sedentary lifestyle -less likely to perform activity (no interest, never thought of doing activity) Lack of knowledge about health benefits or importance of physical activity (e.g., did not see value at their age, old age is time to rest, Lack of motivation owing to lack of perceived effectiveness of physical activity	Activities arranged by staff (15 minutes of group exercise); some residents found these exercises boring	Lack of accessible space (e.g., lack of suitable outdoor walking path) Lack of exercise equipment	Authors described measures to ensure rigour and trustworthiness Overall rating of study suggests that results appear to be trustworthy (Beck, 2009)

Table1: Barriers to Physical Activity and Restorative Care in Long-Term Care (LTC) Homes

Investigator and Country	Design and Sample	Methods	Barriers			Comments
			Resident-Related	Organizational	Environmental	
Galik et al. (2009), Maryland, USA	Qualitative study focusing on restorative care 7 nursing assistants on dementia unit	Focus groups Audiotaped Interview guide used Content analyses	Anxiety and agitation; nursing assistants avoided resident anxiety and agitation rather than optimizing function Fear of injury for resident and staff (e.g., when transferring) Use of medications to control behaviour, sedated residents less likely to participate	Communication breakdown among staff		27 codes reduced to 3 themes: (a) knowing what made residents “tick,” and move (b) teamwork and utilizing resources, and (c) barriers to restorative care Overall rating suggests that results appear to be trustworthy (Beck, 2009) Authors recommended use of socioecological framework for future research
Resnick et al. (2006), USA	Qualitative Focusing on restorative care 13 nursing assistants (NA) from 1 nursing home	Audiotaped Focus groups Interview guide Content analyses	Refusal to participate, lack of motivation High function seen as prerequisite to restorative care Fear of pain, fatigue, or falling/injury on part of resident or family Pain and fatigue (less frequently mentioned)	Major barrier- lack of support from nurses; lack of communication among staff; not giving NA more voice in planning resident care Time & workload demands, pressure to get work done Fear that resident would fall or sustain injury Family demands to complete specific tasks		35 codes reduced to 4 themes: (a) resident barriers to restorative care, (b) facility or system barriers to restorative care, (c) NA strategies, and (d) system facilitators of restorative care. Overall rating suggests that results appear to be trustworthy (Beck, 2009)

Table1: Barriers to Physical Activity and Restorative Care in Long-Term Care (LTC) Homes

Investigator and Country	Design and Sample	Methods	Barriers			Comments
			Resident-Related	Organizational	Environmental	
Resnick et al. (2008), USA (location not reported)	Qualitative study focusing on restorative care 93 nursing assistants from 6 LTC homes who had participated in restorative care intervention	Focus groups Interview guide used Content analyses	Cognitive impairment Refusal to participate Learned dependency, resident expected certain level of care Medication use Fatigue Pain	Nursing assistants felt pressure to get care done Family expectations that residents should be “waited on” Overuse of wheelchair by families and staff Lack of quality time for bonding with resident Nursing assistants felt that residents could not do activities Nursing assistants feared they would be accused of abuse if they encouraged self-care activities Lack of nursing support; need for more information on how to motivate residents with cognitive impairment		61 codes reduced to 4 themes: (a) facilitators of restorative care, (b) barriers to restorative care, (c) benefits of restorative care, and (d) sustaining restorative care Overall rating of study suggests that results appear to be trustworthy (Beck, 2009)
Footnote: Walkabout interview refers to an interview that was conducted while the administrator and interviewer did a walking tour of the LTC home.						