Intersections in Rural Long-Term Care

A Comparative Case Study in Alberta

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Executive Summary

In this report, we outline the results of a comparative case study of long-term care (LTC) in rural Alberta. In what follows, we outline some brief background information, our research methods, and our key findings. We conclude with some targeted recommendations.

Our aim was to deepen our understanding of the strengths and challenges of providing LTC in rural Alberta. In doing this, we situate LTC in specific rural communities with their distinct characteristics and resources. This project helps us better understand rural LTC at multiple levels of analysis, and allows us to share our findings in a way that more clearly identifies the relationship(s) between place, health systems and health care dynamics, and individual experiences. Without sufficient attention to rurality, it is difficult to meet the continuing care needs of rural residents.

For this case study, we conducted weeklong site visits at three LTC homes in rural Alberta. We visited sites in the North, Centre, and South of the province. During our time at each site, we conducted in-depth interviews and observed daily activities and interactions. We asked about the organization of care work, the role that LTC homes play in rural communities, and how various elements intersect in rural care work. Specifically, we were interested in the intersections of formal and informal labour, public and private lives, home and health care facility, expectations and lived experiences, and multiple intersections of identities.

Although participants across the sites shared some common experiences of rural LTC provision, we heard about and observed considerable differences between them. There was a continuum starting with a site in which there was near-unanimous agreement that this was the "Cadillac of long-term care" (HCA, Site 1) and a wonderful place to live and work, to a site in which there were many challenges and lots of sick calls "because people didn't want to come in to work" (Manager, Site 2). The third site fell somewhere in the middle of this continuum with about equal emphasis on their strengths and their challenges. It would be easy, but inappropriate, to create a narrative in which this range of experiences resulted from features at the site level. Instead, by contextualizing our participants' experiences at multiple levels, we were able to glean insights into the nuanced differences between these rural LTC homes. These insights reveal the supports and constraints for making changes in these rural care homes and offer important considerations for continuing care policy and practice.

Background

Alberta's continuing care sector is made up of three streams: home care, supportive living, and long-term care.[1] Since the 1990s, Alberta has seen increases in both the demand for long-term care (LTC) services and the complexity of residents' health care needs.[2] During this same period, the province's health care system and continuing care sector have experienced considerable restructuring, with preferential investment in home care and supportive living. These changes align with systemic efforts to support aging-in-place and independent living as policy goals.[3] Several scholars have documented challenges that have followed from these transitions (e.g., increased reliance on informal care work from social networks, expanded duties for health care aides [HCAs], and considerable burnout for LTC home staff).[4-7] However, most continuing care research is conducted in major urban centres and/or does not reflect the diversity of Alberta's rural communities.[8] As a result, little is known about the current state of rural LTC and the role(s) that LTC homes play in their communities. This is troublesome given that, as Bourke et al. note, rural health is "much more than merely the practice of health in another location".[9] For instance, there are fewer LTC homes in rural regions and a number of rural-specific LTC issues. Broadly, these can include: transportation, moving residents out of their home communities in order to access the first available LTC bed, spouses or partners unable to find housing options near one another, challenges with recruiting and retaining health professionals, and the aging of rural workers and communities.[10,11,12]

Rural residents experience distinct conditions for care that are often overlooked in broader health system analyses. For instance, rural Canadians experienced health care restructuring in the 1990s that led to health care service centralization in urban centres, a withdrawal of government support services, and a limited amount of data on rural health and health services.[10, 13-16] Despite these negative effects, many rural communities exhibit tremendous resilience and firm commitments to high quality community care and support for older adults.[17] The strengths and assets of rural LTC are underexplored. Our research team was curious about the effects that continuing care restructuring has had on those in Alberta's rural regions and designed the study described in the following section.

Method

We designed a multi-site comparative case study.[18] Our research questions were:

1. How is care work organized in LTC homes in rural Alberta? Who performs what work and with what implications?
2. What role(s) do these LTC homes play in their rural communities?
3. How do the intersections of formal and informal labour, public and private lives, home and health care facilities, expectations and lived experiences, and multiple intersections of identities manifest in rural communities across the province?

After receiving ethical approval from the University of Alberta Research Ethics Office and operational approvals from AHS, we conducted weeklong site visits at three rural LTC homes across the province. We purposively selected AHS sites in Southern, Central, and Northern Alberta. In order to maintain confidentiality, we will not name the specific sites. Eligible sites met the following inclusion criteria: were self-identified as "rural", met the Statistics Canada[19] definition for "rural and small town" (population under 10,000 and at least a 60-minute commuting distance from major urban centres), had an auxiliary hospital model (in which there is both acute and LTC in the same health complex—a model that is common in rural Alberta), and were receptive to participating in the research for a week. We selected these specific sites because of the variation that they provide in terms of size, geography, local industries, and health zones within the provincial health authority.

During the site visits, we conducted rapid ethnographies.[20,21] This involved two main types of data collection: in-depth interviews (n = 90) and field observations (~200 hours). We conducted in-depth, semi-structured interviews with anyone who provided care in the LTC facility – this could be paid or voluntary care, nurturant or non-nurturant care (e.g., nursing care vs. food preparation, family members, or laundry services). After the first site visit, we requested an ethics amendment to include interviews with residents who had the cognitive capacity (determined by their nursing staff) to participate in an interview. We made this change for two reasons: 1) based on participants' feedback, our focus began to shift from the care *work* to the care home dynamics more broadly and 2) there were more residents who were able to participate in interviews than we had initially anticipated – given the high prevalence of dementia in LTC settings that is reported in the Canadian literature.[22] We were granted ethics approval and included several residents at Sites 2 and 3. Informal conversations with residents at Site 1 were incorporated in our field notes and impressions of the site, but there were no recorded interviews nor are verbatim quotations used as part of our data set. We informed participants about the study and their rights as participants, and then asked them to sign consent forms prior to their participation in interviews. The interviews lasted approximately 30-60 minutes. The interviews were digitally recorded and later transcribed verbatim. Our interview questions focused on workplace and care-team dynamics, the role of the home in the community, and the challenges and strengths of rural LTC.

For each site visit, we had rotating shifts of research team members (investigators and research assistants) observing the day-to-day activities and dynamics of the LTC home. Observations and interviews took place between 7am-11pm. Our observations were confined to public areas of the home accessible to visitors (hallways, dining areas, social and event spaces). As unobtrusively as possible, we observed the use of physical and social spaces, the rules and routines of the home, the daily events and activities, and interactions between people. We also reviewed any documents that the sites could provide (e.g., their welcome package for doctors, site fact sheet, information booklet for new residents and families, posters and notices/communications hung within the building, and others).

After each site visit, members of the research team coded the transcribed interviews using Braun and Clarke's[23] approach to thematic analysis. We identified key themes for each site and then used those themes and our observation field notes to revise and refine the field note guide and interview protocol for subsequent sites.[18] When all three site visits were complete, we performed a cross-case comparison of themes.

Key Findings

Our findings confirmed and extended themes from the existing literature on rural LTC and provided examples of experiences specific to the rural Alberta context. In the table below, we outline the overarching themes identified in our data and how they presented at each of the participating sites. These include: 1) leadership and workplace dynamics; 2) connection and division in home and community; and 3) empowerment and capacity for action.

Themes	Site 1	Site 2	Site 3
Leadership and workplace dynamics	Distributed leadership and strong teamwork	Unresolved conflicts and strict hierarchy	Insider/outsider mentality and pockets of teamwork
Connection and division (within the care home and the broader community)	Fluid boundaries and strong connections	Isolation	Silos of connection. Therapeutic recreation as a bridge between home and community.
Empowerment and capacity for action	Ruralization and autonomy	Rigidity in policies and practices	Centralization and limited autonomy

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Leadership and workplace dynamics

At each site, we identified distinct leadership styles and staff dynamics. We observed a continuum starting with a site where participants were nearly-unanimous in their agreement that the site was a wonderful place to work, to a site on the far end of the continuum where participants described numerous challenges and lots of sick calls "because people didn't want to come in to work" (Manager, Site 2). The third site fell somewhere in the middle, with participants emphasizing both their strengths and challenges.

Site 1 – Distributed leadership and strong teamwork

Throughout the Site 1 visit, we heard about and observed successful teamwork amongst care providers. The interview participants and researchers attributed this to what we called "distributed leadership". With distributed leadership, every member of the team has a leadership role in the workplace. There are not strict hierarchical divisions, though there are differences in training, education, and job descriptions. Expertise was valued at all levels of care and there was an assumption that everyone had something to

contribute. For instance, the nursing staff regularly praised the therapeutic recreation (TR) department staff for their excellent programming, residents had an active Resident Council where concerns were addressed in meaningful ways, and students finishing their practicum placements had a going-away lunch with residents. Informal care workers (family members and volunteers) were also recognized and included in most activities.

The research team observed collaboration and communication amongst staff and family members, intersections between roles, and flexibility within job descriptions. We did not hear "us and them" language and there was a strong sense of working together with a shared vision. This took the form of a security guard answering a call bell and bringing a resident a glass of water at night, a housekeeping staff member taking a few moments to sit and talk with a resident, or residents having specific jobs in the facility (hand sanitation or garden fertilization, for example). A care routine initiative to have two RNs assist the HCAs with getting residents ready in the morning was seen by many as a positive change that had fostered a greater sense of collaboration and a deeper understanding of each other's work demands.

This strong sense of teamwork was supported by leaders who were adept at managing conflict. We were told several times that when conflict surfaced, it was addressed quickly and was not permitted to fester.

"Well, I think that if I was dealing with conflict, I would bring them both in together and I've done this in the past. You bring them both in together and mediate it. It's not something that we let go on. You don't let it go on forever, right? It just festers if it keeps going on. So as soon as conflict is evident, then deal with it now" (Manager, Site 1).

"In rural, [conflict] has to be resolved because you are such a small group and you have to work out how to work within it... resolving it might not look like we're getting together and sorting it out. It might be an acceptance of 'this is how you play; this is how I play.' And we're still there for the betterment of everybody, because everybody here is. So some of it is accepting that sometimes you agree to disagree" (Unit Clerk, Site 1).

This is not to suggest that this site did not experience any conflict, but rather, that the workplace culture and leadership philosophy encouraged discussion, resolution, and acceptance of difference. We observed a closely-knit group of health care providers, family members, and volunteers who worked hard to provide a caring environment, not only for residents, but also for each other. For instance, if someone called in sick, the staff on prior and subsequent shifts would extend their eight-hour shifts to 12 hours in order to cover the shift and avoid working short-staffed.

"In long-term care we're allowed to do a lot of substitutions with the menus and that kind of thing that you wouldn't be able to do in acute. And you're allowed to have a lot more special meals, that kind of thing, just because we have to treat it like their home. So Christmas and Stampede and all those sorts of things they get to do more fun stuff" (Dietician, Site 1).

Decision-making did not come from the top (management) down to other staff. This was evident when care staff spoke about trusting one another, their team members' capacity to do good work, and the accountability that they have to one another. The minutes from resident council meetings and our observations indicated that residents are encouraged to voice their concerns and that when they do, those concerns are heard and acted upon (to the best of the home's ability). For instance, when there were complaints about repetition of menu items, special dinners were organized as a recreation activity to include sought after meal options that might not work in the regular menu.

It appeared that members of the LTC home felt valued, heard, and included. Several staff members also commuted from out of town for years to continue working there.

Interview participants expressed pride in several aspects of the care environment. They were proud of their strong teamwork, their ability and willingness to care for each other, and of the local community for supporting them through volunteer work, partnerships, and successful fundraising. The research team also noted a sense of pride in the quality of care provided for residents and patients. There was also pride about

improvements in clinical outcomes such as wound care, fall prevention, and in residents' high functioning capabilities. There was great pride expressed by all participants in the facility's therapeutic recreation department. It was evident that the TR department provided a wide variety of meaningful, appropriate, and engaging activities.

In sum, LTC in this rural community was exemplary. The "ingredients for success" appeared to be a) their distributed leadership, b) their willingness to address and resolve conflicts, c) their trust in every member of the care home to make a valuable contribution – and recognition of these contributions, d) their vibrant therapeutic recreation department, and e) the pride that the staff take in their work and their relationships. Taken together, these factors contributed to a supportive and homelike environment. The second site had very different relationships and workplace dynamics than Site 1. In the following section, we discuss how unresolved conflicts affected the second rural LTC home that we visited.

Site 2 – Unresolved conflict and strict hierarchy

Upon arriving at this site, we heard from several participants about a particular conflict between staff members. The conflict had happened outside of work, but, given the intimate nature of the rural community, it had ripple effects within the workplace. These negative effects were never addressed by management and the resulting tensions led to staff absences and poor morale. We were told that this conflict was not an isolated incident. Just weeks before our visit, the entire care staff was required to attend sessions to address bullying and harassment. Though some staff indicated that the sessions had helped to address these issues, others expressed that the "toxic" environment remained relatively unchanged. Some nurses or HCAs refused to work with other members of the team and called in sick if they saw that they were scheduled with them.

"Interviewer: When things don't go well, how are they handled?

Respondent: Oh, they don't go well, they don't go well… we call [the communication book] 'the bitch book' and I'm sure you've heard about it. A lot of people read the bitch book and it's taken the wrong way. And in terms of actually being professional when facing people and saying, you know, "hey, I have this issue, am I understanding this properly? You know, how can we work this out?" Yeah, that doesn't happen.

Interviewer: So if there's a conflict that comes up in the bitch book, how does it get resolved? Does an in-person conversation follow that?

Respondent: No, and resentment builds and frustration builds and people get angry and backbiting starts and gossip starts and it's a terrible place to work. I will be honest, it's terrible" (LPN, Site 2).

This was a stark contrast to the dynamics we witnessed at Site 1. As the LPN quoted above mentioned, the staff at Site 2 experienced issues with communication. This perception was echoed by management:

"The staff weren't always working together. They wouldn't communicate well together. So if you don't have communication, how does teamwork work? It doesn't" (Manager, Site 2).

Multiple care staff claimed that when they raised concerns with management, they felt their concerns were neither heard or adequately addressed. Many participants suggested that management generally avoided conflict and in doing so, set a standard for the rest of the team. At the time of our visit, the manager was months away from retirement. Although some hoped that a change in leadership might improve morale and team dynamics, others were less optimistic. They indicated that the hierarchy ran deep and supported existing conflicts in ways that may continue with new management.

"...there's the big RN vs. LPN clash and there's a real hierarchy system going on here. So that's a huge challenge... And I do find that with a lot of RNs here. And then we run into 'Well, I'm going to report you for insubordination [for disagreeing about the appropriate use of an antipsychotic medication]'... Like, just because you're an RN and I'm an LPN? I'm just as much a professional as you are. So, that's one of our huge challenges here" (LPN, Site 2).

Overall, the team at Site 2 struggled to work together and communicate effectively with one another. There were numerous instances of "us and them" language used by participants. Conflicts in the broader community spilled over on the workplace environment and, as a result, conflict festered and damaged relationships. Tension also affected staffing levels because people called in sick to avoid working with particular staff members, and low morale led to an unwillingness to pick up shifts. Navigating the dynamics of the rural locale (e.g., understanding local politics, relationships, and power dynamics) are thus an important part of the work of rural LTC leaders. In

short, our visit to this site revealed the importance of conflict resolution and the corrosive effects of a rigid hierarchy that prevented more collaboration and distributed leadership opportunities. Despite this, we also heard passion for quality resident care and hope that workplace quality of life would improve. At Site 3, we saw better communication than at Site 2, but the team dynamics were complicated by in- and out-group perceptions amongst the staff.

Site 3 – Insider/outsider mentality and pockets of teamwork

The data from the third site presented variation in participants' perceptions about leadership, as well as in the workplace dynamics. Similar to Site 2, this site was undergoing a change in management during the time of our visit. There were mixed feelings about the past manager, with some praising her leadership and others complaining of favouritism and her insufficient action to address particular issues. The larger community was notably affected by changing demographics. Most of the staff came from other provinces or countries and consequently did not have the shared history we observed at other sites. There was a palpable insider/outsider mentality, which was often expressed along ethnic lines. There were a number of Filipino HCAs and this came up in several of the interviews, often with the implication that these workers were taking job opportunities away from locals.

"I'm not a racist person, but I feel like with the Filipinos and stuff, they're getting jobs over other people. Like I've experienced that when I was in home care and I had applied for a position, I never got an interview and I caught wind that one of the Filipinos got that position." (HCA, Site 3).

"I think if you went around [town] and talked to a lot of younger women and men that are Canadian, they are probably on unemployment or working at an A&W. Give them that chance to get their HCA or their LPN or their RN. Give them that chance. But you don't see that. And I don't know. I mean, I could be biased in saying this, but I think our management hires the – I'm just going to use Filipino as an example because we're run by them – because it's an easy hire. They need the work. They need the money. They're going to do it and they are harder workers. They are. [Management hiring Filipino care staff members] would be my only pet peeve. And again, I'm not prejudiced." (LPN, Site 3).

The manager did not engage with this discourse and claimed instead that the tension was about hours of work. She noted that because more of the Filipino staff accepted overtime shifts, there was a perception of preferential treatment towards them:

"So they'll pick up overtime, where the Canadian staff won't, but then [the Canadian staff] will bitch at the foreign staff for taking all the work." (Manager, Site 3)

Participants expressed concerns about issues related to cultural differences or speaking other languages at work, but these issues did not appear to be addressed in a productive way. As a result, the teamwork seemed to happen in pockets, largely based on job description and/or ethnicity. During daily operations (e.g., shift change report, meal times, getting residents up in the morning) the teamwork at Site 3 was generally quite smooth. There was less overt tension between staff members than we observed at Site 2. Although we did witness some effective teamwork at Site 3, the staff did not appear to have the same sense of collaboration we saw at Site 1 and leadership had not been successful in their efforts to improve this. Similar to Site 2, we saw an opportunity for site leadership to better support their team in navigating rural community issues and bringing people together to address conflicts in a productive and respectful way. There is also a need for management to explicitly address prejudicial comments and ensure that care staff do not experience discrimination based on race or ethnicity.

Theme 1 Summary

A manager's willingness and ability to manage conflict makes a considerable difference in rural LTC homes where care teams are small and the boundary between personal and professional worlds can be fluid. If an issue from outside of work is having an impact in the workplace, it warrants attention and action. If left unaddressed, we learned that conflicts can fester and negatively impact workplace morale and staff attendance. Across all three sites, we saw that strict hierarchies were not conducive to strong care team dynamics. Distributed leadership was effective for empowering staff and creating a sense of joint investment in their work. Challenges arose when teamwork happened in pockets, and was based on job title, ethnicity, or personal connections. In rural LTC homes, it is crucial for staff to feel that they have a shared vision and that their colleagues support them. Acknowledging and celebrating good work is an important part of this.

2

Connection and division in home and community

Our findings highlight differences in the extent to which these rural LTC homes were connected to their auxiliary acute care facilities and their larger communities. We were curious about whether or not residents received many visitors, whether they left the care home to spend time in other parts of the community, and how connected staff felt to members of their community and fellow health care providers. We looked at the ways in which people's personal and professional lives intersected, and the influence of community dynamics on staffing. Our findings reveal considerable variation in the extent to which LTC staff and residents feel connected to one another and their rural communities.

Site 1 – Fluid boundaries

All three sites included in this study are auxiliary hospital LTC homes with a blended model of acute and LTC. This design is common in rural Alberta, but there is limited literature that addresses the benefits or drawbacks of this model. At Site 1, we quickly identified that LTC and acute care operated in partnership, with a flexible or fluid boundary between them. We entered into this research with an

assumption that with this model, a more biomedical acute care approach might spill into LTC and create a more institutional and less homelike environment. At the first site, we witnessed the opposite; the homelike environment of LTC spilled over into acute care. A number of participants at this site spoke about the auxiliary model as a strength or asset. We were told that there is less fear of losing their LTC home because the community relies heavily on the attached hospital. LTC was perceived as benefiting from the presence of acute care because staff get to utilize a wide variety of their nursing skills, which is useful as LTC residents' care needs become more complex. Similarly, having the staff work across LTC and acute care created flexibility when responding to particularly acute or complex needs in either environment.

We also noted that there were more family and community members visiting the LTC home as a result of this model. When individuals come in to see patients in emergency and acute beds, they would often also stop in to visit LTC residents (who they may not have come in to see otherwise). We were also told that this model eases residents' transitions into the LTC home. Prior to admission to LTC, many residents had already spent time in the building as patients in emergency or acute care and were familiar with the space, the staff, and many of the other residents. We were told that this familiarity can ease the transition into LTC. Additionally, when residents have an acute health care issue, they are able to receive their care on site, eliminating the need to be transferred to a completely different care facility. We observed that patients receiving acute care also benefited from the fluid boundary between acute and LTC. The food and dining experiences were significantly enhanced, as acute patients were welcomed into a homelike atmosphere and invited to sit with LTC residents at their dining tables. Acute care patients also had the opportunity to participate in LTC social and recreation activities.

Of course, we also learned about challenges that come with this model. We were told that, because of shared nursing staff, when the emergency department is particularly busy, nurses may be pulled from LTC leaving the HCAs to do the bulk of the work on LTC. However, the impacts of this were mitigated for the following reasons: 1) the team rarely worked short, 2) the many volunteers and active recreation programming kept residents engaged, and 3) the level of understanding and empathy exhibited from HCAs and residents when the regulated nursing staff have to move to acute care.

In addition to the benefits of the auxiliary model, Site 1 also benefitted from fluid boundaries between their LTC home and the broader community. Residents' monthly activity calendars revealed a number of trips out into the community for country drives, meals, fishing excursions, and to attend community events such as concerts or 4H presentations. This spoke to the dedication of their recreation therapy staff and their volunteer workforce. We witnessed many visitors coming in and out of LTC throughout the week. This included regularly scheduled visits from family members, staff who came in to visit when they were not working, relatives of one resident visiting other residents, and a local farmer dropping off fresh produce for a couple of the residents. In this way, the care home acted as a rural community hub.

"And even if I didn't work here, I'd always come visit and stuff. I come here when I'm not working too. And lots of the other ladies do too. Like, I know when I'm working on weekends some of my coworkers come in and just check-in." (Housekeeping, Site 1).

The permeable boundary between the LTC home and the community helped to keep residents from becoming isolated and enabled them to remain engaged in life outside of their home.

Several participants explained that, in working here, their personal and professional lives also had fluid boundaries. They often cared for people whom they had known in the community, worked with people whom they saw outside of work, and they expressed limited expectations of privacy out in the community.

When relationships in the community were good, this intersection of public and privates lives was seen as a tremendous asset with positive effects for caring and working relationships.

"Lots of us have been here for a long time, so we're all kind of friends too. You know everybody's husbands or wives or kids, and kind of what's going on in their lives. So I think that helps because it makes you want to help each other." (LPN, site 1).

"Usually [knowing everyone] has been more of a benefit because it makes people more comfortable when you say, "Oh, I'm from this community too and I understand the farming." And some of the old farmers that come in, you can relate to them a little bit better" (Occupational Therapist, Site 1).

We heard about and observed a sincere, demonstrable, and ongoing investment in each other's well-being, rooted in shared history, experiences, and longstanding tenure with the facility. Several of the younger nurses were born at this facility and multiple nurses had worked there for over 30 years. During our visit, we witnessed a woman, who had previously worked there as a nurse, transition into becoming a resident in long-term care. In short, staff do not simply work there—they begin and end their lives there. When one staff member noted that she could retire and had chosen not to, she said, "this place is my life." When asked what this facility means to the local community, a number of participants indicated that it means being able to grow older in one's own community, to regularly visit family members who cannot be cared for at home, and to trust that one's relatives are being well-cared for.

Site 1 thus revealed several potential assets of rural LTC: 1) its proximity to acute care services, 2) a committed volunteer workforce, 3) the benefits of shared history with residents and fellow staff members, and 4) accessible recreation activities that are tied to regional lifestyle. All of these features contributed to a strong sense of connection for staff and residents. Unfortunately, participants at Site 2 did not experience this same sense of connection.

Site 2 – Isolation

At Site 2, we heard about both geographic and social isolation. The LTC home is located near the edge of the provincial boundary, which left some staff members feeling isolated from the provincial health authority and other organizations in the region.

"I think it's just our isolation, we're like a forgotten part [of the province] and the population has declined here" (Security, Site 2).

Additionally, this site is vulnerable to extreme weather events such as summer wildfires and harsh winter storms. A member of the maintenance staff described difficulty with getting tradespeople out for service work in this area and an HCA said the same about health care specialists. Thus, nurturant and non-nurturant care were affected by the site's geographic location and several participants reported a corresponding sense of isolation.

"We get impacted by weather -storms, forest fires... There's no way to go in or out., So, I mean a good example is that huge grass fire and we're on evacuation notice. We didn't know if we're going to be [evacuating] or not... And it's roads. Some [staff] can't make it, so then you're dealing with whoever's in town. If there's a really bad blizzard, they can't drive on the roads. And so rurally, it's hard to get to work. So then, they're scrambling to find anybody who can work that's in the town. It's difficult" (Manager, Site 2).

Participants also expressed feelings of isolation in their professional practice. Care staff worked strictly in LTC or acute care, without overlap or collaboration. The two sides operated completely independently. Furthermore, there was a long hallway with locked doors that separated the two departments. As a result, Site 2 did not appear to enjoy the same benefits of the auxiliary model that we observed at Site 1.

"There is definitely a sense of "us vs. them" with respect to the LTC staff and acute care staff. [RN] mentioned that the acute staff ask them to do certain things over in LTC and she says, 'uh, no. That's YOUR job. We can't do that over here. We have 50 residents. They don't know LTC. You come work over here and see how it is'" (Field Notes, Researcher).

This professional isolation was also evident with the TR staff. These staff members worked quite independently of other care team members. They were not included in other aspects of care or the social world of the home in the same way that the TR staff were at Site 1. Therapeutic recreation programming was primarily focussed on "treatment" and outcome measures rather than on recreation, pleasure, and quality of life. There were also fewer community groups coming into the home or day trips for residents to go out. With few volunteers, this meant that most residents had quite limited connection to the outside community.

"We would love more volunteers. We have so minimal and it would be great to have more because that's where the residents really need that extra piece, to help when reading a story or playing music or be there when they're just visiting. We don't have as many as we'd like, definitely. And I think because you have such a small community... people get volunteered out. There's only so much of a pool of those individuals that can be that supportive and I'm not finding that we have that" (Manager, Site 2).

Site 2 revealed that the auxiliary model is not inherently beneficial; the construction of the building, the staffing model (whether or not staff work in both LTC and acute), and the planning of activities (to include acute care residents) makes a notable difference. We also learned that while the volunteer workforce was a vibrant asset at Site 1, it was lacking in Site 2 and residents felt the impact. It is thus important to consider the differences in rural communities' assets and resources when planning for service and program delivery. Participants at Site 3 reported that they too experienced isolation as a rural LTC home. However, they used their therapeutic recreation programming slightly differently in order to combat this isolation.

Site 3 – Therapeutic recreation as the bridge between home and community

Site 3 was also impacted by geographic isolation. Because of the site's remote location, we heard about a number of staff coming there to get a "foot in the door" with AHS and this resulted in high rates of turnover. There is a considerable driving distance to many health and social services and, as a result, there was less connection to the broader community outside of the care home. Additionally, there was not much promise of new resources for this community. There was a perception by several researchers in our field notes that it felt like a dying town. This was echoed by one of our participants:

"it's getting smaller and smaller where it kind of looks like maybe one day the hospital will be all that's here. I don't know, it's kind of become a ghost town in the last two years... [stores on the main street] have been closing down a bit...a lot of people have no reason to move up here. When this place was booming it was because oil was booming. Now you drive around and there's houses for sale on every street. People aren't buying in this area. People don't want to buy in this area. They have no need to live in this area" (HCA, Site 3).

Within the facility, there was limited connection between LTC and the acute care unit, with locked doors, an intervening floor, and a required elevator ride standing between the two parts of the facility. Ties to the outside community were limited by geography and circumstance, with many staff who had come from away. Staff did not indicate that there was much social contact that occurred between them outside of work – in fact, the manager said that she drove to another town for her grocery shopping so that she could retain some anonymity.

"I don't go out much in [town]. I do all my grocery shopping in [town 100kms away]. I'm very home, family-orientated ... People say, 'you know, you'd never think that you lived in [town].' Besides hockey, that's all they see me at" (Manager, Site 3).

Although clear boundaries between personal and professional lives can be important for health professionals, we learned that some staff struggle when managers appear to be disengaged from their rural community. Others at this site, such as the TR staff, took on the role of connecting the LTC home with the larger community. This brought community members into the home, got residents out, and enriched quality of life.

"We've got the school kids that come in on Mondays, because we do a lot of intergenerational programs. So now that school's going to be out for the summer, I get to take that slot and to do my Mommy and Me program. There's a group of moms with toddlers in town and they meet every Monday and we're going to get them to come up here twice a month. They do activities like sand tables and water tables and play dough and painting. We just thought that would be interesting for the residents" (Rec Aide, Site 3).

"We usually do outings on Mondays. We actually just started going to the golf club last year. They have great food and they can eat outside on the patio and they can watch people golf. " (Rec Aide, Site 3).

Theme 2 Summary

Our findings provide insight into connections between LTC and acute care, between a LTC home and its rural community, and between a LTC home and the broader health care system. In terms of the connection between LTC and acute care, we learned that the auxiliary model can be an asset for rural communities, but this depends upon the building's design, staffing models, and the structure of activities within the home. With respect to the connection between the LTC home and the rural community, it was evident that volunteers and family members are a tremendous asset in rural LTC. Our findings suggest that inviting volunteers and family members into the life of the rural LTC home has many positive effects. However, not all rural communities have the same informal social networks or volunteer resources. We observed that TR programming is a valuable way to keep LTC residents connected to the community outside of their home. When relationships in the community are good and folks know each other outside of the care home (e.g., an HCA provides care for her best friend's grandmother at Site 1), this can be a real strength that contributes to person-centred care and a sense of meaningful connection. When community relationships suffer, the intersection of personal and professional lives can be a risk that requires mitigation. Lastly, we found that geographic location has a tremendous impact on the connection to allied health services and the provincial health authority. Geographic isolation influences a site's staffing patterns (attendance, retention, etc.) as well as their access to other services to support resident care. Sites that are more remote thus require additional supports to mitigate the challenges associated with geographic isolation.

3

Empowerment and capacity for action

The three sites varied in terms of their level of autonomy. The first site told a story of empowerment and adapting policies and practices to suit local needs. We heard from staff at Sites 2 and 3 that they were much more constrained. They described rigid management approaches and an increasing centralization of services in larger city centres.

Site 1 – Ruralization and autonomy

At Site 1, we were introduced to the term "ruralization." We were told that ruralization is the process by which the facility has opportunities, within AHS guidelines and standards, to customize policies and practices to the rural context. These changes were seen as necessary to meet the community's needs and be consistent with the facility's resources. We reviewed the Rural Continuing Care Policy and Procedures Manual (a ruralized document related to palliative and end of life care) and heard about more informal ruralization practices, such as doing away with set visiting hours and permitting community members to visit at any time.

This site benefited from having their management involved with the Program Specialists office for Seniors Health in Rural. As a result of this involvement, Site 1 may have had greater awareness of ruralization opportunities and a greater voice at the regional level. We also noted management's support for extending shifts to avoid working short and support for making the case for the related overtime hours in the budget. There was a sense that the facility operations did not feel micromanaged by the provincial health authority; participants perceived that they were trusted to make decisions to best serve their community.

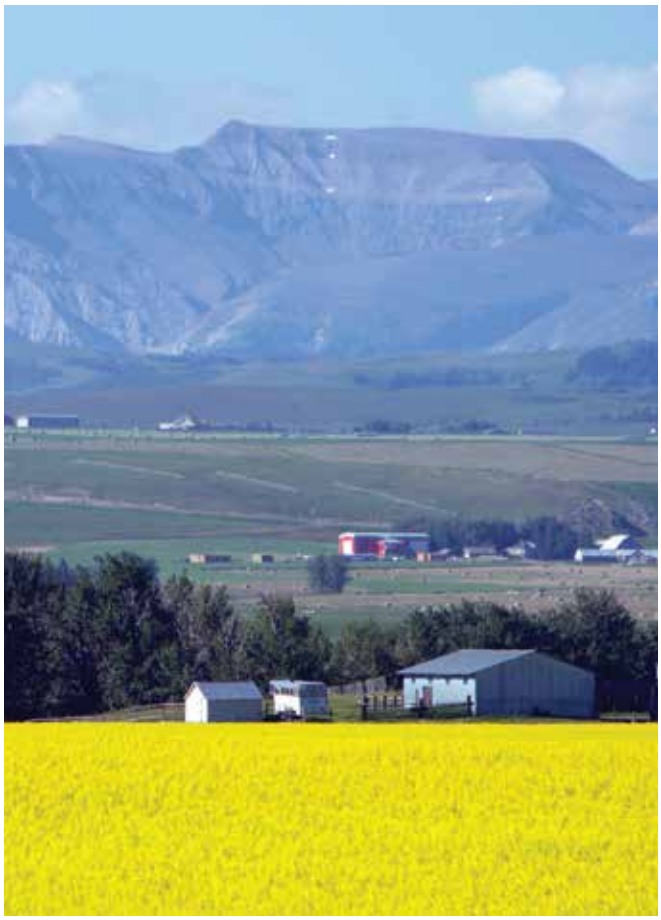
"Somehow you don't feel [micromanaged] so much here. You don't feel that overhead, that big brother staring at you. We go to one [manager] or the other and then they deal with all the upper management [from AHS]. I think when you work in the city in a bigger centre it just feels very corporate. When I worked in [large city] it was very different" (RN, Site 1).

Site 1's community also had a privately-owned and operated LTC home with a secure unit. This provided another care option for people who had responsive behaviours, elopement risk, or advanced dementias. This additional option allowed the site to be more selective with their admissions – an opportunity that few rural LTC homes have. The site's ability to ruralize LTC policies and practices and adapt procedures to suit their needs helped them to feel empowered. They did not describe systemic constraint and expressed an ability to make changes to practice in ways that met the needs of their community. On the other hand, at Site 2, , participants described rigid rules and an inability to resolve the challenges they face.

Site 2 – Rigidity

Site 2 did not have other continuing care homes nearby and, as a result, they accepted residents with a wide range of care needs. For instance, they admitted a number of residents with mental health diagnoses who could not receive adequate support in the community or in supportive living homes. The manager noted that the site often needs assistance from the psychogeriatric team, but that it can take six to eight weeks to get them out for a visit. Furthermore, there has been no additional mental health training or education for the nurses and HCAs. This site seemed to have fewer resources available at their disposal and a great perception of need. The management response to these challenges appeared to be to maintain very strict rules in an effort to keep things 'under control' and safe.

Across our interviews and field notes for this site, we noted a culture of restrictive management and risk aversion. We witnessed restricted autonomy for residents, family members, and staff. For instance, there were policies against bringing in outside food and residents were prohibited from folding towels because of potential infection control risks. Residents were not permitted to use the outside courtyard without a companion (and as a result, we heard that it did not get much use). Furthermore, because their TR program was required to be "treatment" focused, there were fewer social and/or spontaneous activities focused on residents' quality of life. It did not appear that the care approach was locally driven or "ruralized." Rather, participants framed the approach as a strict adherence to provincial policies originating in "the city".



At Site 2, participants claimed that larger urban centres make policy decisions that trickle down to them. They claimed that they were very much influenced, yet also overlooked, by broader health systems:

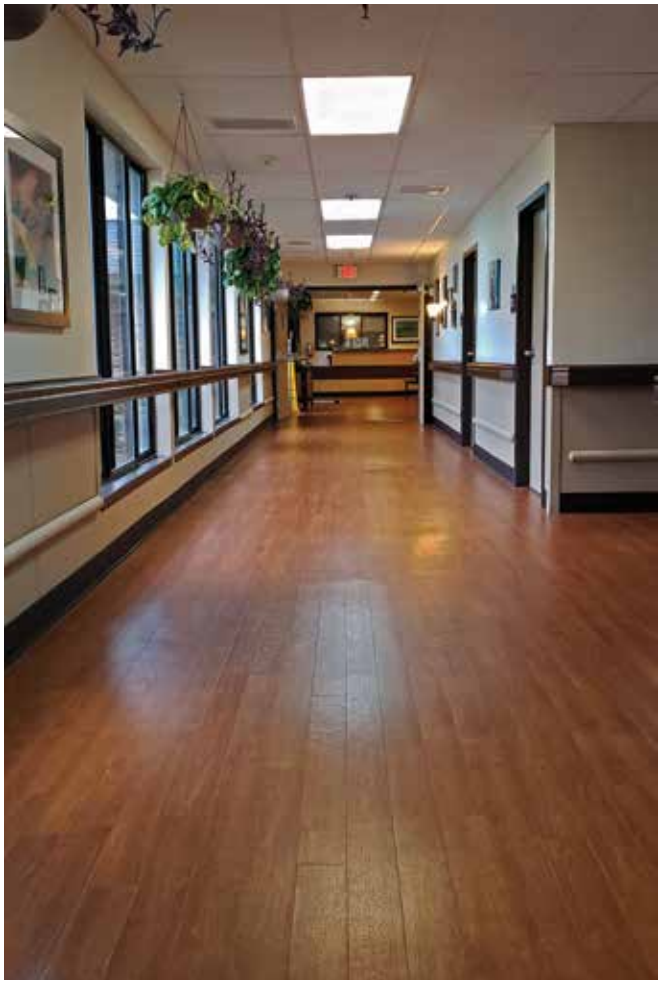
"I also believe that there are policies that are made wherever that don't even apply here. And it's like, okay, well, great, that's a wonderful policy, but it doesn't even apply to us. But it's a policy that we need to know and conform to" (HCA, Site 2).

"...when you're rural, you don't seem to be as visible. Out of sight, out of mind in getting people [in urban settings] to be aware that we're here and we need your help sometimes" (Manager, Site 2).

We found that there were limited opportunities to be/feel heard at the local level, and that much of the management and everyday operations relied upon external decision-making. Requirements to follow rigid rules made this care home feel less like a home and more like a hospital. Both residents and staff appeared to have a limited sense of ownership over the use of space, the meals and activities, and the scheduling. The staff at Site 2 described several experiences of moral distress related to external constraints – i.e. knowing what they needed to do to support residents, but feeling unable to do it because of a lack of systemic resources. Participants from all demographics expressed a sense of constraint, even the family members, for example:

"Give the frontline care workers latitude to do what they think is best, and that's totally different [than what they do] right now. Everything's got to be by the book... but scrap that, do what's right" (Family Member, Site 2).

In sum, participants at Site 2 expressed feelings of disempowerment. This disempowerment seemed to be inextricably intertwined with the need to adhere to strict rules in order to maintain some level of control in a chaotic environment. Unfortunately, this control left little room for spontaneity, flexibility, or adapting to local needs, all of which are required to support the quality of life of residents in LTC. Most participants expressed that although they knew that changes needed to happen, they did not feel heard by those in power, nor able to make needed changes on their own. Participants at Site 3 were somewhat more empowered than those at Site 2, but they struggled with an increasing centralization of services in urban centres.



Site 3 – Centralization and lack of autonomy

At this site, we heard a great deal about the centralization of services in urban centres. For instance, staff scheduling, residents' laundry, and even the residents' petty cash are all managed by "others" in larger cities. Managers of various disciplines are also located elsewhere—most in a town 2 hours away (for instance, the manager of housekeeping services and the manager of rehabilitation medicine and therapies). With respect to the offsite staff scheduling, we heard:

"Yeah, it's called electronic scheduling and it's out of [major city] and they don't get how we [work or what we need]. First of all, we don't have pools of people [to call in from in a casual pool], but when you have two separate units, you need two nurses. They're still having problems understanding this – and they'll just phone you and say, 'Well you only have one nurse tomorrow'" (RN, Site 3).

The staff at this site informed us that they were stretched too thin and did not have additional time, energy, or people to do much beyond their prescribed tasks. Morale was better than at Site 2, but staff described feeling burnt out and frustrated about being unable to take care of particular services in- house. This centralization of services and management appeared to lead to disempowerment at the least (e.g., the recreation therapist answers to someone who she only talks to once a month who does not know what recreation therapy is) and chaos at the worst (e.g., laundry getting lost or taking three weeks to turn-around, and staff working overtime and short on a regular basis).

Theme 3 Summary

Our findings suggest that a combination of site-level and systemic factors contribute to a LTC home's level of empowerment and autonomy. For instance, 1) having someone from the site's leadership involved in regional activities helped to maintain a connection with the larger health authority and with opportunities for ruralization. 2) Sites may not be aware of their abilities to ruralize policies and procedures. Although this concept seemed commonplace at the first site, Sites 2 and 3 appeared to be unfamiliar with the term "ruralization" and did not have any such documents or practices. 3) Some rural LTC homes had residents with more complex care needs because of the lack of other services (e.g., mental health supports) in their communities. This diversity of needs can impact the flexibility of their programming and create a need for additional supports. 4) We observed that empowering and supporting rural LTC homes does not necessarily mean taking particular services "off of their plate" by centralizing or standardizing them – it may, in some cases, mean affording rural sites greater autonomy or flexibility to meet their needs. 5) At the site level, we observed that a manager's leadership style shapes the culture of a LTC home. When residents, family members, and all staff members were trusted to exercise choice and be involved in decisions about the home's policies and practices, we witnessed much more investment in the work and better quality of life for those who lived and worked there.

Conclusions and Recommendations

1) Identify and respond to the distinct needs of rural communities and understand that "rural" is not homogenous.

Our findings offer new insights related to how staff at rural LTC sites are empowered to create change and/or constrained from doing so. Geographical differences certainly played a role, but there are other, important considerations as well. Site 1 provided an example of what is possible for rural LTC, but the comparative case study provides context for why particular strategies may yield different outcomes in other rural communities. Community dynamics, local industries, and other social and political factors contribute to a community's ability to make change and ruralize their LTC provision.

With limited healthcare resources, we observed there is some expectation that rural communities will fill in service gaps with informal or voluntary care work. The ability to do so depends, of course, on the resources of that community. Some communities have vibrant volunteer workforces, stable local industries, many family members nearby, and considerable financial and social resources. Others do not. As we saw, only one of the three communities in our case study was able to accomplish this in a sustainable way. We need to understand the actual capacity of not only the LTC facilities, but of the rural communities themselves in order to provide sustainable, high quality care.

There is also a need to address changing rural workforce demographics. We need to ensure that staff members who are newcomers to Canada or members of racialized groups working in rural settings do not experience discrimination. When these issues surface, they should be dealt with in direct and meaningful ways. In addition, it is important to consider what is needed for newcomers or individuals from racialized groups to feel welcomed and included in a new rural community.

2) Capitalize on the assets of rural LTC.

Site 1 (and, in some instances, Site 3) really highlighted some of the assets of rural care, as well as some promising practices. These assets include 'being known' (i.e., familiarity amongst staff and with residents that results from living in a small community), connection with the broader community, and the care home acting as a community hub. When these strengths were supported in rural care homes, we saw positive effects. At Site 1, we found that having a strong connection between the LTC and acute care beds presented multiple benefits. These include: easier transitions for residents into LTC, less disruption when more acute care nursing was required, a strong sense of community and visitors that spent time in both the acute and LTC parts of the building, as well as flexibility for staff who worked between the LTC home and the hospitals. Although rural LTC homes and their auxiliary hospitals are each constructed differently, the practice of sharing staff, physical spaces, and recreational activities presents a potentially promising practice for both staff and residents.

We also learned that LTC homes are crucial for rural communities. Rural LTC homes allow many people to receive 24 hour nursing care close to home and remain connected with land, people, and a way of life that is familiar and nourishing for them. LTC planning

needs to account for rurality, not only as a geographic consideration, but also as a social determinant of health that may exacerbate or ameliorate the effects of poorer service availability and more hazardous environmental and transportation conditions. It is thus important to support rural sites in capitalizing on their strengths and learning from each other's successes.

3) Recognize the importance of nursing leadership and invest in rural nursing leaders.

At Site 1, the nursing leadership established an exceptional workplace culture and home environment. As noted above, this leadership allowed all members of the LTC home to feel empowered and valued. At this site, there was flexibility, opportunities for spontaneity, recognitions of good work, prompt resolution of conflicts, and active efforts to engage all community members in the work and life of the care home.

Distributed leadership is also good for rural communities because of the sustainability in positive leadership practices that it supports. Distributed leadership enables a culture of effective communication and high quality care that does not rely on the skills and talents of a particular leader. In the case of Site 1, distributed leadership created and maintained positive workplace morale that will likely continue once their manager retires, which is good for recruitment, retention, and resident care. Empowered rural leaders are better able to advocate on behalf of their site so that their local needs are heard (e.g., building in overtime budget to cover shifts so that they do not work short). We observed that when leadership was rigidly hierarchical and avoided conflict instead of resolving it, negative outcomes followed. Rural nursing leaders that are prepared to navigate the dynamics of rural communities are in a better position to ensure that their small teams are able to work together and communicate effectively. There is a perennial under-investment in LTC leadership and the effects of this are felt profoundly in rural settings. For this reason, there is a need to support the leadership development for nurses in LTC, and the retention of these nursing leaders in rural LTC homes. Lastly, rural LTC managers would also benefit from focused training to help them prevent and respond to instances of racism and discrimination.

4) Support therapeutic recreation (TR) programming and its capacity to make a LTC facility a home.

We learned that a dynamic, creative, and well-staffed TR program can be one of the most effective ways of ensuring that a rural LTC facility feels like a home. At Site 1, a robust TR program brought the home to life and helped make it a community hub. When asked what made the building feel like a home, participants at this site almost unanimously said "the TR department". Similarly, at Site 3, TR was the primary bridge between the care home and the broader community. For many residents who did not have family members in town, the groups that visited as part of the TR program became like family to them. Without relatives to take them for day trips, the TR excursions often presented their only opportunity to leave the care home. Despite limited community resources, a strong TR program enhanced quality of life at this site and improved residents' connection to the greater community. TR is not considered an essential service and is vulnerable to budget cuts. It is an area of allied health that is not always well understood or sufficiently appreciated. However, its capacity to add joy and spontaneity to the lives of residents, and to bridge the home and community (by bringing others in and taking residents out) cannot be overstated. The unique ability that TR has in enhancing the quality of life of residents make it all the more important to develop robust TR programs in rural LTC homes, where other services might be at a distance, visitors may not be able to come as often, and volunteer levels may fluctuate.

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