Resident-centered care and work satisfaction of health care aides working with personal care home residents living with dementia

By

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ABSTRACT

Resident-centred care has been the standard philosophy in accredited personal care homes (PCHs) across Canada since 1990. Health care aides (HCAs) are the primary health care providers in PCHs and key to residents' quality of care and quality of life. However, studies have not examined HCA work satisfaction in relation to the four elements of resident-centred care: providing flexible scheduling, following residents' preferences, promoting a home-like environment and offering permanent assignment to promote consistency of care. This cross-sectional, ethnographic study was conducted using face-to-face interviews with nine HCAs working in four PCHs in Winnipeg, Manitoba, Canada. The results indicate that HCAs' work satisfaction was highly related to their caring relationships with residents and their working relationships with other HCAs and staff. The implementation of resident-centred care depended on institutional and managerial support. Lack of this support created stressful situations for HCAs and caused them concern about the quality of care and quality of life of the residents.

This thesis is written for all elders in care in the hope that the words written here will help, in some small measure, to increase their quality of care and quality of life by educating and enlightening all those involved, both directly and indirectly in caregiving activities and in the pursuit of putting the philosophy of resident-centered care into daily practice.

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CONTENTS

CHAPTER ONE

This thesis research examined the relationship between resident-centered care and the work satisfaction of health care aides (HCAs) working with personal care home residents living with dementia. This research was conducted in four personal care homes in Winnipeg, Manitoba, Canada in 2006. HCAs provide upwards of 90 percent of care to personal care home residents, many of whom have cognitive limitations, often referred to as dementia. Resident-centered care emphasizes four characteristics: providing flexible care scheduling, following residents' preferences, promoting a home-like environment, and providing consistent care through the permanent assignment of HCAs to a group of residents. Simply stated, work satisfaction relates to how HCAs feel about their work life. This chapter provides a statement of the problem, the research goal and objectives, study significance and a summary of the chapter.

INTRODUCTION

Background

Personal care homes provide permanent housing and nursing care support for older adults who, because of cognitive and/or physical limitations, are no longer able to provide their own personal care and who require varying levels of assistance with their daily activities and health care needs. Personal care homes are known by other names such as nursing homes and long-term care facilities. "Personal care homes" is the term used in Manitoba. The majority of older residents who live in personal care homes have some level of diminished cognition, most often referred to as dementia.

Increasingly, PCHs are adopting a resident-centered care philosophy in their mission, goals, policy statements and care protocols in order to meet the complex needs of residents with diminished cognition and physical frailty. Resident-centered care (RCC) has been the standard philosophy of care in accredited long-term care facilities across Canada since at least 1990 (CCHFA, 1990). A philosophy motivates our beliefs, concepts and principles for addressing life (Jarvis, 1986).

Resident-centered care is a holistic paradigm that seeks to meet both residents' quality care needs and quality of life needs, and engages individual residents in their definition of quality of life (Gilster, Accorinti & Dalessandro, 2002). The RCC philosophy rests upon respect for values, independence, well-being and empowerment of individuals and their families; on actions that enable "the person to feel supported, valued and socially confident;" and on a response to the agency and subjectivity of persons with dementia (Epp, 2003, p. 14).

Resident-centered care emphasizes four characteristics: providing flexible care scheduling, following residents' preferences, promoting a home-like environment, and providing consistent care through the permanent assignment of HCAs to a group of residents. These characteristics are identified and widely understood as basic to RCC in official statements of care (Manitoba Health, 1991; Evans, 1996) and the long-term care (LTC) research literature (Thomas, 2003; Gnaedinger, 2003; Rader, Lavelle, Hoeffer & McKenzie, 1996; Tolerico, O'Brien & Swafford, 2003; Chandler Hall Health Services [CHHS], 2005; The Bethany Group, n.d.).

The health care workers who most often provide resident care in PCHs are HCAs. HCAs are also known by other titles, including health care assistant or nurses' aides and nursing assistants (Lemieux-Charles, 1990; Assiniboine Community College [ACC], n.d.; Red River College [RRC], n.d.). In Manitoba, the usual title is health care aide for those who work in personal care homes. HCAs constitute sixty percent to seventy percent of all staff and provide approximately eighty percent to ninety percent of the care to residents in PCHs (Tellis-Nayak & Tellis-Nayak, 1989; Chappell & Novak, 1992; Bowers & Becker, 1992; Yeatts & Seward, 2000; CUPE, 2000). Maas, Buckwalter and Specht (1996) found that common ratios for HCAs to residents in intermediate-level care facilities in the U.S. was 1:11, whereas the ratio for licensed nurses was 1:100, making nursing assistants the primary care providers in LTC.

HCAs are unregulated health care workers (CIHI, 2004) who form part of the Province of Manitoba's nursing personnel along with regulated health care workers including Licensed Practical Nurses (LPNs), Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs) (MNPAC, 1997). Most HCAs have earned a certificate from a technical school or a college-based program. HCAs "assist with care of

patients in hospitals, extended care facilities, nursing homes, clinics and similar establishments" (Manitoba Health, 1982, p. 128). As nursing personnel, HCAs provide basic nursing care and work as team members beside, and with supervision, from nurses (LPNs, RNs or RPNs).

HCAs provide basic custodial care for residents in PCHs, including helping with activities of daily living (ADLs) such as grooming, bathing, dressing, toileting, eating and mobilization. The shortage of nurses (RNs, LPNS and RPNs) that has occurred within the past ten years in Manitoba has meant an expanded role for HCAs in relation to monitoring, charting and assessing residents as well as using judgment skills when providing care to residents (CUPE, 2000).

The work of HCAs is expected to go beyond physical care needs and address residents' psychosocial needs, such as the need to feel safe and secure, to be shown respect, consideration, and kindness, to be independent, to feel valued, needed and successful, and to feel loved and cared for (Wolgin, 1997; RRC, n.d.). Because of their daily contact and care role with residents, it has been suggested that HCAs are key to residents' quality of care and quality of life (Stone, 2001; Mesirow, Klopp & Olson, 1998; Bowers & Becker, 1992; Maas et al. 1996).

Statement of the Problem

Much of the research on HCAs originates in the United States and focuses on issues of work dissatisfaction and retention. Few studies have examined HCAs work and their work satisfaction in general or specifically in relation to the philosophy of RCC. A larger literature exists in relation to work satisfaction and RNs, particularly in the context of nursing shortages. Simply stated, work satisfaction relates to how workers feel about their work life.

Research has identified several systemic factors within the work environment that lead to nursing work dissatisfaction including: heavy workloads, friction with colleagues, inappropriate tasks, insufficient skills and knowledge, poor management, unsafe working conditions, inadequate resources and inflexible work schedules (Baumann, 2007). Work dissatisfaction is associated with absenteeism, job inefficiency and staff turnover (Bauman et al., 2001) to the detriment of care and the continuity of care.

Health care facilities with high retention and work satisfaction (often referred to as "magnet" centres) tend to exhibit features of adequate staffing, flexible schedules, strong leadership and adequate salaries (Havens & Aiken, 1999; Scott, Sochalski & Aiken, 1999). Autonomy and the involvement of RNs in defining their work as well as opportunities for basic and continuing education are consistently associated with work satisfaction (Bauman, 2007). It is not clear how some of these factors might relate to HCAs and their work satisfaction given that the scope of practice, and opportunities for autonomy and continuing education are different for HCAs in comparison to regulated nursing staff. However, the literature on work satisfaction and HCAs does seem to indicate similar findings. This research does not examine work satisfaction of HCAs in general, but instead focuses on the four aspects of resident-centered care and work satisfaction among HCAs.

Purpose Statement and Objectives

The purpose of this research is to examine the relationship between resident-centered care and the work satisfaction of HCAs working with personal care home residents living with dementia. The relationship is examined from the perspective of HCAs and in their own words.

The specific objectives of this research are related to the four aspects of resident-centered care: providing flexible care scheduling, following residents' preferences, promoting a home-like environment, and providing consistent care through the permanent assignment of HCAs to a group of residents. Each objective deals with one aspect.

1) To examine the relationship between flexible scheduling of resident care and work satisfaction of HCAs working with personal care home residents living with dementia;

2) To examine the relationship between following residents' preferences for care and work satisfaction of HCAs working with personal care home residents living with dementia;

3) To examine the relationship between promoting a home-like environment and work satisfaction of HCAs working with personal care home residents living with dementia; and

4) To examine the relationship between consistency of care through permanent assignment and work satisfaction of HCAs working with personal care home residents living with dementia.

This research was conducted at four personal care homes in Winnipeg, Manitoba, Canada. Face-to-face interviews using a structured and semi-structured format were carried out with nine HCAs. The HCAs responded to questions on the four aspects of resident-centered care and their work satisfaction, as well as to items related to their background and work experiences.

Study Significance

The significance of this research relates to the lack of research involving HCAs and their work satisfaction. Because HCAs constitute a proportionately large health care worker group, particularly in PCH settings, more is needed to be known about their work satisfaction as they provide care to vulnerable older adults with complex needs. In addition, because of the current emphasis on resident-centered care as a holistic paradigmatic approach to care of residents, it seemed appropriate to examine the work satisfaction of HCAs in relation to the four aspects of RCC. It seemed likely that aspects of RCC such as flexible scheduling of residents' care, for example, might enhance feelings of autonomy and choice among HCAs and thus enhance their work satisfaction. It was thought there is value in understanding how promoting a home-like environment might increase HCA awareness of concerns for their health and well-being in the workplace, which then increases their work satisfaction. Lastly, because permanent assignment allows HCAs to individualize care which then supports providing flexible care, following residents' preferences and promoting home-like environments, it was deemed important to understand the effect this has on their relationships with residents and work satisfaction.

Conclusion

This chapter provided rationale for the selection of this research topic. The purpose statement and objectives related to examining the relationship between resident-centered care and HCA work satisfaction have been provided. Potential assumptions that might have been active during the research process have been identified and declared. Finally the significance of the research has been presented. This research attempts to address a gap in knowledge about HCA work satisfaction and resident-centered care.

CHAPTER TWO – LITERATURE REVIEW

This research on the relationship between resident-centered care and the work satisfaction of health care aides is guided by a theoretical framework that takes into account the institutional context of personal care homes and is grounded in the literature on resident-centered care and the work satisfaction of HCAs. The first section describes the theoretical framework, introducing the concepts of culture, adaptation and coping strategies in relation to medical ecology. The second section provides information on the history and role of HCAs in Canada. The third section describes personal care home residents. The fourth section focuses on the concept of resident-centered care with emphasis on the work of the social psychologist, Thomas Kitwood and the emergence of the philosophy of resident-centered care and its four primary elements. The fifth section deals with knowledge about work satisfaction and HCAs. The final section is a summary of the chapter.

THEORETICAL FRAMEWORK

Health Care Aides and Elders in Care – The Interface for Resident-Centered Care

The focal point of this research is institutional context, that is, the interface between HCAs providing care to residents living with dementia in a PCH and the resident-centered care environment. The predominant assumption underlying this research is that by asking HCAs about their work satisfaction, it is possible to understand the relationship between resident-centered care, their work with residents living with dementia, and the institutional context of their work environment. Within the field of anthropology (and more specifically medical anthropology), medical ecology emphasizes “the study of health and disease in environmental context” (McElroy & Townsend, 1996, p. 6) and by extension it is the study of systems (Foster & Anderson, 1978). Furthermore, the insiders’ perspective is viewed as a key component of medical ecological studies (McElroy & Townsend, 1996). Thus, for this research on HCAs work satisfaction and

resident care within the "system" context of resident-centered care, it is the insiders or HCAs perspective that is most needed and valued.

Medical Ecological Perspective

Culture

The definition of culture ranges from the simple to the omnibus, and debate continues regarding the most acceptable definition among anthropologists. The work of Foster and Anderson (1978) in defining culture from a systems perspective seems most meaningful and closely aligned with this research. Foster and Anderson (1978, p. 11) define culture as a system, the purpose of which is to form an "integral whole." Using their systems approach, culture is a system that is "an aggregation or assemblage of [people] united by some form of regular interaction or interdependence; a group of diverse [people] so combined . . . to form an integral whole, and to function, operate, or move in unison" (Foster & Anderson, 1978, p. 11).

Organizational culture is the set of beliefs, values, assumptions and norms shared by its members. Every organization has a unique culture because of "its own history, patterns of communication, systems and procedures, mission statements and visions, stories and myths" (Newstrom & Davis, 1993, p. 59). For this research, the organizational cultural norm or organizational vision is that of resident-centered care and employees, such as the HCAs, are expected to share this vision and manifest it in the care that they provide within the organizational structure.

Adaptation

Sharing and making manifest the organizational vision involves the process of adaptation, and adaptation is a concept central to medical ecology. McElroy and Townsend (1996, pp. 11-12) define adaptation "as changes and modifications that enable a person or group to survive in a given environment." When changes are made in an organization, the consequential adaptations may be stressful overall for members and create individual anxiety and discomfort. The strategies used by individuals or groups to cope with stressful change can be either beneficial (adaptive) or harmful (maladaptive). McElroy and Townsend (1996) suggest that positive feedback is instrumental in the selection of adaptive strategies.

Coping strategies

Lazarus and Folkman (1984) have identified two types of coping strategies used to deal with new and potentially stressful events: problem-based coping strategies and emotion-focused copying strategies. Problem-focused coping strategies aim to manage or alter the "problem." They also help us to manage internal motivational or cognitive changes through altering our focus or level of involvement, or through creating new standards of behaviour or "learning new skills and procedures" (Lazarus & Folkman, 1984, p. 152). Emotion-focused coping strategies include reappraisal, avoidance, minimization, distancing, selective attention, and positive comparisons and aim to decrease the impact or distress caused by a problem while not directly dealing with the problem (Lazarus & Folkman, 1984). The effectiveness of coping strategies depends on the relationships between situational demands, personal resources, and cognitive appraisal (Lazarus & Folkman, 1984). Determination of the effectiveness of coping strategies and cognitive appraisal lie within the cultural context in which they occur.

To summarize, for this research on the relationship between resident-centered care and the work satisfaction of HCAs, the medical ecological framework has guided the design of the research. First the framework placed the interface between resident and HCA within the larger context of the organizational culture or vision of the personal care home. Since the emergence and embracing of the concept of RCC and notably through the work of Thomas Kitwood (1990, 1997), the organizational vision of most PCHs has undergone a change with new policies and guidelines based on the resident-centered approach. HCAs are expected to accept and manifest this vision and associated policies and guidelines in the care that they provide to residents.

Second, the medical ecological model stresses the concept of adaptation and behavioural responses that may be adaptive or maladaptive. As HCAs attempt to manifest the vision of RCC in the care that they provide, there may be stressors in that process. The vision and the guidelines may lack clarity or consistency or may be disparate with other organizational expectations, leading to stressful circumstances. Third, the framework speaks to individually-based coping strategies related to dealing with the "problem" or

dealing with the emotions that emerge from the problem. As a consequence of stressful circumstances, HCAs will respond using a variety of coping strategies.

HEALTH CARE AIDES: CANADIAN CONTEXT

The History of Health Care Aides

Across Canada, personal care workers have a variety of designations (see Lemieux-Charles, 1990). In Manitoba, common usage is Health Care Aide (ACC, n.d.; RRC, n.d.) for those working in PCHs, Home Care Assistant for community-based workers, while Health Care Assistant is common in hospitals.

In Canada, HCAs are unregulated health personnel (CIHI, 2004). The Canadian Institute of Health Information (2006, p. ii) defines an unregulated health profession as "one for which there is no legal requirement or restriction on practice with regard to licensure/registration. Registration with a provincial/ territorial or national professional organization is voluntary and not a condition of practice." HCAs can receive certification from recognized colleges (see ACC, n.d.; RCC, n.d.) and trade schools, and this may be a condition of employment in healthcare facilities. HCAs are part of the province's nursing personnel along with Licensed Practical Nurses (LPNs), RNs (RNs) and Registered Psychiatric Nurses (RPNs) (MNPAC, 1997). HCAs (and orderlies) account for sixteen percent of self-reported healthcare workers (CIHI, 2006).

HCAs are support workers and work under the direction of professionals to deliver health care services (Lemieux-Charles, 1990). Support workers have been part of nursing healthcare teams since at least the 1940s (Manitoba Health, 1966; Lemieux-Charles, 1990; McGillis Hall, 1998). Support workers worked and/or trained in PCHs and mental hospitals prior to 1940 (Manitoba Health, 1966). Originally hired by hospitals to help relieve nurse shortages (Lemieux-Charles, 1990; Manitoba Health, 1966; McGillis Hall, 1998), support staff took on non-nursing duties, which allowed RNs to concentrate on clinical duties (Manitoba Health, 1966). Initially, the only support workers were health care aides, nursing aides, porters and orderlies (McGillis Hall, 1998), but as hospital and community needs grew, new types of support workers appeared. Nursing assistants eventually formed their own organizations to become LPNs (Lemieux-

Charles, 1990; Glover, 2001). Today, healthcare systems employ a wide range of support workers (see Wunderlich, Sloan & Davis, 1996), possibly as many as sixty-five (McGillis Hall, 1998).

The changing role of health care aides

The role and function of HCAs has undergone rapid evolution, changing from the initial focus on non-nursing duties to soon having greater involvement in patient care (Manitoba Health, 1966). Eventually, HCAs were relieved of housekeeping and dietary duties to focus more on providing direct personal care (Manitoba Health, 1982). As nursing personnel, HCAs practice basic nursing which "in its broadest sense is caring. The practice of the profession of nursing is defined as those functions which, in collaboration with the clientele and other health workers, have as their objective, promotion of health, prevention of illness, alleviation of suffering, restoration of health, and maximization of health capabilities" (Manitoba Health, 1977, p. 4).

Consistent with HCAs in the U.S., Canadian HCAs account for sixty to seventy percent of all PCH staff and provide eighty to ninety percent of residents' personal care (Chappell & Novak, 1992; Bowers & Becker, 1992; Yeatts & Seward, 2000). HCAs provide basic custodial care, including assistance with all activities of daily living (ADLs) such as bathing, dressing, toileting, eating and mobilization. HCAs also help to meet residents' psychosocial needs (Wolgin, 1997; RRC, n.d.), something for which most have no training (Beck, Doan & Cody, 2002). HCAs work and their daily relationships with personal care home residents are critical to residents' quality of care and quality of life (Stone, 2001; Mesirow, Klopp & Olson, 1998; Bowers & Becker, 1992), especially since workload and paperwork often prevent nurses from giving the direct care that people require and desire (MNPAC, 1997; Manitoba Health, 2001).

To summarize, HCAs in Canada have a distinct history. They are unregulated, usually certified members of the health care team who work under the supervision of nurses. Originally hired to assist nurses by taking over non-nursing duties during periods of nursing shortages, the role of HCAs has changed so that they are now the primary care providers in PCHs, having a direct role in providing custodial, nursing, and psychosocial care to personal care home residents.

ELDERS AND PERSONAL CARE HOMES IN MANITOBA

Elders in Personal Care Homes

The main reasons for placement into a personal care home are very old age, lacking a family caregiver, being cognitively impaired (often referred to as dementia), having functional disability, musculoskeletal disorders and chronic diseases (MSHA-2, 1999; Tomiak, Berthelot, Guimond & Mustard, 2000; WRHA, 2006). Alzheimer's disease is the most common form of dementia, accounting for seventy-five percent of all dementias in Manitoba (Manitoba Health, 2002b). Since 1990, the average age on admission to a PCH and the average age of residents have been increasing. Currently, the majority of new admissions are in the oldest age group (85 years and older) (Menec, MacWilliam, Soodeen & Mitchell, 2002; Currie, 2002). For those admitted to PCHs in Winnipeg, the average age increased from 82 to 82.7 between 1990 and 2000. The average age of residents living in Winnipeg Regional Health Authority PCHs also increased during this time from 83.1 to 84.3 years of age (Frohlich et al., 2002).

Personal Care Homes in Manitoba

In Manitoba, PCHs are proprietary (privately owned) or non-proprietary (owned by religious or philanthropic organizations). Residents pay a portion of the daily cost of their residence based in their previous year's income. The baseline daily rate reflects the income received through Old Age Security and the Guaranteed Income Supplement, the federally-based social programs to which every older Canadian is entitled. If for some reason, a resident is unable to pay their portion of the daily costs, there is a process to make application for financial assistance to the provincial government (MHSC, 1990).

There are 124 PCHs in Manitoba with 9,805 beds in total (9,611 licensed beds and 194 non-licensed interim beds), with 5,697 beds in Winnipeg (3,555 non-proprietary beds and 2,142 proprietary beds). There are 39 personal care homes located in Winnipeg; the other 85 are in rural and northern regions of Manitoba (Manitoba Health, 2002a; WRHA, n.d.).

The Personal Care Home Program in Manitoba

Here in Manitoba, a personal care home is defined as a facility:

> for persons requiring long-term supervision and assistance with activities of daily living, basic nursing care under the supervision of a registered nurse and usually with a medical component to their care; and/or for persons requiring continual supportive and/or restorative care under medical direction and professional nursing supervision, with professional nursing staff required to perform direct, skilled nursing care (MHSC, 1990, p. 3).

Personal care home residents in Manitoba receive institutional housing and services that include meals (regular, special and therapeutic diets), nursing and medical support, medical and surgical supplies, prescribed drugs, physiotherapy and occupational therapy, laundry and linen services (MHSC, 1990), and assistance with or supervision of ADLs (Frohlich, De Coster & Dik, 2002). Residents with special needs for care include those with cognitive impairments, psychiatric and behaviour problems, medical conditions (such as Parkinson's disease or Multiple Sclerosis) and palliative care needs (CCHFA, 1990). The program of care for those with special needs may include medical interventions, specific techniques to maximize independence and functioning, providing opportunities for social interaction and a supportive environment, and special dementia care units (CCHFA, 1990).

The panel process

In Manitoba, in the panel process there are four levels of care for classification and each applicant is assessed to one of these levels based on clinical, health and social functioning criteria. When an individual is deemed in need of the 24-hour care provided in PCHs, their application is presented to panel following a period of assessment. The panel consists of a number of health care practitioners. "Level of care refers to a person's degree of dependency on nursing staff time for [ADLs] and basic nursing care to maintain his/her functioning" (MHSC, 1990, p. 4), Level 1 being the lightest and Level 4 the heaviest (see Box 2.1).

The levels of care classification system also determine nursing staffing guidelines (MHSC, 1990). However, these guidelines, established in the 1970s (Chute, 2007) only now underwent their first review (Hancharyk, 2007) and staffing increase ("Province," 2007). The new guidelines "ensure 3.6 hours of direct

care from nurses and aides per resident every day" ("Province," 2007), which is only a slight increase from the original 3.5 paid hours per resident per day for Level 3 and Level 4 residents (MHSC, 1990; Manitoba, 1995).

Levels of Care		
Level of care	Degree of dependence on nursing time	# of required ADLs
Level 1	Minimal	At least 1 ADL
Level 2	Partial	At least 1 ADL
Level 3	Maximum	At least 2 or 3 ADLs, or maximum support/supervision and moderate for 2 or more ADLs
Level 4	Maximum	4 or more ADLs

Box 2.1: *The Levels of Care criteria based on degree of dependence on nursing time for help with a number of required activities of daily living* (see MHSC, 1990).

Population Aging and the Levels of Care Classification System

According to the Interdepartmental Steering Committee Report on seniors' care facilities in Manitoba, there is a noticeable increase in admissions of older adults who are cognitively impaired and who require a significant amount of attention. This increase has not been captured or reflected in the levels of care (Manitoba, 1995). As well, the stakeholders noted that "the time and expertise required to care for a cognitively impaired individual can equal or exceed that required by more physically frail individuals, the existing system/tools focus primarily on physical rather than psychological needs to classify residents and determine the mix and levels of staff" (Manitoba, 1995, p. 12). Furthermore, stakeholders noted that increasingly more residents are admitted at levels 3 and 4 status, and that the care needs of level 4 residents are heavier than in the past (Manitoba, 1995).

The trend of panelling increasingly more frail older adults exhibiting cognitive limitations to PCHs continues today (Menec, Lix & MacWilliam, 2005). Frohlich et al. (2002, p. 5) noted that the "proportion of

residents requiring Level 2 care decreased between 1990/91 and 1999/2000 from [thirty-seven percent to twenty-eight percent], while the proportion requiring Level 3 increased from [thirty-three percent to thirty-nine percent], and Level 4 from [twenty-six percent to thirty-three percent]." The shift towards admission of heavier care residents does not indicate that the definitions of the levels of care have changed, but rather that their interpretation may have. This means that an older adult assessed at Level 3 is now frailer than "a comparable person ten years ago. Thus, decreasing survival time is not a reflection of poorer quality of care in PCHs, but more likely a reflection of the greater availability, variety and quality of care in the community (through home care and other providers), which enables people to reside in their own homes longer" (Frohlich et al., 2002, p. 6).

In summary, residents in PCHs in Manitoba represent the most physically, mentally and socially vulnerable older adults. Their needs are complex from a medical and nursing care perspective and because of cognitive impairment, there may be communication limitations that impede expression of needs, concerns and desires. During the past several years, the acuity level of older adults who are placed in personal care homes has increased without a proportionate increase in staffing levels. Of particular concern are the unmet psycho-social needs of this frail population within an organizational structure that emphasizes criteria of care and staffing from the 1970's.

PERSONHOOD AND RESIDENT-CENTERED CARE

Thomas Kitwood and Personhood in Dementia Care

Resident-centered care is closely associated with the development of a theory of personhood (see Kitwood, 1990; Kitwood, 1997; Kitwood & Bredin, 1992). Generally, this work comes from Great Britain, though an appreciation for the "new culture of dementia care" (Kitwood, 1997) has grown rapidly in North America (Talerico et al., 2003; Epp, 2003). The credit for introducing the concepts "person-centered care" and "personhood" into dementia care belongs to the late Thomas Kitwood, a social psychologist (Nolan, Ryan, Enderby & Reid, 2002; Dewing, 2004; Nolan, 2001; Brooker, 2004; Baker, Edwards & Packer, 2003).

The primary concept of personhood was adopted from psychotherapy, that is, the work of Carl Rogers and client-centered psychotherapy (McCormack, 2004; Brooker, 2004). Kitwood and Bredin (1992) presented personhood as a social relationship in which the human being is in relation to others. Personhood "carries essentially ethical connotations: to be a person is to have a certain status, to be worthy of respect. ...[P]ersonhood is not at first a property of the individual; [but] rather it is provided or guaranteed by the presence of others" (Kitwood & Bredin, 1992, p. 275).

According to Kitwood (1990), the standard 'paradigm' of thinking about dementia is faulty and deficient. The paradigm assumes that "a straightforward linear causal relationship between neuropathology and dementia [exists, leading to] far too negative and deterministic implications for the nature of caregiving" (Kitwood, 1990, p. 177). This paradigm is what those who work closely with dementia sufferers have been taught, though according to Kitwood, these caregivers "seem to operate with a kind of 'doublethink'" (1990, p. 179). This "doublethink" is the incongruence between a linear approach to the decrements of dementia and the experience of care providers who perceive this linear approach as being far too simplistic.

Thus, according to Kitwood's theory, individuals with dementia do not proceed down a straight line of predictable and inflexible diminishing capacities but instead as individuals, will experience idiosyncratic variation and improvement with eventual decline. Care providers who observe this individualistic phenomenon as they provide care often discover or recognize that the "individual" in the resident still remains. Kitwood wrote that this incongruence perpetuates the "malignant social psychology" that damages the self-esteem and diminishes the personhood of individuals with dementia (Kitwood, 1990, p. 181). The primary goal in doing "positive 'person-work,' [is to allow the person with dementia to be] and remain a full participant in our shared humanity" (Kitwood, 1993, pp. 104-05).

Kitwood's concept of dementia care is unique because it not only asserts the personhood of people living with dementia, but it also recognizes the personhood of care providers. His new culture of dementia care states that, "respect for the personhood [of staff] is as much on the agenda of the organisation as respect for the personhood of those who have dementia" (Kitwood, 1997, p. 10). Providing care to persons

living with dementia requires training and support. Caregivers need to understand the factors influencing the individual with dementia (Kitwood, 1993).

As well, caregivers need to know and understand that the caregiving relationship is not between someone who is "damaged, derailed, [and] deficient" and themselves as persons who are "sound, undamaged, competent, [and] kind" (Kitwood & Bredin, 1992, p. 272). Rather, though the person with dementia "may be more vulnerable in some ways, the caregiver is likewise also 'damaged' in at least some areas of function," perhaps emotionally or psychologically (Woods, 2001, p. S13). Person-centered care means that caregivers need support, to not only recognize their own vulnerabilities, but to be able to identify the specific contribution they make to the people in their care. For a caregiver "alone will, despite excellent intentions, struggle to put into practice person-centered care. . . . [Caregivers] need to be valued in the new culture; they cannot deliver person-centered care, if they are not themselves treated as valued individuals" (Woods, 2001, p. S13).

William Thomas and the Eden Alternative®

While Kitwood's work has been highly influential in promoting thinking about the personhood of individuals with dementia, it remained for others to take his ideas and put them into principles to guide care. There is an array of PCH culture change models, all espousing resident-centered care and more or less, these models tend to hold similar values, principles, and practices (see Fagan, 2003; Niederer, 2005). There is an emphasis on turning "the traditional nursing home model into a new type of community in which both residents and staff have a quality of life [rather than relying on the old one with] increased regulations and federal and state band-aid approaches" (Niederer, 2005, p. 6). For the purpose of this research, only one RCC model is presented and discussed, that is, the Eden Alternative® developed by Dr. William Thomas at Chase Memorial Nursing Home, New York in 1991 (Thomas, 1996). The Eden Alternative® is one of the most influential models and has become very popular in Canada over the last ten years (Eden Alternative Support Office, n.d.; Thomas, 2003).

Dr. Thomas recognized that older adults in care suffer needlessly with basic human needs unmet, simply because care providers, confusing treatment for care, focus on disease, disability and decline. Because of this mistaken focus and institutionalization, the "person" in the resident disappears to become "bloated with therapy and starving for care" (Thomas, 1996, p. 20). The main unmet needs older adults suffer are the needs for companionship, to care for others and for variety. The failure to meet these basic needs creates an optimum setting for the development of the three plagues of neglect – loneliness, helplessness, and boredom that define the experience of many older adults in care (Thomas, 1996).

The Eden Alternative® focuses on creating a home-like environment around "the axis of the plants, the pets, the children, the relationships, and the garden" (Thomas & Johansson, 2003, p. 284). The Eden Alternative® principles developed by Dr. Thomas emphasize creating human habitats built on biological, social and natural diversity. The principles focus on residents' needs (see Thomas, 1996). For example, one principle reads, "Define work by resident's needs and capacity, not ours." And indeed, this is one of the basic elements of resident-centered care.

The Eden Alternative® Golden Rule:

1) Decisions belong with elders or as close to elders as possible. Caregivers must be integrated into the decision-making that shapes daily life for the elders. ...The way managers treat staff is the way staff will treat the elders. This is an iron law.

2) An organization that learns to give love, respect, dignity, tenderness and tolerance to members of the staff will soon find these same virtues being practiced by the staff. This is elemental justice (Thomas & Johansson, 2003, p.284).

Box 2.2: *The Eden Alternative® Golden Rule for culture change*.

The idea of human habitats is a return to a "normal" or as close as possible, a usual home environment. The Eden Alternative® seeks to support individual growth, variety and spontaneity; empowerment of residents and staff, specifically HCAs; and employs a decentralized committee and team management model (Barba, Tesh & Courts, 2002). The model de-emphasizes the typical programmed-activity approach and rejects the institutional model (Thomas, 1996). The Eden Alternative® golden rule

(Box 2.2 above) speaks to placing decisions into the hands of residents and involving caregivers in this decision process, as well as integrating caring qualities into resident care and staff management. It also speaks to the basic fact that empowering residents begins with empowering HCAs.

Resident-Centered Care and the Four Elements

Resident-centered care

There are a wide assortment of names associated with the RCC philosophy including resident-focused care (CCHFA, 1990); personalized care (Beattie, 1998), resident-directed approach or care (Keane & Shoesmith, 2005; PHS, 2005a) and person-centered dementia care (Paun, Farran, Perraud & Loukissa, 2004; Martin, Rozon, McDowell, Cetinski & Kemp, 2004). However, in recognition of common usage of resident-focused care (WRHA, n.d.) and resident-centered care (Hill & Honeyman, 1992), the term used for this research is "resident-centered care."

Because of the diversity of names and models, there is no widely acceptable definition of resident-centered care. For this research, the following definition was used:

> Resident-directed care is health and personal care directed by the residents themselves. Each resident chooses the daily routines and services he/she wishes to receive. Staff place supreme value on listening and knowing residents backgrounds and personal preferences, while educating residents about concerns related to their well-being. Understanding needs, learning and collaboration are the ingredients that create the plan of care – a plan that is fluid and evolves with changing needs and wishes, and continued sharing and listening (PHS, 2005b, p.4).

This definition speaks directly to and emphasizes two elements of resident-centered care, that of instituting a flexible and evolving schedule of care, and of understanding residents preferences for care and following their direction in providing that care. Two other elements commonly associated with resident-centered care but not clearly present in the above definition are: promoting a home-like environment, and providing consistent care through permanent assignment of care providers. The element of home-like environment is present in Dr. William Thomas' work and the development of the Eden Alternative®. Thomas (1996) is unclear about permanent assignment, though other culture change models clearly articulate that it is a major tenet of resident-centered care (see Fagan, 2003; Niederer, 2005; Jones, 1996; Fabiano, 2002;

Gnaedinger, 2003), and it is crucial to the success of special care units (see Teresi, Grant, Holmes & Ory, 1998; Grant, Potthoff, Ryden & Kane, 1998).

Relationships among the four elements of resident-centered care

For this research on resident-centered care and the work satisfaction of HCAs, the four elements of resident-centered care are: providing flexible scheduling of care; following resident preferences for care; promoting a home-like environment; and maintaining consistency of care through permanent assignment of care providers. These elements overlap. For example, flexible scheduling implies home-like environment to some extent because when we are at home, we can control our own schedules of eating and going to bed. Also an understanding (and therefore following) of preferences, particularly for residents with dementia, can be gleaned from the experience of providing care over a long period of time which is gained from permanent assignment. In the research literature, most attention has been paid to the major elements of flexible scheduling and following preferences for care, with the elements of home-like environment and permanent assignment being interrelated with, or sometimes subsumed under the first two.

The Four Elements of Resident-Centered Care

Flexible scheduling

The aim of flexible scheduling is to "encourage residents to live according to their own schedule, as they would at home, rather than rising, eating and going to bed when *we* say they should" (Gilbert & Bridges, 2003, author's emphasis). Flexible scheduling should permit residents to maintain consistency with their own familiar routines and habits (Rantz & Flesner, 2004). The goal is to create a natural "daily rhythm" similar to living with a family (Gnaedinger, 2003, p. 359) by giving residents choice and control over their personal routines (Rantz & Flesner, 2004).

Flexible scheduling flies in the face of traditional care approaches that emphasize the "task" more than the "person." Task-oriented nursing care as an organizational way of structuring work separates care into a set of tasks that are performed by caregivers based on optimal time management for the benefit of the

unit rather than for the residents. For example, caregivers might assist residents with breakfast from 7:00am-8:00am and then move on to assisting residents with baths from 8:00-10:00am. This task-focused arrangement works well for scheduling the work of staff but offers no individual expression for residents who might prefer to sleep late and bath in the evening, as was their habit at home. A routinized environment makes it easier for caregivers to focus on the completion of predictable tasks and getting things done on time, but can lead to staff working on "auto-pilot," and missing physical or psychological changes in residents' health (Walls-Ingram, 2006). For staff and management, getting everything done by day's end can constitute "doing a good job" (Walls-Ingram, 2006, p. 75).

On the other hand, flexible scheduling may allow both residents and HCAs more latitude and less stress. A study by Kane, Urv-Wong, Freeman, Aroskar and Finch (1997, p. 1091) indicated that HCAs reported that they "hated" getting residents up in the mornings and that they occasionally let some remain in bed. Matthews, Farrell and Blackmore (1996) found that HCAs felt less stressed and residents benefited as well when there was flexible scheduling. Matthews et al. (1996) reported that flexible scheduling on the morning shift increased cooperation, decreased confrontation, and made staff more tolerant of residents' agitated behaviours, although this finding did not carry over to the evening shift. Perhaps because some residents slept later in the day, they became more active and alert during the evening, thereby increasing interpersonal interaction and agitation levels at a time when there are fewer staff members on duty. The investigators recommended that flexible scheduling should be accompanied by an increase to resident staff ratios in the evening shift to meet the potential increased workload demand (Matthews et al., 1996). However, this may not be seen as a realistic option from a financial or human resources perspective.

Gnaedinger (2003) found that workload was the primary impediment to providing individualized and flexible care, creating much frustration and stress for HCAs. The HCAs in her study reported that increasing acuity levels among residents translated into more time and effort needed to support ADLs (e.g. bathing, grooming, dressing, feeding and toileting). In addition, residents with cognitive limitations or dementia were more likely to become agitated or even combative during personal care. The combination of heavy workload

and time pressure when providing care to cognitively frail residents potentially creates situations of depersonalized care and increases stress.

HCAs do not work in isolation and the scheduling and pace of their workload affects and is affected by the work of other staff members. Morgan, Semchuk, Stewart and D'Arcy (2002) also concluded that time pressure and heavy workload are detrimental to providing quality care. A rushed approach decreased work satisfaction because staff perceived their care as unsupportive and because it increased their risk of injury (Morgan et al., 2002). As well, staff reported increased stress due to rushing residents through their meals so that the dietary staff could clear and clean the dining room. They also reported that the rescheduling of activities (an outcome of flexible scheduling) was difficult, citing the rescheduling of baths, specifically (Morgan et al., 2002). Hoeffer, Rader, McKenzie, Lavelle and Stewart (1997) found HCAs were concerned that with flexible scheduling, the consequential rescheduling might lead to criticism of poor time management and create more workload for others. Roberto, Wacker, Jewell and Rickard (1997) found that for HCAs, providing respectful care by giving residents more time to choose their own clothing might mean later reprimands for not completing assigned tasks "on time." Clearly, administrative and managerial support is essential. HCAs and nurses have identified that the main barriers to RCC, in general, are inadequate staffing, staff attitudes and poor communication between team members (Walker, Porter, Gruman & Michalski, 1999).

There is some evidence from residents that they do indeed prefer flexible scheduling. Mitchell and Koch (1997) indicated that while staff believed that residents preferred a structured morning routine, in fact, the residents disliked being rushed through breakfast and morning care, and felt that the routine benefited staff and not them. Walls-Ingram's (2006) study suggested that residents living in environments perceived as less flexible are more likely to report lower satisfaction with their quality of life, mainly due to lack of autonomy, and lack of privacy and dignity. She also found staff and resident interaction was negatively related to routinization, suggesting that routinization of care does not support an optimal environment for resident and staff interrelationships.

Residents' choice

Along with the element of flexible scheduling, there has been some research conducted in relation to the RCC element of following residents' preferences. Flexible scheduling allows for the expression of a resident's preferences in relation to scheduling, but the element goes beyond this to include the resident's preferred way of being addressed and of participating in decisions about care, treatment and activities. Respecting residents' preferences is related to respecting personal autonomy and recognizing "rights." In Canada, residents maintain their full rights as Canadian citizens (CNPEA, n.d.). In Manitoba, each PCH is responsible for developing their own residents' "Bill of Rights" as a way to remind everyone involved in care that residents do have rights (CNPEA, 2005; Spencer, 2002).

A related concept is autonomy, something that has received much attention, but is nonetheless, difficult to define. Despite this, Caplan (1990, p. 45) asserts,

> But for the most part, it is the presumption in our society that whatever autonomy is, the individual is in the best position to [determine its meaning for them]. This leads to the conclusion that when the capacity for autonomy is present, it must be respected and enhanced. It also means that the principle of respect for personal autonomy ought to be given the highest priority relative to other values or moral principles. If it is true that each individual knows what is best for himself or herself, then people ought to be able to control their lives and their environment in accordance with their personal values.

When the capacity for autonomy is absent, then greater care and caution must be undertaken to ensure that persons in care do not suffer the denial of their rights and freedoms as individuals.

High and Rowles (1995) have identified eight types of decisions facing PCH residents. Only three are related to providing care in relation to residents' preferences and these are: daily living decisions, decisions about physical environment and decisions about the social environment. Daily living decisions concern the timing of activities and this relates closely to the element of "flexible scheduling." Decisions about physical environment involve decisions about living space and personal belongings, while decisions about social environment involve social activities. Both of these decision types relate to residents' preferences and the promotion of a home-like environment. Because of their close proximity and interactions with residents during care and support of ADLs, HCAs "play a major role in whether autonomy is enhanced or diminished" (Aroskar, 1990, p. 181).

Indeed, High and Rowles (1995) found that due to progressive decline in residents' health and cognitive status, most residents will increasingly need someone to preserve their personal autonomy. This role often belongs to family members but in their absence it may be staff members who help or ultimately make decisions for residents (High & Rowles, 1995). The staff members who are most familiar with residents' preferences tend to be the HCAs (Shawler, Rowles & High, 2001). Rosher and Robinson (2005, p. 192) found that the "life's daily pleasure survey" introduced during the implementation of the Eden Alternative®, provided staff with information enabling them to offer choices about pets, gardening and other activities to each resident according to individual preferences.

Gnaedinger (2003) found that for some care providers, fulfilling residents' preferences increased workload without concomitant additional resources. Mattiasson and Andersson (1995) found that while HCAs consistently gave lower priority to residents' preferences than nurses did in their study, they concluded that it was due to a time factor. They pointed out that HCAs "who provide most of the daily basic care and most often are closest to the patient – have experienced that it is very time-consuming to enhance patient autonomy and thereby individualize their care" (Mattiasson & Andersson, 1995, p. 128).

Kane et al. (1997) asked HCAs about the kinds of special requests that residents might have, as a way of learning more about residents' control and preferences in everyday life. Some special requests were care-related (e.g. getting ice water, doing massages, setting hair, brushing teeth and doing laundry) and socially-focused (e.g. helping with correspondence, socializing and going out). HCAs could deal independently with some requests, but most HCAs indicated that they still obtained permission to do them. Discussion with supervisors was needed when the special requests involved food choice, staying longer in bed, concerns about medications and going outside the facility. HCAs were concerned about the limited opportunities for residents' choice and control over activities within the nursing home. In addition, HCAs cited the helplessness of residents, institutional rules and routines, and busy schedules as reasons preventing them from increasing residents' choices (Kane et al., 1997).

Home-like environment

In terms of promoting a home-like environment, the physical structure and associated function of the building is a major consideration, especially with older PCHs that are less likely to have private rooms and private spaces for residents. In addition, a common complaint raised by staff is the lack of private staff lounges (Deutschman, 1985). The economics of building shared bedrooms in comparison to private bedrooms took precedence in years gone by; something the WRHA (2006) and Health and Welfare Canada (1991) are seeking to change. The current situation is one where recently built PCHs have attempted to incorporate more home-like attributes with a majority of private rooms. But even so, most PCHs seem still to be based on the hospital model (Alzheimer Society, 1995), with double-loaded corridors, prominent nurses' stations which physically separate staff from residents, noisy communication systems and shiny floors (Goldman, 1998). According to Coons, Mace, Whyte, Boling, Rapelje and Senders (1996, p. 12), this sterile, cold and often disruptive environment relays a "sickness" message because,

> The long corridors, multiple sleeping rooms, the traditional nursing stations enclosed with formidable dividing walls, large day rooms and activity rooms all create a sense of institution that can be depressing to alert persons and can becoming increasingly confusing and disturbing to persons who are cognitively impaired.

One area of home-like environment that has received attention and is pertinent for this research is the introduction of permanent or visiting pets. Interaction with animals has been associated with emotional and social benefits in both acute and LTC settings (Gammonley & Yates, 1991), and has contributed to reduced mortality (Sloane, Zimmerman, Gruber-Baldini & Barba, 2002). Having pets in PCHs has been suggested as a strategy for putting the 'home' back in 'nursing home' (Morley & Flaherty, 2002). However, results of studies on animal assisted therapy have been mixed, primarily because it is difficult to separate the effect of the animal *per se* from the effect of larger changes in policy and procedure that occur when animals are introduced to a PCH (Hooker, Freeman & Stewart, 2002). The introduction of pets requires institutional and managerial support, and teamwork.

The introduction of pets into personal care homes is a popular means of creating a home-like environment. It is intuitively appealing and some studies support the benefits for residents who feel lonely or

who have diminished cognitive abilities (Banks & Banks, 2002; Kongable, Buckwalter & Stolley, 1989). The downside of pets in PCHs relates to animal maintenance (care, feeding and cleaning), cost (food and veterinary care) and issues with staff, residents, and families (allergies and fear of animals) (see The Beverly Foundation, 2000). Also, some of the maintenance functions might fall to HCAs. It seems that there are no studies that address how the introduction of animals into PCHs, as a way of promoting a home-like environment, affects the work and work satisfaction of HCAs.

Many health care reformers (IOM, 1986; Wunderlich et al., 1996; Miller & Mor, 2006; IOM, 2001) and proponents of culture change (Kitwood, 1997; Thomas, 1996; Jones, 1996; Fabiano, 2002; Thomas & Johansson, 2003) argue that improving living conditions for PCH residents must equally focus on improving the work environment for workers. Unfortunately, in the rush to create home-like environments the overwhelming focus is on the physical environment, often at the expense of the social context (Taft, Delaney, Seman & Stansell, 1993), in particular resident and staff relationships which are critical for dementia care (Mace, 1989; Lyman, 1989; Werezak & Morgan, 2003).

Rantz and Flesner (2004) found that for HCAs, after extensive physical renovations in the study facility, RCC meant increased workload without additional resources, and more varied tasks but less time with residents. Gnaedinger (2003) found building design a serious impediment to providing RCC, in that the larger the facility the longer the distances HCAs had to walk, which detracted from spending time interacting with residents. The HCAs also reported that though they worked in institutions they were expected to act as if they were in a house. Pekkarinen, Sinervo, Perälä and Elovainio (2004) found for staff that unit size and the amount of assistance required by residents with ADLs influenced work stress levels. This study showed that the greater residents' need was for assistance and the larger the unit, the higher the work stress experienced by staff, this in turn, leading to poorer quality of life for residents. In the study by Morgan, Semchuk, Stewart and D'Arcy (2003) staff reported that though time spent with agitated or noisy residents went a long way towards maintaining a quieter environment, they often did not have the time to do this. Staff also found that safety and the inability to regulate stimulation levels were physical design problems.

The success of RCC depends on the messages relayed to HCAs, in particular, those reminding them that elders and meeting their psychosocial needs are their central focus. Pekkarinen et al. (2004) found that unit staff shared common perceptions about work stressors. It is important with environmental modification to keep this in mind, because the messages relayed to staff must be consistent and visible (Deutschman, 1985). Any incongruence between messages hinders care delivery and makes it easier to return to old habits. This is very concerning given that many residents will continue to live in older buildings, most not designed to meet the needs of current resident populations. This will place greater demand on HCAs to provide RCC in unsuitable buildings thereby hindering their efforts (Gnaedinger, 2003), making it incredibly difficult for them to work towards making them homier.

Permanent assignment

The final element of RCC is providing consistent care through permanent assignment. Along with education, staff assignment has been identified as the most important element in caring for residents with Alzheimer's disease (Grant, Potthoff, Ryden & Kane, 1998; Morgan, Stewart, D'Arcy & Werezak, 2004). The two forms of staff assignment are rotating assignment (RA) and permanent assignment (PA) (Burgio, Fisher, Fairchild, Scilley & Hardin, 2004). RA results in 'assembly line' care which inhibits providing individualized care and limits residents' opportunities to realize maximal health and well-being (Campbell, 1985). Furthermore, it fosters decreased opportunities for nurse-resident communication necessary to meet residents' need for love and reassurance, can leave their basic needs unmet, and hinder the provision of effective nursing care, crucial factors especially when dealing with residents with cognitive or speech and sensory problems (Thomas, 1994). As a result, members of the nursing care team, including managers, nurses and HCAs may experience "a general sense of job dissatisfaction from an inability to fulfill their commitment to the older adult. Consequently, a major problem experienced in many long-term care facilities is a high nursing turnover rate" (Campbell, 1985, p. 12).

With permanent assignment HCAs are assigned to specific residents until death or discharge, a practice that allows for close and reciprocal relationships, increased continuity and quality of care, and

improved quality of life (Campbell, 1985; Laakso & Routasalo, 2001; Cherau, 1983). Concentrating on a small number of residents permits HCA investment in resident independence (Cherau, 1983), and fosters a home-like environment because HCAs can provide individualized care in a timely and consistent fashion and can anticipate problems before they arise (Goldman, 1998). For HCAs, PA increases personal accountability and responsibility, affords greater autonomy and offers increased opportunity for job satisfaction. It is highly dependent on managerial support because of the need for increased HCA participation in rehabilitative care, case conferences and interdisciplinary team activity (Cherau, 1983).

Permanent assignment is especially important in working with people with dementia, who because of communication limitations may not be able to clearly articulate their needs and preferences. It ensures that care providers who have frequent contact with residents will be more knowledgeable about residents' preferences for care. Approximately, fifty percent to seventy percent of Manitobans residing in PCHs have some form of dementia, with Alzheimer's disease accounting for two-thirds of all dementia cases (Alzheimer Society, 1995). This may be a conservative estimate, perhaps reaching as high as eighty percent of residents, given the aging of Canadian society (see Frohlich et al., 2002; Menec et al, 2005).

Most research on primary nursing and work satisfaction occurred in acute care settings. For example, Thomas (1994) conducted a study on hospital wards, finding with PA that irrespective of staff grade, patients received more choice, more explanation about their care, and more opportunities for verbal feedback about their care. The few studies conducted in PCHs show a positive relationship between permanently assigned HCAs and work satisfaction (Teresi, Holmes, Benenson, Monaco, Barrett & Koren, 1993; Teresi, Grant, Holmes & Ory, 1998). In their study Teresi et al. (1993), HCAs reported being in favour of PA and they liked the routine because it allowed them to know what to expect each day, how to plan their day, and have control over when and how to care for each resident. They also reported that they felt PA helped them to know residents better, notice physical/emotional changes sooner, be more visible to family members and be efficient with their time (Teresi et al., 1993). Unfortunately, the HCAs found PA made it difficult to care for residents with behavioural problems long-term, a problem easily overcome by implementing bimonthly or quarterly rotation models (Teresi et al., 1993). Morgan et al. (2004) noted that a

common reason managers give for not implementing PA is the perception that HCAs will resist changing approaches.

Burgio et al. (2004) showed there was little difference in quality of care indicators between RA and PA, though they did find differences with these indicators between morning and evening shifts. The likely reason for these findings is that even in PA homes, residents were at best assigned to their primary HCA only half of the time. Grooming and hygiene were worse for the evening, likely a result of decreased staffing on the evening shift which prevented HCAs from having time to spend on these activities. HCAs who worked in PA homes reported higher job satisfaction, though this was not associated with increased turnover, reports of burnout, or with more consistent work attendance. In fact, HCAs working in PA homes had higher rates of absenteeism than those working in RA homes, suggestive of intense care routines on the day shift as opposed to the evening shift, and competing family obligations (Burgio et al., 2004).

Rantz and Flesner (2004) studied the changes that took place in a PCH in the process of implementing RCC. The owners took a radical approach by implemented PA, nurse aide 'Team Leader' positions, open eating hours, buffet dining, and fully stocked kitchenettes accessible during after-hours, and a 'Wants and Desires' form for residents. As well, changes included involving ancillary departments in team meetings and care plan conferences, personalized activity planning for each resident, involving direct care and other support staff on outings and making a cash kitty accessible to staff for special events planning.

Rantz and Flesner's (2004) study demonstrated that PA was crucial to the success of RCC in several ways. PA enabled staff to get to know residents well, to anticipate needs, to detect subtle changes and to keep incontinence to a minimum thereby reducing the use of costly incontinence products. It also helped to establish relationships with families. HCAs indicated their satisfaction with the changes and reported feeling empowered to make decisions, even if wrong ones, and with having the support of managers or co-workers. The evidence presented here suggests that primary assignment is essential to RCC because of the critical role it plays in supporting the provision of flexible scheduling, the following of residents' preferences, and the actions of promoting a home-like environment.

In summary, the concept of personhood as developed by Thomas Kitwood came into practice as resident-centered care through the efforts of others such as William Thomas who originated the Eden Alternative. Resident-centered care has come to mean four elements: providing flexible scheduling of care; following resident preferences for care; promoting a home-like environment; and maintaining consistency of care through permanent assignment of care providers. The literature suggests that residents and HCAs appreciate that elements such as flexible scheduling of care and following residents' choice can add value to living and working in a personal care home. It is also clear that residents' living environment and HCAs working environment, both the physical and social aspects significantly affect the provision of resident-centered care and residents' quality of life. The few instances involving the study of permanent assignment show that it supports the other three elements of resident-centered care, increase residents' quality of life and quality of care, and add to HCA work satisfaction. However, there are also issues related to workload and supervisory and management support that must be addressed if these elements are to be implemented in the care of personal care home residents. Additionally, this support must equally focus on improving residents' living environment and HCAs work environment by shifting focus from physical care and the physical environment to the psychosocial environment, in particular social relationships between residents and HCAs.

HEALTH CARE AIDES AND A MODEL FOR STUDYING WORK SATISFACTION

Health Care Aide Work Satisfaction Research

Much of the research on HCAs and their work satisfaction comes from the United States and focuses on work *dis*satisfaction as it relates to staff turnover, absenteeism, morale and poor retention across both long-term care and acute care settings. Eaton (2000) has suggested that two themes dominate long-term care in the United States, one being poor quality care for residents and the other being HCAs who experience low quality jobs and work environments. Statistical information on health human resources, healthy workplaces and work satisfaction has focused more on RNs (rather than HCAs) and issues of retention, especially in times of staff shortage (Health Council, 2005; CIHI, 2003; Romanow, 2002;

Armstrong & Armstrong, 2002). Yet, shortages of HCAs in Canada, while not widely known, is becoming extreme and is expected to continue to be the case in future (Lapointe, Dunn, Tremblay-Côté, Bergeron & Ignaczak, 2006). Extrapolation from research findings regarding RNs to HCAs should be done with caution. The scope of practice is different and RNs delegate and supervise the work of HCAs. However, it may be that as groups of health care workers, there are similarities that go beyond designation and job description.

A common challenge facing both Canada and the U.S. is the shortage of adequately qualified health care staff, including RNs and HCAs. The shortage became readily apparent in the late 1990's and has continued to this current time. Much emphasis has been placed on regulated health care workers, particularly RNs, and understanding more about their work satisfaction as a basis for developing healthy workplaces, promoting retention and preventing turnover. Of course, the driving force is to achieve better patient (or resident) outcomes and efficient organizational performance (Collier & Harrington, 2008).

The idea is that healthy workplaces will motivate workers, thus improving recruitment and retention, workers' health and well-being, quality of care and patient safety, organizational performance and societal outcomes (Shamian & El-Jardali, 2007). Among RNs, the main sources of work dissatisfaction have been identified as: lack of professional support and recognition; heavy workload; lack of technical equipment and material resources; poor physical environment; poor relationships with co-workers and support services (housekeeping, pharmacy, human resources) (Leiter, 2006; Gagnon, Ritchie, Lynch, Drouin, Cass, Rinfret, Rouleau and Valois, 2006). Not surprisingly, work satisfaction has been associated with: supportive leadership; satisfaction with pay and work schedules; feelings of organizational and co-worker support; feelings of autonomy; satisfactory balance of work and lifestyle; and having a safe working environment (Baumann, 2007; Wilkins, McLeod & Shields, 2007). Healthy workplaces promote the quality of work life by enabling staff members to achieve their personal and professional goals (Lowe, 2006).

Health care aide employment patterns

Research on employment change patterns of HCAs in nursing homes has been conducted since the early 1970s (See Mullins, Nelson, Busciglio & Weiner, 1988; Garland, Oyabu & Gipson, 1988; Caudill &

Patrick, 1989; Caudill & Patrick, 1992; Brannon, Cohn & Smyer, 1990; Helmer, Olson & Heim, 1993; Remsburg, Armacost & Bennett, 1999). American researchers are advantaged by the presence of a central registry for HCAs (called certified nursing assistants or CNAs) that allows tracking of HCAs, their numbers, and their current employers. More importantly, this registry provides a means to identify employment trends longitudinally. Canada lacks this type of registry and consequentially lacks accurate estimates of long term employment trends. In the U.S, turnover among all nursing home personnel has ranged from 40 percent to 75 percent with some facilities reaching rates as high as 500 percent (Cohen-Mansfield, 1997). Turnover among HCAs has ranged from 80 percent to over 100 percent across the US, or as high as 200 percent to 400 percent in some facilities, making turnover one of the main issues facing the long-term care industry (Wunderlich et al., 1996).

High turnover rates mean high costs associated with the replacement and training of new staff. In addition, staff shortages brought on by high turnover rates mean that the remaining staff must work short-handed until replacements arrive, and must deal with "lost friendship, uncertain expectations, and [an] ensuing sense of job instability. ...which can make it difficult for an otherwise caring staff to deliver medically proper and humane treatment to their [residents]" (Waxman et al., 1984).

Several explanations have been reported for HCAs high turnover rates including inadequate wages and benefits, lack of proper job orientation, inadequate training programs, facility size, and personality traits of HCAs themselves (Waxman et al., 1984). Research in the 1980's focused on why some HCAs stay with an employer for an extended period of time. "Stayers" tended to be HCAs who report that they care deeply for the residents for whom they provide care (Garland et al., 1988, p. 23; Sung, Chang & Tsai, 2005). Some studies suggested that HCA relationships with residents motivated them to stay even when work satisfaction is at a low level (Anderson, Aird & Haslam, 1991; Parsons, Simmons, Penn & Furlough, 2003). Grieshaber, Parker and Deering (1995) found when comparing the results of their study of the job satisfaction of HCAs in LTC with those of Waxman et al. (1984) ten years earlier, that HCAs took the greatest satisfaction from the care they provide residents because of the opportunity to do things for other people.

The Quality of Nursing Worklife Research Model

A model for examining work satisfaction was developed at the Quality of Nursing Worklife Research Unit at two Canadian universities (University of Toronto and McMaster University) in the 1990's and this model provides a way to organize the research on HCAs and their work satisfaction (see McGillis Hall, 2005). The model suggests that both internal and external factors affect work life quality and satisfaction (O'Brien-Pallas & Baumann, 1992). Internal factors relate to the organization or agency and include: 1) individual factors, including home-work interplay factors (such as job sharing opportunities and day care resources) and individual needs (such as the need for respect and recognition); 2) social/ environmental contextual factors (such as the facility's decision-making and management style); 3) operational factors (such as workload); and 4) administration (such as the philosophy of management).

External factors are based outside of the facility and include: 1) client demand on systems (such as chronic illnesses common among the aging population); 2) health care policy (such as funding); and 3) labour markets (such as regional variation factors). Depending on the specific factors, the "outcomes" for work life satisfaction (or dissatisfaction) for staff are: retention, client satisfaction, staff satisfaction, stress, group cohesion, commitment, motivation, and quality.

Individual internal factors

Placed within the Quality of Nursing Worklife Research Unit framework of internal versus external factors, research tends to support the primacy of internal factors in relation to HCAs and work satisfaction. A pervasive theme is the importance that HCAs place on the relationship with the residents for whom they provide care and with their co-workers. Relationships with residents has been cited as a primary reason for HCAs staying (Caudill & Patrick, 1992), for doing their work (Garland et al., 1988) and for making their jobs rewarding and satisfying (Brannon et al., 1990; Anderson et al., 1991). HCAs seem to value having input into what happens to residents through care planning, and receiving praise from residents (Caudill & Patrick, 1989; Caudill & Patrick, 1992; Sung et al., 2005). HCAs indicated having a sense of connection to residents, whom many consider to be 'family' (Secrest, Iorio & Martz, 2005) or 'extended family' (Marquis, Freegard &

Hoogland, 2004). Their commitment determines the quality of the care they give (Tellis-Nayak & Tellis-Nayak, 1989), with job satisfaction positively related to quality of care (Redfern, Hannan, Norman & Martin, 2002).

The work of HCAs is physically and mentally demanding and relationships with residents can be challenging, particularly when residents display disturbing or challenging behaviour. The majority of residents in PCHs have cognitive limitations and some of these residents express their confusion, frustration and anger as verbal and physical aggression toward HCAs (Morgan et al., 2002). During the 1990's, two separate projects (Chappell & Novak, 1994; Goodridge, Johnston & Thomson, 1996) were conducted in Winnipeg to examine the work of HCAs. These studies are valuable because although they do not compare length of employment with job satisfaction, they do indicate that the majority of HCAs interviewed about their work satisfaction were indeed long-term employees. HCAs worked, on average, at least five years with their current employer (Chappell & Novak, 1994; Novak & Chappell, 1996) while most worked between five to more than fifteen years with their current employer (Goodridge et al., 1996). Others had worked in long-term care settings for almost ten years (Novak & Chappell, 1996).

In Chappell and Novak's (1994) research, when asked about the impact of resident aggressive behaviours, perhaps surprisingly, HCAs who reported dealing with such behaviours tended to report feeling more satisfied with their work. The researchers speculated that HCAs who feel more skilled at handling these behaviours feel a sense of satisfaction when their efforts are successful. When these skills lead to an appropriate response from residents, the HCAs experience a greater sense of accomplishment (Chappell & Novak, 1994). Those who were less skilled in dealing with aggressive residents were more likely to experience burnout. Ross, Carswell and Dalziel (2002b) recommend reducing the likelihood of HCAs encountering emotionally exhausting situations and instead increasing their opportunities for personal involvement with residents.

In the second study, Goodridge et al. (1996) noted that HCAs assisting cognitively impaired residents with ADLs, in particular with personal hygiene are likely to regularly encounter resistance and some form of physical and verbal aggression (being pushed, grabbed, shoved, or pinched by residents).

Often, these incidents go unreported because HCAs tended to consider them as a normal part of working conditions. Findings indicated that many HCAs do not hold cognitively impaired residents responsible for their behaviour (Goodridge et al., 1996). Secrest et al. (2005) found that the sense of family HCAs felt towards residents engendered a protective response even when residents physically assaulted them.

Another often cited internal factor of work satisfaction is relationships with co-workers. Brannon, Cohn & Smyer (1990) compared the job satisfaction of HCAs with that of other types of service workers. The HCAs described their jobs as very rewarding, especially in terms of relations with co-workers, while pay was the least satisfying. In a study conducted in Australia, Chou, Boldy and Lee (2002) reported that team spirit contributed the most to job satisfaction, while the lowest reports of job satisfaction related to workload (Chou et al., 2002). Marquis et al. (2004) also found staff considered having "a sense of team spirit [a] part of a community of care" which contributed to feelings of being equal and respected. HCAs have reported that their satisfaction with social opportunities at work is an important part of building teamwork and morale (Gaddy & Bechtel, 1995). In a study conducted in Ontario, Canada, other internal factors of job satisfaction were cited by RNs, RPNs, and HCAs. Respondents made recommendations for improving the quality of their work environment, suggesting decreased emphasis on the task orientation to care; ensuring opportunities for autonomy and innovation; and increased peer cohesion and supervisory support (Ross, Carswell & Dalziel, 2002a).

Access to training and staff development programs has been identified in relation to work satisfaction, something that has been identified as crucial to HCA work with elders living with dementia (Morgan et al., 2002). HCAs indicated that receiving training helped to alleviate work-related stress (Chappell & Novak, 1992). The HCAs in the study by Sung et al. (2005) considered training opportunities that focused on dementia care helpful and one of the benefits of working in their workplace. Overall, they desired more training in self-protection techniques (Sung et al., 2005). In another study, HCAs expressed concerns that they were unlikely to integrate specialized skills gained from dementia-care bathing techniques in their workplace (Schindel Martin, Rozon, McDowell, Cetinski & Kemp, 2004). They felt that the

lack of clinical and managerial support would likely mean they would not receive the support needed to reassure them that the new techniques were acceptable and to be continued (Schindel Martin et al., 2004).

Social, environmental and contextual internal factors

While internal factors such as relationships with residents and other co-workers, the need for recognition and rewards and continued training exist at the individual level, there are clearly contextual, operational and administrative factors that also carry weight in relation to work satisfaction. In their study on ways to improve the psychosocial work environment Lavoie-Tremblay, Bourbonnais, Viens, Vézina, Durand and Rochette (2005) found that the key element to lasting change was staff involvement in proposed changes. Supportive environments, where "management expected that staff would become involved and connected with residents and families" fostered "a caring ethic" among the staff, and contributed to their retention (Marquis et al., 2004, p. 5). Work environments in which staff observed "a good match" between personal and organizational values about care practices contributed to increased work satisfaction and loyalty to the organization (Marquis et al., 2004). Workers also reported that having senior management identify with organizational values through their leadership and supervision enhanced the quality of work life. Conversely, work dissatisfaction was associated with a lack of recognition from supervisors and managers (Helmer et al., 1993).

McGillis Hall, McGilton, Krejci, Pringle, Johnston, Fairley and Brown (2005) looked at the nature of relationships between nursing staff and supervisors in LTC settings in Ontario. Participants included nurses, HCAs and personal support workers. Findings indicated that staff rated highest those leaders who listened, praised, recognized and provided positive reinforcement to others. Furthermore, staff indicated feeling stimulated in their work setting when leaders showed respect, trust, communication, control and decision-making behaviours (McGillis Hall et al., 2005). Similarly, Gruss, McCann, Edelman and Farran (2004) found that supportive leadership, educational opportunities, access to information and participation in decision-making increased feelings of empowerment among HCAs.

In 2000, Gnaedinger undertook a study to evaluate the introduction of a new LTC model from the perspective of staff members, some of whom were HCAs. The model resembled the resident-centered care model and emphasized the involvement of all staff members in care planning and used permanent assignment (Gnaedinger 2003). Staff members found that the new model emphasized flexible routines, increased familiarity with residents and made it easier to provide individualized care. In addition, this approach allowed family to become more familiar with staff and to share information about residents. As well, staff members felt that PA helped reduce residents' agitation, possibly due to increased efficiency in anticipating and meeting individual residents' needs (Gnaedinger, 2003).

Unfortunately, increased workload was a consequence of the new model because many of the residents were severely cognitively impaired and staff needed more time to communicate with them. Other concerns included the lack of training for working with cognitively impaired elders, a poorly designed physical building, and the absence of leadership for team building and problem-solving (Gnaedinger, 2003).

In their pilot study, Hoeffer et al. (1997) reported a management driven change in work orientation that received support from all levels of staffing and promoted work satisfaction. The change was a shift from task-focused (i.e., getting the assigned bath done) to person-focused care (i.e., attending to the perspective and preferences of residents). Whereas, prior to the change, HCAs expressed concerns that co-workers and supervisors might perceive them as not doing their job if they altered standard routines, following the change they reported feeling validated and supported. For HCAs, the process of implementing the change appeared to make supervisors more aware and appreciative of their work. For instance, during the bedside consultations with supervisors, HCAs felt that supervisors better understood the challenges faced when bathing aggressive residents (Hoeffer et al., 1997).

Involving HCAs in decision-making is an administrative and management decision associated with work satisfaction. Ross et al. (2002a) found that HCAs scored higher on personal autonomy and innovation and lower on peer cohesion than the nurses in their study on the quality of work environments of front line workers. This finding reflects the way that HCAs work. That is, HCAs are part of a team but the majority of the time they work on their own, especially while engaged in direct care to residents. HCAs commonly

complain of exclusion from team activities (Mather & Bakas, 2002), such as care conferences. This not only separates HCAs from a team activity that could provide other team members the opportunity to recognize and appreciate their contribution, but it may affect resident care in situations where HCAs' familiarity with residents' needs is pertinent to the meeting.

External factors

The Quality of Nursing Worklife Research Unit framework also identifies external factors including: client demand on systems, health care policy and labour market. As is evident, most of the research on HCAs and work satisfaction explores internal factors, not these external ones. However, external factors, such as client demand on systems clearly have an impact on HCAs work and work satisfaction, especially given the increased cognitive, social and physical frailty exhibited by older adults in need of institutional care. A health care policy external factor is the level of funding or the lack thereof. This external factor translates into staff mix issues and workload, and the lack of specialized programs for residents with complex social, physical and cognitive needs. These two factors were described earlier in the section on residents in PCHs in Manitoba. They clearly affect workload and thus, work satisfaction, in a broad sense. Currently, there are no studies that link HCA work and work satisfaction within this broader context. Similarly, external factors such as labour market have not been explored specifically with HCAs and their work satisfaction.

In summary, much of the research on HCAs work participation is American in origin and focused on retention with the intent to decrease turnover among this group of health care workers, many of whom are highly mobile and tend to change employment settings frequently. The research on HCAs work and work satisfaction has been associated with several "internal" factors including: positive experiences with residents and co-workers; being valued for their work; having input into care planning and decision making; having opportunities for more training; working in supportive and caring environments; and working with stimulating and respectful leaders. Factors associated with work dissatisfaction are: heavy workload; low pay; emphasis on task-based care; and lack of managerial and administrative support when needed.

External factors, that is, those based outside the facility that tend to reflect societal changes and demands, health care policy and labour market demands have not been directly studied in relation to HCAs work and work satisfaction.

Conclusion

This chapter provided a theoretical framework to set the context for this research on resident-centered care and work satisfaction of HCAs who work with personal care home residents living with dementia. The concepts of culture, adaptation and coping are central to this framework and the perspectives of HCAs are of chief importance as a methodological strategy and analysis. This chapter also set the stage for understanding the work of health care aides and the residents for whom they provide care. HCAs work in a team to provide personal care to residents most of whom are physically, socially and cognitively frail. HCAs' daily contact with residents means that they, more than other health care workers in personal care homes, have an opportunity to get to know residents as individuals. For this reason, their perspective is essential to improving residents' quality of life and quality of care.

The fourth section of this chapter dealt with the concepts of personhood and resident-centered care. Emphasis was placed on the work of Kitwood and Thomas to outline the four elements of resident-centered care: providing flexible scheduling of care; following resident preferences for care; promoting a home-like environment; and maintaining consistency of care through permanent assignment of care providers. The literature on resident-centered care was outlined and it indicated that HCAs were generally supportive of these elements and further to this, that residents were also positive about this approach.

The final section was on work satisfaction and HCAs. The research in this area has tended to focus on internal factors associated with work satisfaction, that is, the factors that are active within the person of the HCA or the walls of the PCH. Internal factors associated with work satisfaction include positive relationships with residents, co-workers, and managers, feeling involved, appreciated and supported and having opportunities for more training. Work dissatisfaction is related to heavy workload, low pay, emphasis

on task-based care and lack of management support. External factors, or those based outside of the PCH have not been studied in relation to HCAs and their work satisfaction.

The next chapter provides information on research methods including sections on design, setting, sample and inclusion criteria, measurement and research procedure.

CHAPTER THREE – METHODS

This chapter outlines the methodology or "logic-in-use" that guided this research on the relationship between resident-centered care and work satisfaction of HCAs, specifically in relation to the elements of providing flexible scheduling of care, following resident preferences for care, promoting a home-like environment and maintaining consistency of care through permanent assignment of health care workers. The one section in this chapter outlines the quantitative and qualitative research methods used in this study. Each sub-section describes the design, beginning with the quantitative, and then followed by the qualitative research methods, data collection, and data analysis and research rationale. The section closes with the research analysis procedure. The final section concludes the chapter.

QUANTITATIVE AND QUALITATIVE RESEARCH METHODS

Quantitative Research Data Collection, Analysis and Rationale

Collecting the quantitative data

The interview format consisted of three sections (see Appendix A). The first section contained socio-demographic questions (asking about age, ethnicity and highest level of education) and work background questions, asking about training as a HCA, and work experience (number of years working as a HCA overall, and in their current employment, and the number of personal care homes in which they had worked). These questions were asked in order to gain a profile of the HCAs. Although it is sometimes possible to do comparisons with other studies based on the similarities of subjects, this was not the major thrust here. Given that this is a convenience sample of nine, the intention was to provide basic information on the socio-demographic and pertinent work characteristics of the HCAs who participated in this research.

The second section employed the McCloskey Mueller Satisfaction Scale (MMSS) to measure work satisfaction (Mueller and McCloskey, 1990). In 1974, McCloskey and Mueller studied nurses who had resigned from their jobs and asked whether or not certain rewards would have kept them on the job. Based on Maslow's (1943) Hierarchy of Needs model, the scale items were constructed and categorized as either

safety rewards (protection against dangerous threat), social rewards (need to belong) or psychological rewards (autonomy, responsibility, recognition and appreciation). The original 1974 scale was modified in 1987 and 1990. The previous versions (McCloskey, 1974; McCloskey & McCain, 1987) had reported face and content validity and test-retest and Cronbach's alpha reliability.

The current 31 item version of the MMSS (see Mueller & McCloskey, 1990) has 8 subscales that supported the original three theoretical dimensions (safety, social and psychological). The eight subscales are related to: extrinsic rewards, scheduling, family/work balance, satisfaction with co-workers, satisfaction with interaction opportunities, and satisfaction with professional opportunities, praise/recognition, and control/responsibility. Mueller and McCloskey (1990) reported Cronbach's alphas for the eight subscales that ranged from .52 to .84, with the smaller alpha belonging to the subscales with few items. An alpha of .89 was reported for the global scale. In additions, test-retest correlations between measurements taken at six and twelve months were consistent.

Analyzing the Collected Quantitative Data

Analysis was both quantitative (socio-demographic and work characteristics, and MMSS work satisfaction) and qualitative (open-ended interview questions on the four elements and work satisfaction). Quantitative data were analyzed using SPSS (Statistical Package for the Social Sciences) and facilitated by the Manitoba Nursing Research Institute in the Faculty of Nursing, University of Manitoba. The SPSS software is capable of univariate (frequencies), bivariate (correlations) and multivariate (ANOVA, regression, etc.) analyses. For this research, univariate analysis was undertaken to present a profile of the HCAs who participated (socio-demographic and work characteristics) and to examine individual items on the MMSS.

Quantitative Research Rationale

This tool was selected because there were no HCA work satisfaction tools in existence. Naturally, a tool that is designed for one population (nurses) will not fit completely with another population (HCAs). For example, one subscale addressed "professional opportunities" and an item of this subscale asks about

"opportunities to interact with faculty of the College of Nursing." This item was clearly not applicable to HCA who are unregulated health care workers. However, another of the subscale items asked about "opportunities to belong to departmental and institutional committees" and this item was applicable to HCAs. Modification of the MMSS (1990) for this study involved ten items belonging to three subscales. Under the subscale "satisfaction with co-workers" there were two items, "your nursing peers" and "the physicians you work with." To reflect the work experience of HCAs these items were changed to ask about "your work with other health care assistants" and "the nurses you work with."

The subscale "satisfaction with interaction opportunities" had four items, two of which required modification. The two items were "the delivery of care method used on your unit (e.g. functional, team, and primary)" and "opportunities to interact professionally with other disciplines." The first item was modified to read, "the delivery of care method used on your unit (e.g. resident-centered care)" to stay in tune with the focus of the research. The second item became "opportunities to interact with other disciplines (e.g. social workers, recreation therapists)." While both nurses and HCAs directly communicate with and coordinate their work activities with social workers and recreation therapists, there are differences with respect to the formality of these relations. Nurses engage in formal communication with other disciplines through multi-disciplinary team meetings and consultation. HCAs are members of multi-disciplinary teams but their interaction with other disciplines are less formal (Jervis, 2002) and often take place by happenstance outside of formal team meetings.

For the subscale "satisfaction with professional opportunities," three items were changed. The items included "opportunities to interact with faculty of the College of Nursing," "opportunities to participate in nursing research" and "opportunities to write and publish." These items were more reflective of nurses' experience than that of HCAs, though only minor adjustments were required to make these applicable for HCAs. In recognition of the need for education related to caring for residents with dementia for all health care workers (West, Barron & Reeves, 2005; Boettcher, Kemeny, DeShon & Stevens, 2004; Hoeffer et al., 1997) and because HCAs may desire further education related to their work, the first item under this subscale became satisfaction with "opportunities for continuing education (e.g. workshops)." For similar

reasons, the next item under the subscale "opportunities to participate in nursing research" became "opportunities to participate in research." The final item under this subscale related to opportunities to write and publish was deleted and replaced with "opportunities to participate in union activities," to reflect the high proportion of unionized facilities in Winnipeg, and to attempt to capture the degree of union participation among participating HCAs.

Under the third subscale "satisfaction with praise and recognition" two items changed. The original items asked about satisfaction with respect to "recognition for your work from superiors" and "recognition of your work from peers." The changes to these items were minor, to ensure consistency with the work experience of HCAs. The first item asked HCAs about their satisfaction with "recognition for your work from managers/directors," in recognition of the RCC model. The second item asked HCAs about their satisfaction with "recognition of your work from other health care aides," rather than satisfaction with recognition by peers. Finally one question was added to the format of the MMSS and it asked HCAs about their "overall work satisfaction." The information gained from this question will give a general idea of how satisfied HCAs are with their work.

Given the number of items on the MMSS (n=31) and the number of subjects in the study (n=9), no attempt was made to test for psychometric properties of the MMSS. Instead, analysis was on each of the 31 items as scored by HCA as being satisfied, dissatisfied or neither satisfied nor dissatisfied.

Qualitative Research Methods, Assumptions, Data Collection, Analysis and Rationale

Qualitative Research Methods

Nursing home ethnography

A major thrust of anthropology is creating ethnography, which is the work of "describing a culture" (Spradley, 1975, p. 43). The goals of ethnography are to describe and explain the culture of a distinct group of people and to represent their informants' viewpoints. Ethnography is a common research approach in PCH research. In 1975, when personal care home research was in its infancy, Jaber Gubrium wrote the classic ethnography of personal care home life, *Living and Dying at Murray Manor*, based on observations

of residents and HCAs. Later, Timothy Diamond, a sociologist who studied health care organizations, became a HCA for his research on PCHs (Diamond, 1992). He conducted field research using participant-observation and institutional ethnography.

This research on resident-centered care and the work satisfaction of HCAs intentionally relied on HCAs as informants in order to understand the relationship between work satisfaction and resident-centered care in the personal care home culture from their perspective. It focused on collecting the viewpoints of HCAs as experts in their "community" through a structured and semi-structured format. Taping of the interviews with HCAs and qualitative analysis of the verbatim transcripts kept their voices central to this research. The research process involved both qualitative and quantitative data collection and analysis.

This research is cross-sectional and data were collected during a six week period from May to June in 2006. The subjects were nine HCAs who worked in four personal care homes in Winnipeg. The HCAs were recruited after the selection of the personal care homes.

Researcher's role and assumptions

The beliefs and life experiences of the researcher can affect the research process and the potential assumptions that might have been active require exploration and declaration.

During her formative years, the researcher lived in a small Canadian town where the community norm was for grandparents to continue to live in their homes with the support of family and neighbours rather than leave the community for placement in a PCH. However, having moved to a large urban centre, the researcher became aware of another norm, that of PCH placement even with family and neighbour support. The researcher has been employed as a HCA for more than 20 years. Her perspective of older adults in care emphasizes their vulnerability and the consequential need for advocacy by others, the primacy of quality care and caring, and the unacceptable lack of caring and loss of dignity that sometimes occurs. The researcher values her work and the work of other HCAs who provide dignified, caring and competent care to vulnerable older adults. At the same time, she recognizes that not all workers share the same perspective and values.

It was anticipated that the researcher's work experience could have several effects on the process of the project. Although the researcher at the time of the project was not working in a PCH and did not know any of the subjects personally, it was anticipated that the researcher would feel relatively comfortable interviewing individuals with whom she shared a similar work experience. Subjects consequently might have felt more comfortable, as well. The researcher would be familiar with the HCA role, their work tasks and the context of this work in relation to resident care and the larger institutional system of policies and procedures. This was an anticipated benefit that did seem to materialise during interviews.

However, this same familiarity can lead to assumptions that might not be fully explored during the interview process and it was a concern that the researcher had to take into account. To offset this problem I sought to maintain distance by not disclosing my work experience to participants, feigning ignorance of contexts and concepts shared by HCAs so to probe for more explanation, adopting an open and welcoming attitude like that of a 'student' there to learn, and by employing a number of interview strategies gained through personal experience as a trained family mediator and as a research assistant. Family mediators are trained in the common communication skills of active listening, namely, attending, paraphrasing and summarizing, and in interviewing techniques, such as reframing, mirroring and re-directing. To help establish rapport during the interviews, I used a non-directive approach, much like that of Whyte and Whyte (1984). I began the interviews with broad questions like "Tell me what home-like environment means to you," then followed these with probing questions like "Who decides how care is provided?" and "What does that mean for your work?" This approach was similar to the grand and mini tour questions Spradley (1979) suggests to use. As participants became caught up in answering questions, I withdrew to let them speak, occasionally providing feedback as needed to maintain the flow. So, while I was looking for specific information related to the four elements of resident-centered care and HCA work satisfaction, I used open-ended questions designed to allow HCAs to talk about what mattered to them.

I became aware that in some instances potential participants and informants were mistakenly informed by some Directors of Care that I was a nurse. To offset this, I reminded informants that I was a

university student conducting research, and I dressed casually, spoke simply and in the common vernacular of HCAs, and I focused on maintaining good eye contact to establish trust.

Issues of objectivity and subjectivity are common during the process of data collection and analyses. The qualitative analyses for this research were done jointly by the researcher and her advisor. More information is available below.

Ethical review procedure

The University of Manitoba requires that all graduate student research projects that involve human subjects be reviewed by the advisor's associated Research Ethics Board, and in this situation, it was the Education Nursing Research Ethics Board (ENREB). Health Care Aides are not seen as a vulnerable population so much of content of the ENREB questions related to the process of recruitment in relation to the information placed on the posters and the storage of data. The certificate of approval is in Appendix B.

Qualitative Data Collection Methods

Inclusion Criteria

Choosing the research sites

The process of selecting settings was multi-staged and involved the gathering of information about the PCHs in Winnipeg from a variety of informal and formal sources prior to contacting individual facilities and making final selection. The aim was to elicit interest from the Directors of Care from several PCHs that held the philosophy of resident-centered care and to create a sample of PCHs representing a diversity of characteristics. From an original group of seven PCHs, the Directors of Care of four PCHs in Winnipeg were approached and asked to participate in the study. The choice of PCHs was based on the Directors of Care providing evidence that their facility held a resident-centered care philosophy that included flexible scheduling, following resident preferences for care, promoting a home-like environment and maintaining consistency of assignment of care providers. Examples of evidence included mission statements and

pertinent policies reflective of the four elements of RCC. Prior to selection of the four PCHs, the researcher toured all of the seven PCHs.

The four chosen PCHs were diverse in ownership status (proprietary and non-proprietary), size (a range of 88 to 218 residents) and geographic location in the city. All four PCHs were unionized and participated in collective bargaining. This diversity meant that a wide range of factors associated with work satisfaction might be uncovered. Sheridan, White and Fairchild (1992) indicate that diversity of setting can provide a broad base for study. The recruitment of the four PCHs took about six months to complete.

Although diverse, these four PCHs shared similar resident characteristics. Based on the Winnipeg Regional Health Authority Central Intake System whereby older adults are panelled (or admitted) to PCHs based on their place on the waiting list rather than financial status or preference, it was anticipated that there would be little difference with respect to the frailty of residents across the four settings. Furthermore, while in the U.S., differences between for-profit (proprietary) and non-for-profit (non-proprietary) facilities exist because of differences in payment systems, leading to differences in resident populations and resident outcomes with respect to quality and cost (Aaronson, Zinn & Rosko, 1994), in Manitoba, all PCHs receive funding from the same source (MHSC, 1990). In Manitoba, the level of care classification system is standardized across all PCHs (Frohlich et al., 2002; MHSC, 1990). Again, as indicated in chapter 2, PCHs provide care to frail residents with complex social, cognitive and physical needs.

Choosing the informants

Inclusion criteria for HCAs were having at least one year of employment with their current employer; being female; and having the ability to speak fluent English. The inclusion criteria were based on several considerations. The employment criterion presumed that these HCAs would be familiar with facility policies and procedures related to RCC. In their study, Bowers and Becker (1992) noted differences between junior and senior HCAs in the quality of care services delivered to residents, in their organizational style and the degree of focus on residents' care versus being task-oriented. The gender criterion reflected

the demographics of HCAs in PCHs. Most HCAs are female (Goodridge et al., 1996; Novak & Chappell, 1996; Geiger-Brown, Muntaner, Lipscomb & Trinkoff, 2004).

The ability to speak fluent English was clearly related to the need to collect accurate information. Data collection consisted of face-to-face interviews. During recruitment, it became clear that some of the HCAs who showed interest in the research, had difficulty with English. As it was, there were potentially eleven HCAs who met the criteria for inclusion. Of these eleven, one did not appear for her interview and another cancelled because of a family emergency. These individuals were not available for a second appointment. The final number of HCAs who met the inclusion criteria and who participated in the research project was nine.

This research was conducted with a convenience sample of nine HCAs who worked in the four personal care homes. Several strategies were used to inform and recruit HCAs. With the support of the PCH directors, information sessions were planned, advertised and conducted. Each formal session lasted about fifteen minutes and there were one to two more follow-up sessions. Occasionally, directors might attend a session but most often it was the researcher who introduced herself and described the study. The researcher sometimes remained at the PCH all day to be available for opportunities to speak with HCAs during breaks and at shift changes. Posters were placed on bulletin boards in prominent places in each PCH to announce the project and provide contact information to anyone who may be interested. Originally, the posters offered either individual or group interviews (that is, focus groups). This strategy was intended to provide maximum choice and meet the needs of HCAs who might prefer a private interview as well as to address the needs of HCAs who preferred a group context. In the end, all of the interviews were planned to be individually-based. However, a situation arose when an interview planned with one HCA became a two–person joint interview when a second HCA arrived to inquire about being interviewed.

Recruitment was slow moving and hampered perhaps by posters that seemed to disappear from the bulletin boards. One of the directors suggested that slow recruitment might be because many HCAs have second jobs elsewhere or other commitments after work. Also, some who might have been interested had just participated in another research project. In relation to second jobs and other commitments, Castle,

Engberg, Anderson and Men (2007, p. 202) described HCAs as the "working poor, many being single parent minorities." The Paraprofessional Healthcare Institute (PHI) suggested that these direct care workers not only have stressful jobs but that these workers do not always have the resources needed to address the sometimes conflicting demands of work and family" (PHI, 2005, p. 1.2). In this case, the director involved agreed that any HCA who wished to participate for a half hour interview could do so if they gave up half an hour of their break time. After this message was announced, four HCAs agreed to participate.

Collecting the Qualitative Data

The interview format consisted of three sections (see Appendix A), the first two sections collected quantitative data (presented below) while the last section, the interview proper collected qualitative data which is presented here.

After completing the socio-demographic questions and the MMSS, research participants participated in a taped face-to-face interview. The interview focused on open-ended questions targeted at the four elements of resident-centered care (research questions 1 to 4) plus three other general open-ended questions on work satisfaction (questions 5 to 7). The questions are given below, including the probes that were used:

1) With resident-centered care, the emphasis is on flexibility. What does flexible scheduling mean to you as a HCA? What does it mean to the way that you do your work? What does it mean to residents' quality of life? What does it mean to your work satisfaction or dissatisfaction?
2) In resident-centered care, health care aides are expected to follow residents' preferences. What does following residents' preferences mean to you as a HCA? What does it mean to the way that you do your work? What does it mean to residents' quality of life? What does it mean to your work satisfaction or dissatisfaction?
3) Resident-centered care is also about promoting, as much as possible, a homelike environment. What does creating a homelike environment mean to you as a HCA? What

does it mean to the way that you do your work? What does it mean to residents' quality of life? What does it mean to your work satisfaction or dissatisfaction?

4) Sometimes, permanent assignments are part of resident-centered care. What does permanent assignment mean to you as a HCA? What does it mean to the way that you do your work? What does it mean to residents' quality of life? What does it mean to your work satisfaction or dissatisfaction?
5) Is there anything else that you would like to tell me about what adds to your work satisfaction?
6) What takes away from your work satisfaction?
7) Do you have any other comments you want to make? Are there any other questions you think I should be asking?

The combination of these open-ended question and the MMSS closed-ended questions, some of which were modified, provided an opportunity to explore the relationship between resident-centered care and the work satisfaction of HCAs and address the four objectives of this research.

Analyzing the Collected Qualitative Data

Qualitative analysis of the open-ended interview questions (section three) aimed to generate codes from the responses and to further identify categories and prevalent themes related to resident-centered care and the work satisfaction of HCAs. This involved intense reading and re-reading of the transcripts by the researcher and the thesis chair on an individual basis and then together for comparison. The procedure was content analysis with constant comparison of the raw data and the emerging codes. Sandelowski (2000, p. 338) has emphasized that "qualitative content analysis is the analysis strategy of choice in qualitative descriptive studies."

Qualitative analysis of the open-ended interview questions (section three) aimed to generate codes from the responses and to further identify categories and prevalent themes related to resident-centered care and the work satisfaction of HCAs. The researcher relied primarily on the work of Graneheim and Lundman

(2004) and Sandelowski (1995, 2000) for the qualitative analysis of the interview transcripts with HCAs. A "rudimentary" analysis occurred when the researcher proofed the transcripts against the audio-taped interviews. Sandelowski (1995) points out that this is the time to underline key phrases and jot down ideas in the margins. The researcher and her advisor read each transcript and attempted to get an understanding about each interview before attempting to think across interviews. The initial organizing framework was the questions themselves, that is, the questions on the four elements and the broad questions on work satisfaction. Again, Sandelowski (1995, p. 375) has suggested that "data can be segmented according to the responses to each question." The data analysis procedure consisted of two levels. A first level of coding asked the question, "Does the HCA's answer have relevance?" meaning "Is it relevant to the research questions/objectives?" These questions were answered by the researcher and her advisor working separately, reading each transcript and flagging meaningful pieces of text for analysis. This followed the process of abstraction as suggested by Graneheim and Lundman (2004).

Then, each of these pieces of text was coded in relation to the four elements of resident–centred care (a= flexible scheduling; b=resident choices; c=home-like environment and d=permanent assignment) and other things that added to or took away from work satisfaction. Thus the unit of analysis became the answers to each of the questions across subjects (HCAs). At the second level of analysis, the "manifest" content of the "piece of text" from the transcript was detailed and this consisted primarily of a shortened or edited version of the wording. The "latent" content was then derived. For example, when asked what added to her work satisfaction, one HCA said, "I'm not doing this because it's my job. I feel it enhances my life." The manifest content was "not a job, enhances my life." The latent content was "having a fulfilling job." Similarly, another HCA said, "Well, I do enjoy my job, it's very enjoyable." The manifest content was "enjoy my job" and the latent content was "having a fulfilling job." Thus, having a fulfilling job included enjoying the job and having a job that enhanced life. The researcher took the first step in developing manifest and latent content with her advisor reflecting and responding to this analysis and with discussion arriving at agreement. This is a long and detailed process and lends credence to the words of Chenail (1995, p. 65) that

"qualitative research is the practice of asking simple questions and getting complex answers" and furthermore, that these complex answers require complex analyses.

It should be noted that this research asked four related questions under each element, for example under flexible scheduling: 1) What does flexible scheduling mean to you as a HCA? 2) What does it mean to the way that you do your work? 3) What does it mean to residents' quality of life? 4) What does it mean to your work satisfaction or dissatisfaction? However, in the analysis phase, it became clear that questions 1 and 2 were closely related and difficult to separate. Retrospectively, this made intuitive sense because these two questions are almost identical in substance. In addition, the relationship between questions 3 and 4 was clearly evident as HCAs responses generally drew the researcher's attention to the reality that improving residents' quality of life was a major force in HCAs' work satisfaction. So, these four questions were sometimes collapsed into two questions for subsequent analysis.

Qualitative Research Rationale

The data collection procedure used here reflected the theoretical work suggested by Lincoln and Guba (1985), Morse, Barrett, Mayan, Olson and Spiers (2002), and Sandelowski (2000). These researchers have written extensively on issues of reliability and validity in relation to qualitative research and although their terminology may differ (for example the use of terms such as "verification" versus "trustworthiness"), the core message is that qualitative researchers must attend to issues of reliability and validity with openness in the data collection and analysis process. Chenail (1995), in paraphrasing the anthropologist Gregory Bateson, has said that "it takes two studies to present one in qualitative research. One study is the 'official" research project and the other study is the study about the study." In order to present "the study about the study" and address reliability and validity, information on the data collection and analysis process must be evident.

In the 1980's, Lincoln and Guba (1985) substituted reliability and validity with "trustworthiness" and its four aspects: credibility, transferability, dependability and confirmability (Morse et al., 2002). Furthermore, Lincoln and Guba (1985) offered guidelines to establish these aspects of trustworthiness.

Building on Lincoln and Guba's work, Morse et al. (2002, p. 9) instead emphasized "verification" specifically during the data collection phase and offered this definition, "verification is the process of checking, confirming, making sure and being certain … it refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigor of the study." Morse et al. (2002, p. 11) also attended to the role of the researcher, indicating that creativity, sensitivity, flexibility and skill are critical attributes and they caution that the researcher must "be willing to relinquish any ideas that are poorly supported [by the data] regardless of the excitement and the potential that they first appear to provide." Five guidelines stipulated the verification process: methodological coherence, appropriate sample, concurrent collection and analysis of data, thinking theoretically, and theory development (Morse et al., 2002).

To begin with, methodological coherence refers to congruence between the research question and the components of the method. For this research on resident centered care, the four objectives can be rephrased as research questions. For example, the objective, "to examine the relationship between flexible scheduling of resident care and work satisfaction of HCAs working in personal care homes with residents with dementia" could be rephrased to "What is the relationship between flexible scheduling of resident care and work satisfaction HCAs working in personal care homes with residents with dementia?" And each objective/research question for this research can be directly linked with a question in the open-ended interview. Also, additional questions were asked about work satisfaction, that is, questions about what adds to and takes away from work satisfaction, in order to take a broad approach to HCA work satisfaction beyond the four elements. These questions gave the researcher an opportunity to go beyond the modified MMSS and to better understand what work satisfaction means to HCAs. The questions also provided an opening to pursue additional questions and probes if the answers warranted further examination. The analytical procedure was based on the framework of the four elements of resident-centered care and the related questions and responses. In reviewing the transcripts, when a HCA talked about something related to following resident preferences in relation to the question about flexible scheduling, that piece of the transcript was folded into the analytic process related to resident preference. In fact, it was difficult at times

to separate these two elements because they can be interconnected, especially because flexible scheduling often involved resident preferences but resident preferences did not always relate to flexible scheduling.

The second guideline is that the sample must be appropriate, "consisting of participants who best represent or have knowledge of the research topic" (Morse et al., 2002, p. 12). The research objectives on the four elements could have been met by asking personal care home directors about resident-centered care and work satisfaction of HCAs. However, for the purposes of understanding the perspective and giving voice to HCAs, asking directors would be inappropriate. Also sampling was a two stage process where first, the researcher had to be confident that the four personal care homes met the criteria of holding a resident-centered care focus. After that, the second stage was to recruit HCAs. Clearly, the nine final subjects are HCAs who agreed to participate, that is, they self-selected themselves into the study for some reason. It is regrettable that the following question was not asked, "Why did you decide to participate in this study?" because it would have provided information on their motivations and reasons for self-selection.

The third guideline is that data are collected and categorized concurrently. This allows the researcher time to examine collected data and modify or add questions. The questions were pre-tested for clarity and coherence with HCAs who were colleagues of the researcher. Their feedback was very helpful. However, during the first few interviews with the nine HCAs, it became clear that although there was no question that asked about how HCAs understood the term "resident-centered care," it was essential to have this question formalized in the interview. It followed that six HCAs were asked about the concept of resident-centered care, of which four answered the question and of these four, only one demonstrated a complete understanding of the concept of resident-centered care. The other three HCAs demonstrated a partial understanding of resident-centered care. During early data collection, the researcher and her advisor would discuss what HCAs were saying and even at that point, would begin to think about preliminary categorization and emerging themes. However, the formal analysis process did not take place until after all data were collected.

Another issue that arose during data collection meetings was the interconnectedness of the elements of flexible scheduling and resident preferences, with the decision to attempt to focus questions as

much as possible with probes and to deal with overlap at the analysis phase, as needed. Similarly, promoting a home-like environment and permanent assignment did relate to HCA work satisfaction but were much more removed from their ability to control in a care provision capacity, unlike the elements of flexible scheduling of care and following resident preferences. For this reason, HCAs struggled more with questions related to home-like environment and permanent assignment and the researcher had to provide more guidance and prompts in relation to these two elements.

The fourth guideline is about thinking theoretically, that is, as ideas emerge, they are reconfirmed in new data and a cycle of ideas and confirmation continues. According to Morse et al (2002), this means taking a macro-micro perspective, but moving forward in small steps, checking and rechecking in order to build a solid foundation. For this research, the researcher fed-back to HCAs what she thought they were saying and this is sometimes referred to as "member checking." It means that clarification occurs throughout the interview as well as at the end of it. For example, in asking about resident preferences, it became clear that residents with severe dementia cannot express a clear preference. One HCA said, "Their [resident] ability to really make decisions on how to wash and, or to do it properly or how to pick clothes out and put them on the right way are, you know, the majority don't have that ability." The researcher responded, seeking clarification regarding the identity of the decision-maker, asking, "So, the decision to have care provided in this way is, who has decided that this is the way that care is provided? Is that the health care aide's preference? Is that the manager, the director of care [who decides]?" This interaction between the HCA and the researcher at the micro level raised a macro question and that was "does resident-centered care in relation to resident preferences have limited applicability in situations where residents, for whatever reason, have lost the ability to make decisions?" This research was not designed to answer this question but it creates a new context for asking and understanding other questions and answers.

The final guideline is that of theory development and it tends to be an outcome of the research process rather than a means of moving analysis along and it may lead to further development of already existing theory (Morse et al., 2002). For this research, there was no current theory of resident-centered care but there was a framework of four elements. Similarly, there has not been theoretical development of a

model of work satisfaction of HCAs although, there are factors associated with their work satisfaction, most of which are intrinsic factors (e.g. positive experiences with residents and co-workers, feeling valued, etc.). Theory development was not a major goal of this research. In fact, even with this research and the subsequent findings (chapter 4), it seems likely that more research will be needed to build a theoretical framework. These then are the five guidelines for verification as outlined by Morse et al. (2002).

Conclusion

This chapter presented information on the qualitative and quantitative research methods employed in this research. The material presented described the qualitative data collection and analysis methods, and the rationale for using the instruments used to measure HCAs socio-demographic and work characteristics, work satisfaction and perceived connection between work satisfaction and resident-centered care. The questions and tools outlined here are available in Appendix A. The chapter culminates in a description of the research analysis process including steps taken to address rigor in relation to Morse et al.'s (2002) strategies to ensure verification, including: methodological coherence; appropriate sample selection; concurrent data collection and analysis; thinking theoretically; and moving toward theory development. The process of analysis was based on Graneheim and Lundman's (2004) guidelines and relied on the theoretical work of Sandelowski (1995, 2000). The subsequent chapter provides the presentation of findings based on this methodology.

CHAPTER FOUR – FINDINGS

This chapter presents the findings, beginning with a description of the social and work characteristics of the sample of nine HCAs. Quantitative results from the McCloskey-Mueller Satisfaction Scale (MMSS), focusing on items of work satisfaction and dissatisfaction of HCAs, are presented next, leading into the qualitative findings from the questions on what added to, or took away from, work satisfaction. The third and major portion of this chapter presents the qualitative findings on HCA perceptions of resident-centered care and the findings that emerged from the questions on the four elements of resident-centered care and the relationship between these elements and the work satisfaction of HCAs.

The questions coming from the four objectives are:

1) What is the relationship between flexible scheduling of resident care and work satisfaction of HCAs working in personal care homes with residents living with dementia?

2) What is the relationship between following residents' preferences for care and the work satisfaction of HCAs working in personal care homes with residents living with dementia?

3) What is the relationship between promoting a home-like environment and the work satisfaction of HCAs working in personal care homes with residents living with dementia?

4) What is the relationship between consistency of care through permanent assignment and the work satisfaction of HCAs working in personal care homes with residents living with dementia?

The final section is a summary of the chapter.

QUANTITATIVE AND QUALITATIVE FINDINGS

Quantitative Findings

The social and work characteristics of health care aides

All of the HCAs completed a short series of questions related to their social and work characteristics. The social characteristics questions asked about their place and date of birth, self-identified ethnicity, highest level of education and other courses or training. The work-related questions asked about training and experience as a HCA, including years of service, number of personal care homes worked in,

and number of years at their current place of employment. The final work-related questions were about the number of residents regularly assigned to them and the frequency of changing resident assignment.

The nine HCAs worked in four personal care homes. They were female and ranged in age from 37 to 55 years of age, with an average age of 41. Six of the nine identified themselves as born in Canada, two were born in the Philippines and one declined to answer the question. Their level of secondary and post-secondary education ranged from Grade 10 to the completion of a university baccalaureate degree. Two of the HCAs provided information on work-related courses that they had completed. These courses include Non-Violent Crisis Intervention, Cardio-Pulmonary Resuscitation, First Aid, Palliative Care Certificate, and a number of union-based steward and leadership training courses.

All of the HCAs had achieved certification from a *bona fide* educational institution and seven of them indicated the year of certification. Two of the seven had achieved certification since 2001 while the other five had received their certification between 1986 and 2000. All of the HCAs reported that they worked as HCAs after attaining certification, with the average number of years worked as approximately 9 years (range of 3 to 20 years). Eight of the HCAs indicated the number of PCHs in which they had worked. Four of the eight had worked in only one PCH, their present employer. The other four HCAs had worked in from two to seven PCHs. The nine HCAs had worked at least 3 years with their present employer and two reported working more there than ten years. This fit well with the inclusion criterion of being employed for at least one year in their current workplace. All nine of the HCAs worked during the day shift, with six of them working the day shift only. The remaining three participants worked alternating day and evening shifts or alternating day and night shifts.

In answer to the questions related to resident assignment, eight of the HCAs indicated that they have resident assignments ranging between seven to thirteen residents each. Four of the eight HCAs had an assignment of twelve to thirteen residents (1:12 or 1:13 ratio). The other four HCAs reported having assignments of between seven to ten residents. The remaining HCA has a special assignment in her PCH so her ratio was lower. Of those HCAs (eight) with resident assignments, the majority (seven) have regular rotations, meaning that they will be assigned to a particular unit or section of the PCH. These HCAs

reported that the frequency of rotation across resident groups varied between daily, weekly, bi-weekly, monthly or tri-monthly. What this meant was that only one of the eight HCAs has a permanent assignment to a specific group of residents. This finding clearly had implications for the research objective based on permanent assignment and work satisfaction.

To summarize, the profile of the nine HCAs who participated in this research depicts a group of varying age with the majority having Canada as their birthplace. All have achieved certification as HCAs and have work experience in one or more PCHs with most having worked for at least three years in their current PCH workplace. Generally, they are long-term employees with most remaining at only one PCH, some as long as 12 or 15 years. All of the participants work the day shift, though some have rotating shifts requiring that they work a portion of their hours on the evening or night shift. The majority of HCAs have rotating resident assignments and most have approximately 12 to 13 assigned residents on the day shift. Only one HCA had a permanent assignment to a specific group of residents.

Health Care Aide Work Satisfaction and the McCloskey-Mueller Satisfaction Scale (MMSS)

As described in chapter 3, the MMSS originally had been designed to measure work satisfaction among Registered Nurses and thus, it had to be modified to better fit the work context of HCAs. The MMSS has eight sub-scales (extrinsic rewards, scheduling, family/work balance, satisfaction with co-workers, satisfaction with interaction opportunities, satisfaction with professional opportunities, praise/recognition and control/responsibility) for a total of 31 items that together measure general work satisfaction. For this research, one question was added to the end of the tool and it asked about overall work satisfaction. The remainder of MMSS questions modified for this research mainly entailed subtle changes in wording to reflect the work environment of HCAs rather than that of registered nurses, the subjects of the original questionnaire. Respondents answered each question using a five point Likert scale: “very satisfied,” “moderately satisfied,” “neither satisfied nor dissatisfied,” “moderately dissatisfied” and “very dissatisfied.” It should be noted that HCAs tended to choose “neither satisfied nor dissatisfied” when the questions were not applicable to them. This had implications for the relevance of the responses.

The univariate (frequency) analysis of the MMSS indicated a range of responses across satisfaction and dissatisfaction choices and a decision was made to collapse the two satisfaction categories (very satisfied and moderately satisfied) into “satisfied” and the two dissatisfaction categories (very dissatisfied and moderately dissatisfied) into “dissatisfied.” This was done in order to cluster the HCA responses into the two major distinct categories of satisfaction and dissatisfaction. Once categories were collapsed, each cell that contained a majority of HCA responses, that is, at least five of the nine HCAs, a clearer picture of areas of work satisfaction and dissatisfaction became evident. As indicated earlier, the MMSS has eight subscales containing two to five items. Except for the subscale of extrinsic rewards (with items on salary, vacation and benefits), and satisfaction with co-workers (with items on satisfaction with other HCAs and with nurses), the clustering of responses did not completely represent any other subscale. It should be noted that the two MMSS items on satisfaction with co-workers were modified for the purpose of this research from focusing on the nursing peers and physicians to work satisfaction with other HCAs and nurses.

Of the 31original MMSS items, five or more HCAs were clustered in categories of satisfaction for ten items, dissatisfaction for one item and neither satisfied nor dissatisfied for five items. The remaining items (n=15) showed no distinct clustering. Six of nine HCAs indicated satisfaction with the added item of “overall satisfaction.”

In Box 4-1, the “satisfaction” items are followed by the number of HCAs who expressed satisfaction. Not completely surprising is that most HCAs are satisfied with salary, vacation and benefits. Although more money and benefits are desirable for most occupational groups, the salary, vacation and benefits are likely similar across PCHs, lending a stabilization of salary and benefits for HCAs in Winnipeg that might promote a feeling of equity and possible satisfaction. The situation in the Winnipeg Regional Health Authority is that some PCHs are unionized and others are not. However, after the collective bargaining process is completed at the unionized PCHs, the non-unionized ones tend to follow suit with similar salary, vacation and benefits packages. These three items (salary, vacation and benefits) comprised the MMSS subscale of extrinsic rewards.

Four of the five items related to scheduling were rated by HCAs as satisfactory in their current job: the hours worked; flexibility in scheduling hours; opportunity to work straight days; and flexibility in scheduling weekends off. It would seem that there is some overall flexibility in scheduling or perhaps, re-scheduling days and shifts. Work satisfaction has been associated with satisfaction with work schedules (Baumann, 2007; Wilkins et al., 2007). The one dissatisfaction item, "compensation for working weekends" may be related to a policy of low compensation for working weekends at the four PCHs. Five HCAs reported dissatisfaction for this item.

One of the four items from the MMSS "praise and recognition" subscale was rated as satisfactory by HCAs, satisfaction with "your immediate supervisor." The literature on work satisfaction and HCAs emphasizes the importance of leadership and having stimulating and respectful leaders (Hoffer et al., 1997; Ross et al., 2002; Marquis et al., 2004). It should also be noted that the other two items in the praise and recognition subscale ("recognition of your work from managers/directors" and "recognition of your work from other HCAs") presented no apparent pattern with the nine HCAs being almost equally distributed across the satisfaction and dissatisfaction responses. It may be that the immediate supervisor is the most important entity in relation to praise and recognition.

Two MMSS items are related to satisfaction with co-workers: feeling satisfied with "your work with other HCAs" and feeling satisfied "with the nurses you work with." Both of these items were rated at satisfactory by five or more HCAS. Again, the general literature on health care workers (nurses, HCAs and others) affirms the importance of teamwork and team spirit in work satisfaction (Brannon et al., 1990; Chou et al., 2002). One item related to the subscale of "professional opportunities" was rated as high satisfaction and this item had been tailored to fit the context of HCAs. The item was "opportunities for continuing education, e.g. workshops" and certainly access to training and staff development programs has been identified in relation to work satisfaction (Chappell & Novak, 1992; Waxman et al., 1984). Finally, as indicated earlier, the item that asked HCAs about overall satisfaction in their current job was rated as satisfactory by six of the nine HCAs.

Looking to items that were rated as "neither satisfied nor dissatisfied" by the majority of HCAs, there were five. Two of the three "balance of family and work" subscale items were rated as neither satisfied nor dissatisfied and were probably not applicable to this group whose average age was 41 years old. These items on satisfaction with "maternity leave" and "child care facilities" were marked neither satisfied nor dissatisfied by seven and five HCAs respectively. The last three items marked by a majority of HCAs as neither satisfied nor dissatisfied were "opportunities for social contact with your co-workers after work" (MMSS "satisfaction with interaction" subscale), and "opportunities for career advancement" and "opportunities for union activities" (two modified MMSS items from the MMSS "satisfaction with professional opportunities" subscale). For the first one, it may be that work and home demands make seeing one's co-workers outside of the work setting a rare occurrence or simply with the amount of time spent with co-workers outside after work is not highly satisfactory or unsatisfactory. The second item on career advancement is difficult to interpret. It may be that career advancement is not of interest or that it is not possible in general or within the current job setting. The third item relates to participation in union activities and because this is a voluntary decision, it may be that most choose not to participate and therefore, are neither satisfied nor dissatisfied with the opportunity in their current job. Alternatively, for those to whom this may have mattered, perhaps they already were participating in union activities and were satisfied with their participation.

The MMSS results suggest that the majority of HCAs are (overall) satisfied in their current job and that salary, benefits, flexible scheduling, immediate supervisor and co-workers and continuing education reflect aspects of work satisfaction. Some items in the MMSS may not be relevant to this sample of HCAs including maternity and child care benefits, interaction with co-workers after work, career advancement and union activities.

One area of dissatisfaction was the lack of compensation for working weekends. The findings from the MMSS fit with the literature but require speculation with further testing. A notable absence in the MMSS is an item that reflects HCA satisfaction with providing care to residents. The literature emphasizes the value that HCAs place on the care that they provide to residents and the relationships that they feel they have with

residents (Caudill & Patrick, 1992; Garland et al., 1988). The MMSS captured some aspects of work satisfaction of HCA while missing others. During the interviews, HCAs were asked about what added to and what took away from work satisfaction and this qualitative analysis follows.

Qualitative Findings

Health care aides and work satisfaction: Analysis of open-ended questions

There were two open-ended questions on work satisfaction. One asked about what added to work satisfaction and the other asked about what took away from work satisfaction. Not surprisingly, for things that added to work satisfaction, the lack of these things took away from work satisfaction. The things that were identified by HCAs could be categorized as being related to relationships with residents, families, co-workers and management and those that had to do with feelings of value and the opportunity to achieve personal growth and feelings of security, fulfillment and choice.

"What adds to your work satisfaction?"

In relation to things that HCAs identified that added to their work satisfaction, the four major categories were: relationships with residents, relationships with co-workers, relationships with management, and having opportunities to achieve personal and professional goals. This certainly reflects the literature that suggests HCAs receive the greatest work satisfaction from providing care to residents and having good relationships with residents (Anderson et al., 1991; Brannon et al., 1990; Caudill & Patrick, 1992). HCAs provided several examples of the link between their work with residents and their work satisfaction. There were three categories under the theme of "relationships with residents" (see Box 4-2): "rewarding relationships with residents," "putting the needs of residents before mine" and "meeting residents' social and emotional needs." In terms of "rewarding relationships with residents," two HCAs stated:

> "But really, it's giving a smile to the residents and, 'Hello, how are you? It's good to see you'. And I do that and I enjoy it. And I cannot say, I do have nice co-workers and the nurses by and large, well 'so so'. I mean, really, it's the residents that give me work satisfaction." (HCA#5)

> "Well, it makes you feel good because you are making them feel good. That's the reason you got into the job." (HCA #2)

In order to meet the care needs of residents, HCAs sometimes "put the needs of residents before their own" and go beyond the call of duty by missing breaks or adding unpaid time to their day.

> "I missed many, many a break just to make sure my residents are taken care of. They come first. To heck with my break. I'll grab a piece of toast or something. That's good enough. I'm on the go." (HCA#2)

> "Like I'm here earlier than 7:15 and I actually do, do a few things [for the resident] before I technically start. That's my own choice." (HCA #8)

HCAs talked about going beyond the job description of providing physical and personal care and addressing the "residents' social and emotional needs." One HCA described her taking a resident outside and into an attached courtyard for a cool drink. This was more than making sure that the resident was hydrated, it was doing something special for the resident. And another HCA stressed the importance of emotional needs.

> "We have a nice courtyard. And even just, you know, you make them a little drink with a little umbrella in or something. Just anything. Just to make them feel a little bit special for a few minutes, that's the key. They may not remember what you did but they remember that feeling, I'll tell ya." (HCA #3)

> "…[the residents] depend on us. And we are thankful because they trust us, you know for giving them the care. And like, to support their emotional needs." (HCA #7)

The second category of items that add to work satisfaction was grounded in teamwork and was titled, "relationships with co-workers." Two themes emerged from the transcripts: "supportive work relationships" and "working with competent co-workers." The context of "supportive work relationships" held elements of working smoothly together and liking to work together. Again, the literature supports the notion that work satisfaction is closely linked with good working relationships with other health care providers (Brannon et al., 1990; Chou et al., 2002). Supportive working relationships were cited by several HCAs.

> "If you've got a good team that you're working with and everyone gets along and likes each other, trust me, it makes things easier." (HCA #2)

> "I mean I do have some issues with some of my co-workers. But, in general, we really, in the end, are a good group of workers when you look at the conditions [current situation of "upheaval"] that you work under." (HCA#4)

> "It makes a big difference. The people you work with. Teamwork." (HCA #8)

The concept of competence among co-workers was also cited as important to work satisfaction. Competence might mean skill-based competence or it might relate to knowing the residents of the unit.

> "The second person that you working with, it sure helps if you, if the person knows the floor. It's a big, big help. And if she or he doesn't, a lot of it falls on you. And it can be a very, very pressuresome day." (HCA#5)

> "… a change for the better is if, when you work with other health care aides and that who again are there, we're all here, the four of us are here so [a resident] needs the extra help. They'll come over and help you. It none of this "well [that is] your resident," that kind of stuff." (HCA #6)

The third category of items related to work satisfaction was "relationship with management" and the two themes in this category were: "having input into decisions involving my work" and "receiving praise and recognition." Certainly the literature speaks to the importance of supportive leadership, organizational support, and workplace recognition and respect in relation to work satisfaction (Baumann, 2007; O'Brien-Pallas & Bauman, 1992; Wilkins et al., 2007). Similarly, HCAs indicated the presence of these positive organizational attributes in relation to work satisfaction.

> "…we're pretty open around here, you know. Like we can pretty much say anything to the boss. Like if there's new ideas coming along or something, she pretty much involves us…so we have a lot of say…I think bottom line, it would be her decision but it's kept pretty open . The communication is pretty open." (HCA#3)

> "[In this PCH] there's no power tripping and control you see in a lot of workplaces." (HCA#6)

In terms of receiving praise and recognition, two HCAs described the value of a "pat on the back" and feeling respected for the good work being done.

> "A pat on the back every once in a while. I like it when someone walks up to me and says, 'You did a good job today'." (HCA#2)

> "Satisfaction is just like…the nurse manager's saying you're doing a good job. It's just like. Or your other health care aides saying 'you're a good buddy'." (HCA#9)

The final categorization of things related to work satisfaction is "having opportunities to achieve personal and professional goals" and there were three themes in this category: maintaining personal values; having a fulfilling job; and maintaining good mental and physical health. Lowe (2006) described healthy workplaces as ones that enable staff members to achieve their personal and professional goals. Marquis et

al. (2004) also suggested that work environments in which staff felt "a good match" between personal and organizational values regarding care were associated with work satisfaction and loyalty to the organization. The "personal values" that HCAs espoused related to their placing themselves or their family members in the place of the residents for whom they provided care.

> "I do my work on how I would like somebody to treat my Mom. I try to do the same thing." (HCA#1)
>
> "See, I work at this. I know how I want to be treated. I want someone who can have fun and smile and that's how I'm going to treat somebody else. I want to be treated with respect therefore, I am going to treat them [residents] with respect. My grandmother raised me, and she taught me to respect my elders and therefore the whole place is my elders so I respect them. "(HCA#2)
>
> "…I really work that way I want to be treated. The way I want to be washed." (HCA#5)

The theme of "having a fulfilling job" was evident from several of the HCAs and was related to pride in the work, the place of the work in their lives and the rewards and fulfillment of working with older vulnerable adults.

> "I'm not doing this job because it's a job. I feel that it enhances my life." (HCA#2)
>
> "There's a lot of rewards. When I go to work in the morning, maybe some of the girls that have worked so long are exhausted. But I will say that I do not dread going. And you know why? Because I love the people." (HCA#5)
>
> "[I] had a dilemma. [I was] offered another position with more money and less work. I really struggled with it, but in the end, no. [I] had to stay because you've that whole bond thing with residents that you don't get in the hospital because they're there and gone." (HCA#3)

The theme of "maintaining good mental and physical health" related to HCAs taking care of themselves, thinking positive and using laughter as a positive outlet.

> "Look after your body, look after yourself, that's what I try to do." (HCA#6)
> "It's a very physical job and you know, if you do something wrong and touch wood I've never had any. You only get one back." (HCA#8)
>
> "You should still be able to laugh. You know they say 'laughter is the best medicine' for a reason…" (HCA#8)

To summarize, the things that HCAs identified as adding to their work satisfaction were remarkably coherent with the literature on factors associated with work satisfaction. They spoke positively of their relationships with residents, co-workers, management and having opportunities to achieve personal and

professional goals. The primacy of satisfaction is providing good care to residents is a category in itself but also underlies HCAs' positive relationships with co-workers and management and their desire to achieve personal and professional goals.

"What takes away from your work satisfaction?"

When asked what took away from their work satisfaction, HCAs responded with several things, many of which were the "other side of the coin" for things that added to their work satisfaction. For example, relationships with residents, co-workers and management were also cited as taking away from work satisfaction. Relationships with families were sometimes cordial and respectful but more often were presented as difficult situations. However, throughout the transcripts even when HCAs were talking about the negative aspects of their work, the primacy of good, safe and loving care to residents was evident. The four categories of things that took away from work satisfaction were: relationship with residents, relationship with families, relationship with co-workers and relationship with management.

The four themes contained with the category of "relationship with residents" are: dealing with difficult residents, residents' quality of care, residents' quality of life and grieving the death of residents (see Box 4.3). As noted earlier, the resident profile in PCHs is one of older adults who are physically and cognitively frail. And associated with cognitive limitations are expressions of anger, frustration and sometimes verbal and physical abuse aimed at health care workers in general and at HCAs specifically because they provide the majority of personal care and support (Morgan et al., 2002). Although the HCAs are upset by the difficulties presented by some residents, there is also a notion of not blaming and forgiving the residents.

> "When your residents are being pleasant and enjoying their day, you want to go out of your way even more than you normally would. Once they start striking out or yelling at you, you do what you can for them, either way." (HCA#2)
>
> 'If they are going to yell at me, I'll stand there and let them and then I'll say 'Are you done now? Do you feel better?' and usually they say 'yes'. That's the way I was raised. I love the elderly." (HCA#2)

> "What takes away from my job satisfaction? …well sometimes the ones where you try to everything that you can for them and it's just not enough. And you don't know what you can do to make it any better. You know, sometimes you just give up." (HCA#8)

The theme of "residents' quality of care" has some overlap with the later theme of "inadequate resources" but the quality of care theme focuses more on "people" resources for residents. One HCA spoke about not having time to spend with a resident to provide care and another about the need for more recreation activities.

> "I would have a little more staff on so there's more time for one-on-one. Sometimes you would just like to spend that extra few minutes visiting. You don't always have it." (HCA#3)

> "A little more money for recreation so that their activities could be a bit broader, you know, a few more trips, things like that. They all cost money. It's recreation that's the big one. And everything costs money so it's limited. Unfortunately." (HCA#3)

Connected to the theme of "quality of care" was the theme of "quality of life" but this quality of life related more to issues of loneliness and lack of family contact. This was difficult for HCAs to deal with and was of course, totally out of their control to change.

> "Holidays and birthdays, we get a lot of families visiting, but otherwise they don't and it's sad. That's the sad part of your job. You see the people [residents] everyday and they have no visitors." (HCA#2)

The last theme for "relationship with residents" was "grieving the death of residents" is noted by Teresi et al. (1993) and Gnaedinger (2003). HCAs spoke quite lovingly and compassionately about the loss of a resident. The literature does speak of HCAs' thinking of residents as "family" (Secrest et al., 2005) or extended family (Marquis et al., 2004) so it is not surprising that the death of a resident will have an impact on the thoughts and feelings of the HCAs who felt close to this person.

> "You can't help it. And when they pass away, it hurts so bad because they become like family. When you come back and they're gone, you say, 'My God, I never got to say good-bye!' You don't like to see them suffer but you remember them when they were walking down the hall, and it hurts. It's hard. I cut out the clippings of their obituaries now, because I knew that person." (HCA#1)

> "The hardest things [in my job]? When they get sick. When they die. Yeah, that's very very hard…It's just hard. Actually, you know, we could do more debriefing and things. I think that would be something that would be maybe helpful. I can't say for sure. But I would almost think that it would be." (HCA#3)

One of the HCAs also talked about losing a resident but the loss was through transfer to another PCH and not because of death.

> "Losing a resident. That's the biggest thing. And not just to death. There are those [residents] where this might be a stopover. This might not be their first choice of home. They have been here for six months and then they leave… You lose them in different ways." (HCA #2)

The second category related to job dissatisfaction was 'relationship with families" and although there was some positive comments made by HCAs about families, most of their comments were critical and especially in relation to how family members affected their work. When families complained about care, HCAs said that their managers did not always support them.

> "I find working with families very stressful, actually. Not the families per se, but if you doing something and the family is here and they need something, they expect you to drop what you're doing and who you're doing it with and go to their family member. It's hard to make them understand that you have 25 people that you're taking care of and they aren't the only person. I mean I would want my Mom taken care of, too, but my Mom isn't the only one here." (HCA#1)

> "Because sometimes when the family complains, and then she's [the nurse manager] gonna talk to us. Then we are going to tell her how the family is - because of like this and like that [the family is not satisfied with care]. And then she [the nurse manager] won't say anything. It's just like it's a blank. It's like you can hear a pin drop." (HCA#9)

The third category in relation to job dissatisfaction is "relationship to co-workers" and just as a positive relationship, trust and value can add to work satisfaction so can the lack of these attributes in the workplace take away from job satisfaction. The problems presented by HCAs related to co-workers such as other HCAs and nurses, and were grounded in personal or work-related situations. Problems with teamwork and poor supervision are detriments to work satisfaction (Brannon et al., 1990). This category contains three themes: problems with other HCAs, lack of teamwork and problems with nurses. "Problems with other HCAs" was often related to situations where another HCA was not performing adequately or appropriately but there were also situations that seemed based in personalities.

> "And the other thing is, unfortunately dealing and working in a facility that's 98% women is just a little difficult because of the gossiping and the backstabbing…It's the cattiness and the immaturity and it's just, it's really bad. I mean it is in a lot of work places… I mean women are great and everything but it is different." (HCA#4)

> "And sometimes I can be a little bit unkind to my co-workers. To the person I work with. It shouldn't be. I mean I try to be nice at all times but she [another HCA] was sitting on her cell

> phone instead of working. Instead of going to the nurse, I just said 'you know what'. This happened this weekend. I say, we have lots to do. I mean she sits on her cell phone in the bathroom." (HCA#5)

The theme of "lack of teamwork" and helping each other related to HCAs' confirming that when each member of the team does not contribute, it creates problems and work dissatisfaction.

> "Sometimes if I leave a resident to go on my break. When I come back, they're right where I left them and nobody has done a darn thing. That's 15 minutes they [other HCA] have been there." (HCA#1)

> "I've worked with people [HCAs] who, they just stay strictly to the residents [assigned to them]. They don't go and help unless you go and ask them. They don't come volunteer. Their work may be all done. They don't go to see if anybody else needs any help. Those are frustrating days." (HCA#8)

The third theme, "problems with nurses" is related to the idea of lack of teamwork but it focuses on nurses, specifically and this might mean RNs or LPNs. In most PCHs, RNs and LPNs might provide some direct care to residents but it is stipulated that only RNs and LPNs can write nursing notes on the resident's record or administer medications. Clearly, they are providing direct care much less often compared with HCAs.

> "If it weren't for us, they [nurses] wouldn't know half of what was going on with the residents, but they [nurses] talk down to us. They make me feel inferior." (HCA#1)

> "It's sad looking at what's happened to nurses. And yes, there is a high level of paperwork and there is a lot of demand, but there's also a time that you [should] still remember that this is a human being that you're dealing with. And you don't just rip the door open. And you don't just put their pills in their mouth… They're pushing pills and they're basically glorified ward clerks at this point." (HCA#4)

> "Sometimes, it's frustrating that you're trying to do a lot of things and the nurses are sitting behind the desk. That's frustrating. And, you know, I realize they have some things to do, but, you know, come help us too." (HCA#8)

The fourth category of things that take away from HCA work satisfaction is the relationship with management and there were four themes: lack of adequate resources, lack of praise and acknowledgement, lack of support and good supervision, and lack of input on decisions affecting one's work. Lack of adequate resources included lack of human resources as well as lack of basic amenities, supplies and equipment. The literature on health care workers has cited the vicious circle of personnel

shortage, increased workload, work dissatisfaction, staff turnover leading to personal shortage and so on (Baumann, O'Brien-Pallas & Armstrong-Strassen, 2001). One HCA described the implications for resident care in the midst of shortage and increased workload in her PCH.

> "With one breath, they talk about residents' rights and with the other breath, they're talking about saving money in all kinds of ways. To me, they are contradicting themselves. When you are short-staffed especially, it's very hard on the residents and us, too. When a resident has to go to the bathroom, and you're short-staffed, you just can't get to them fast enough. Then that upsets them, as it would you." (HCA#1)

> "…I'm in an older facility, we've had problems. No hot water and stuff like that. That can be very disheartening when your [resident] is in the tub and you don't have the proper temperature. The people [residents] start to cry. And you can't do your baths and they want their baths." (HCA#5)

The theme, "lack of praise and acknowledgement" was evident in the transcripts. The importance of support, praise and recognition in the workplace has been highlighted in several documents and in the research literature (Leiter, 2006; Gagnon et al., 2006).

> "…they are so quick to judge you if there is a brief on the floor or the laundry isn't put away. They don't commend you often enough for the good things you do. They focus on the negative. All those petty little things. They don't seem to notice how much time you are putting in on the floor or all the extra things you do. They should be noticing all these other little things, too." (HCA#1)

> "And you know what, sometimes management, sometimes they're, well, they're not exactly the ones paying you the compliment." (HCA#5)

HCAs also noted instances of lack of management support and good supervision. This concern was seen at the unit level and all through the organization. Ross et al. (2002) reported that health care workers recommended several actions for improving the work environment including actions to increase peer cohesion and supervisory support. HCAs in this research were critical of poor supervisors and they also spoke of the need for leadership on pressing issues in care.

> "…sometimes things that aren't being done on the floors the way they should be. And I may go, report it to a nurse and they kind of just [say] "We'll I know", you know. "Yea, what are we going to do?" …well, they're called supervisors. They're getting paid to do their job. They're not doing their job." (HCA#6)

> "There's a lack of participation with your nurses, your charge nurse, your clinical coordinator, your administration. Because they're not following through on their job in setting out priorities or helping with issues that come forward. It just allows this [lack of supervision] to continue and snowball and so that you taking out on each other as HCAs." (HCA#4)

> "What takes away from my work satisfaction is the frustration of things not being followed through on and not being dealt with. That just, if there's an issue, let's get down and dirty and deal with it. And not, you know, quit passing the buck and trying to ignore the issue or the issue will go away. Like just be up front about it." (HCA #4)

The final theme under the category of work dissatisfaction and "relationships with management" was "lack of input on decisions affecting my work" and this sometimes is related to resident safety, such as the policy for transferring residents from bed to chair or other transfers. This policy statement is based in the Winnipeg Regional Health Authority rather than in individual personal care homes but nevertheless, it would seem that these policies are sometimes not adhered to and other times, rigidly adhered to, leading to some confusion about their worth and rationale. Connected to this is the feeling expressed by one HCA, indicating that policies on transferring or lifting residents must be based in adequate staffing and in the absence of adequate staffing, the HCA must make difficult decisions.

> "And I mean you're [HCAs] capable of making … most of the HCAs are capable of making that decision of who really is at risk or who's not. And you should be able to make that decision. Or else put more people on the floor then at that time so they can watch people, put them up and down on the hydraulic [lift]." (HCA#4)

> "…to have the speed they [management] want…it's sometimes very difficult. That you end up transferring where you should be using a 'sit-to-stand' just to accommodate, to save yourself a minute or two. [And I am waiting for a second person to help me with lifting the resident using the mechanical lift.] … I keep calling him and maybe…he can't come. I feel I have a time limit too. …I could get…fired if you transfer by yourself." (HCA#5)

To summarize, HCAs indicate several things that took away from their job satisfaction. These invariably related to the people to whom they provided care to or with whom they worked. Their relationships with residents can be difficult in the face of verbal and/or physical abuse and high demands, and their desire to provide and promote quality of care and life in times without adequate resources and support. Of note were the expressions of sadness around the loss of residents through transfer or death. HCAs spoke of working with difficult families and problems with co-workers and how this affected their work satisfaction. Their relationships with management had an underlying frustration that is based on the tone of the statements and this of course, is not always captured in the paper-based transcripts. Health care workers who feel that they lack input into decisions that affect their work and who see a lack of support, good

supervision, and inadequate resources leading to high workload coupled with lack of praise and recognition are likely to seek a healthier workplace for their skills.

Work Satisfaction and the Four Elements of Resident-Centered Care

This section presents the findings from the four research objectives. However, to place these findings in context, it is necessary to first review how HCAs viewed the concept of resident-centered care. When field research began, there was no question asking HCAs about their meaning of the concept, "resident-centered care." After completing a few interviews, it became apparent that asking this question was essential to ensuring what some qualitative researchers have called the trustworthiness of the data (Lincoln & Guba, 1985) and others have called "verification" (Morse et al., 2002). In short, there needed to be consistency on what was meant by resident-centered before proceeding to ask about the four elements of providing flexible scheduling of care, following resident preferences for care, promoting a home-like environment and providing continuity of care through the permanent assignment of HCAs.

Of the nine participants in this study, only six were asked about the meaning of the concept "resident-centered care." Of the six asked to describe this concept, only four answered the question directly, and of these four, only one demonstrated a complete understanding of resident-centered care. The other three HCAs described separate components of resident-centered care. The components they identified include:

- HCAs are the immediate "hands-on" care providers and have assigned residents,
- Looking after each resident's individual needs,
- Dressing, washing and looking after residents the way they like,
- Involves all aspects of care,
- Residents as the focus of why we are all here,
- Residents depend on HCAs for all their personal care and emotional needs, and

- Residents are in the PCH for HCAs to clean, dress and give them proper care, and for HCAs to give what they need for daily living they are unable to provide themselves.

To summarize, the components of resident-centered care identified by these HCAs are: individualized care, care focused around residents needs, resident assignment, respect for individual preferences, meeting physical, social and emotional needs, residents as dependent on others to provide what they can no longer provide for themselves. The one HCA that demonstrated a more complete understanding of resident-centered care described it as:

> "Resident-centered care should be what is best for the resident; their needs are [our] first priority and work organized around that." (HCA#4)

The fact that only one out of six HCAs asked to describe resident-centered care demonstrated a more complete understanding of the concept suggests that there may be less understanding about resident-centered care among HCAs than was anticipated at the onset of this research. While some of the HCAs demonstrated an understanding of some components of the concept, these findings suggest a need to educate HCAs about resident-centered care.

Objective #1: Flexible scheduling and health care aide work satisfaction

Across the four PCHs, there was a range in the flexible scheduling of meals, bath and other activity choices that were available to residents. The PCH may indeed have resident-centered care and flexible scheduling as a mandate but the implementation of this policy rested with HCAs, some of whom attempted to offer flexible scheduling within some fairly obvious institutional constraints. As indicated in chapter 3, the first two questions that were asked of HCAs were: "What does flexible scheduling mean to you as a HCA" and "What does it mean to the way that you do your work." These two questions are almost the same and thus the responses to these questions were combined. Similarly, the responses to the second and third questions, "What does it [flexible scheduling] mean to residents' quality of life" and "What does it mean to your work satisfaction or dissatisfaction" are interconnected because providing care that seemed to improve

quality of life was associated with work satisfaction. This is clearly seen in the preceding section that outlines what HCAs reported as adding to or taking away from their work satisfaction.

The nine HCAs described how flexible scheduling affected their work and from their responses, it seemed that the smooth or difficult implementation of flexible scheduling was dependent on the institutional support. Hoeffer et al. (1997) report that that the major difficulties of flexible scheduling for HCAs were related to feeling criticized by managers for poor time management and by co-workers for increasing their workload. In some PCHs, the HCAs would rearrange their work in order to provide even a little flexible scheduling to residents. HCAs said that they were not supposed to be forcing residents to wake up, dress and have breakfast at a certain time but they were stymied by rigid institutional deadlines.

> "…I know it's not right, but basically it's their time to get up whether they really want to at the time or not. It basically turns down to that because they're expected to be up …for breakfast." (HCA #4)

When institutional procedure dictates that all the residents should be in their breakfast rooms by 8:30, there were only minor rearrangements that could be made to support flexibility. HCAs could allow a resident who like to sleep later to sleep a little later while another "early riser" resident was assisted with morning care.

> "It's like I said, we have a set routine, the night staff has certain residents they get up. A 6:30 girl comes in and she has certain residents she gets up, and then we deal with the rest. Flexibility, to me, is if I see something else, to be able to go and do that in lieu of something else." (HCA#1)

> "…8:30's breakfast time. And you're expected to have them down at 8:30. But I may have 16 people to get up . . . and I get on the floor at quarter after 7." (HCA #4)

In the absence of formal arrangements for continental breakfast, when a resident misses 8:30 breakfast, there may be only tea and toast available until the noon meal is served or the HCAs have to keep and reheat meals for late-sleepers. The pressure to keep to the set schedule is strong, especially with managers and other co-workers (also reported by Roberto et al., 1997). The HCAs reported they often had to justify their rearrangement decisions to their co-workers. Furthermore, they were concerned about putting themselves and residents at risk of injury when they rush to meet deadlines.

> "… [With] someone that's more rigid, um, there aren't those choices for yourself or the residents so much. Or it ends up that it's just stressful because you're thinking, 'Oh God, here we go, just run, run, run, run. We're looking at the clock.' Or that you're ending up . . . doing people that . . . [are on] a mechanical lift, they're very hard to roll and turn. And you're ending up doing people like that on your own where you shouldn't be. You should be two but because they're running after the clock, it ends up that you're also putting yourself . . . and the resident at risk because they're [co-worker] worried about a time factor." (HCA#5)

In personal care homes where there was institutional support for flexible scheduling, there was a choice to have an early morning breakfast or a later breakfast. The resident was acknowledged as the one controlling the scheduling of meals, for example. This meant that the HCAs were relieved of justifying having a resident sleep late and eat breakfast at noon, if he or she chose to do so. Flexible scheduling tended to liberate the HCAs as well as the residents.

> "When they want to wake up, they wake up, If, you know, they want to sleep in, they get to sleep in. If they want breakfast at 2 o'clock in the afternoon, that's what they get, you know. . . . It's like it's their home, same thing as at home. If they want to get up at 6 o'clock one day, that's fine. If they want to sleep 'til 9 the next day, that's fine." (HCA#2)

> "We have ... [a new concept] which translated to that if they're not awake, they shouldn't be woken up. ... But as opposed to the way it was before that everyone was up at a certain time and so that is no longer supposed to be happening here. ... Again, in the afternoon, when they lie down ... if they're ... wanting to rest, they can. They don't have to be gotten up at an exact hour because they lie down at a certain time or anything. And it's my understanding evenings is the same way. ... Before it was ... more where everyone had to be a certain time in bed, but now, it's . . . their choice to go to bed when they choose to, not be made to. . . . I think the basic goes for everything in terms be it programming or anything." (HCA#6)

Institutional and managerial support is most important when it comes to flexible scheduling because it means a departure from the standard "institutional" approach. The focus is on putting flexible scheduling into practice, and having residents determine their own daily routines. There are resources in place to support this flexibility and HCAs are no longer enforcing a rigid schedule but instead, are part of and in support of the empowerment of residents.

> "…We have ... toasters and coffee pots and everything on the unit. And we have like oatmeal kept warm in crock pots. ... Because we still have to make sure they get 'x' number of proteins ... in a day. So, their nutritional requirements still have to be met. Oh yea, we have lots having breakfast at 10 o'clock, and I'm going to be one of them." (HCA #2)

> "You're there to assist them now, not to tell them, 'Ok, you have to do this, you have to do that.' ... You have to be flexible too. ...The staff [has] to be flexible. It's a hard one to learn sometimes, for us more than for the residents." (HCA#2)

When HCAs see themselves able to be flexible with residents' routines, they also see the results in a better quality of life for residents. Two studies indicated that indeed, residents dislike being rushed though breakfast and morning care (Mitchell & Koch, 1997) and that less flexible environments are associated with lower resident satisfaction (Walls-Ingram, 2006). Flexible scheduling also provides a better quality of work experience for HCAs.

> "I personally like it a lot better, the flexibility. They're happier, they're more relaxed. They're more trusting of you." (HCA #2)

> "I actually, I prefer it this way. ... Not every day's the same. . . .They're not machines. . . . We treat every day as a different day. And ... being in a nursing home, the residents, a lot of them, they've lost a lot of their rights already. ... And let's not take everything away from them. And it makes their day, it makes both our days ... a lot better." (HCA#8)

Examining the relationship between flexible scheduling and HCA work satisfaction was the first objective of this research and when asking about this relationship, there were two broad themes that emerged: "adds to the quality of HCA work" and "adds to the quality of HCA relationship with the resident".

One of the ways that flexible scheduling added to the quality of HCA work is because of the variety that it offers. And inherent in that is the underlying input that HCAs now have in designing their workday, the added feelings of control.

> "I wasn't crazy about the flexibility at first, now I'm the biggest advocate for it. It takes away a lot of the monotony of the job. ... Like before, it was like, 'Okay, I know I'm going in, I have to start getting this person, this person and this person up.'... It's almost like, for lack of a better word, it would be like worrying already ... when you knew exactly what you were going to do. Now it's so flexible that you're not sure and it's like a new day every day. So it's better that way. "(HCA #2)

> "I like it [flexible scheduling] a lot better because the residents are happier… You don't feel like such a warden." (HCA #)

Flexible scheduling does not always make a HCA's job easier but because it places the resident "first and foremost," it has the potential to enhance the HCA's relationship to the resident. Two of the HCAs responded about their improved relationship with residents.

> "Because . . . I used to really dislike the fact that I had to go in and make say, Mrs. Smith get up. . . . 'You have to get up now.' That used to really bother me because I thought, 'Why are we dragging these people out of bed at 7 o'clock in the morning if they don't want to'? It's

> nicer not . . . having to argue with them, not forcing this schedule down them. So, for me, it's made my job a lot more pleasant, not always easier." (HCA#)

> " . . . I'm happier. I go home feeling like I've done my job now. Whereas before it was so regimented, you sometimes just went home thinking, 'Okay, I just pissed 20 people off . . . for 8 hours.' . . . You didn't always go home feeling good. . . . I think . . . it's made a big difference. And if your staff [are] happy, they do provide better care." (HCA#2)

To summarize, in terms of flexible scheduling and HCA work satisfaction, the HCAs seemed to want flexible care schedules. They related this flexible care to providing better care to residents and increasing their own work satisfaction that was well-intertwined with resident satisfaction. It is clear that the extent to which HCAs can offer flexible scheduling is based on institutional support, including managerial and co-worker support. Alternatives to early breakfasts, for example, must be an institutional mandate or there is really only one breakfast offering regardless of having "resident-centered care" in the mission statement. Managerial and co-worker support, if in place, means that a resident sleeping later into the morning does not constitute poor or slack care on the part of a HCA. The analysis also suggests that in the absence of flexible scheduling, HCAs still try to provide some flexibility by making small rearrangements in care that will allow some residents to sleep in a little longer, for example.

Objective #2: Resident choices and health care aide work satisfaction

The second objective of this research was to examine the relationship between following resident preferences for care and the work satisfaction of HCAs. Flexible scheduling often involves the resident's preference but a resident's preference does not always relate to flexible scheduling. Flexible scheduling might be a resident's choice but there are other choices such as choosing what to wear or whether or not to attend a recreational activity. As one HCA expressed it, you must ask before you can know if a resident has a certain preference for care or activity.

> "…[Resident choice includes]…Just . . . any personal choice or whatever. Just ask them I guess is basically the big thing." (HCA #6)

Two important components of resident choice are to give them time to make choices and support their independence.

> " … Resident preference would be allowing them to choose what they want to wear, if they have the ability to. Give them the time and the patience to let them pick it, not just grab something, throw it on them. . . . When I do their hair, ask them if that's how they like it, or how they normally wear it. Don't just slick it back and kind of style it." (HCA #6)

> "Allow them to have the chance to make the decision for themselves, which I think is very important and sometimes doesn't happen because [it's] always such a hurry. If they can do some of their care, allow them to do that. Time is usually the big problem. Everybody's in a hurry and it's quicker to do than allow them to, which takes their independence away." (HCA #6)

One of the HCAs pointed out that the residents with dementia may not have full capacity to always express a preference. With flexible scheduling, mealtimes are not regimented and a HCA can ask a resident a simple question about being hungry and wanting to eat. These are concrete questions with simple answers. It might be more difficult to ask a resident with dementia, which article of clothing he or she would like to wear on that day. One HCA addressed this dilemma during the interview.

> "Their [resident] ability to really make decisions on how to wash and, or to do it properly or how to pick clothes out and put them on the right way are, you know, the majority don't have that ability." (HCA #4)

Some HCAs still had set schedules and found it limited their ability to respond to choices. Much of the work of HCAs is task-focused and resident assignment is based on what is deemed an appropriate workload in relation to the needs of the assigned residents. If for some reason, the PCH is short-staffed or residents require more assistance than anticipated, the resident assignment changes but the time to complete tasks does not. Lack of time can interfere with the follow-up action on resident preferences. West, Barron and Reeve (2005) and Mattiasson and Andersson (1995) noted that following resident preferences can be time-consuming and without sufficient time, these preferences will be given lower priority by HCAs.

> "So [my routine is] getting slower. That's the effects about that, because they're choosing lots. . . . So it's just in the mornings it's . . . so hard for us. We're running out of time. It's just like we want to give the care they want. But sometimes if they . . . really want some attention, we cannot give everything to them. We have to go [to] the other residents too. We have to explain to them that I cannot stay in their room even though we want to talk to them." (HCA #9)

HCAs generally spoke of how having choices had a positive effect on residents' quality of life. HCAs see offering choices as an important part of their job and following the resident preferences, as indicated. One HCA spoke of a resident who made clothing choices that were followed regardless of fashion opinion. And another described resident preferences in relation to recreation activities.

> "You know, who cares if they have a green shirt and purple pants. If they're happy, that's what matters, right? . . . That's basically what we're there for, and it makes way more sense than fighting." (HCA #2)

> "They have a lot of different [recreation] choices . . . and they can go if they want or not if they don't want to. They have a lot of outings and . . . more of a social life than we have, I tell yah." (HCA #6)

In relation to following resident preferences and work satisfaction, there were two major themes: "adds to my frustration and job dissatisfaction" and "adds to the residents' quality of life." The first theme captured the frustration that HCAs felt when they could offer choices to residents but then not follow through on providing these preferences because of a lack of management support or lack of time. Kane et al. (1997) reported similar findings, where HCAs cited the helplessness of residents, institutional rules and routines and busy schedules as reasons preventing them from increasing residents' choices. One HCA was upset when describing the following situation.

> "…If somebody doesn't want to have a bath and I explain to them that they only get one once a week and if they still don't want it, it's their choice. But I have to do it [institutional procedure] and it upsets me. This can lead to dangerous situations with the residents, too. When you try to force someone to do something they don't want to do, they fight back. They can hurt themselves. And it can lead to an emotional and mental attitude where they just give up. They feel like this is a jail." (HCA #1)

And another HCA described how not having one's choices honoured is about losing individual rights and personal dignity.

> "It influences [my work satisfaction] in the way that I feel that residents are not given their rights. They are elderly and they deserve to make their own choices just as if they are still at home. . . . So when . . . [they're not allowed to sleep late], it bothers me. Because [I feel] it's bad enough being elderly and being in a place like this, [but also] losing [their] rights and [their] dignity." (HCA #1)

On a more positive note, HCAs also described situations were being able to ask about preferences and follow through on preferences enhanced the residents' quality of life and thus made the day better for the HCA. Some of the work satisfactions of HCA happen at the end of the day, leaving work, knowing they had done their best, having residents say 'thank you' as a recognition for having done what they said they would do.

> "Well, when they're happy, they're settled. They're content, they trust you. They totally trust you. . . . It's not a big thing for some, but on that unit, [there's] a lot of Alzheimer's and they totally recognize you. I don't know if it's face, voice, touch, [or] what it is. . . . It just gives you a feeling that you've done your job that day. . . . You've made them happy, you've done what you came to do. [It's] not that you changed [them], but that you . . . made their day go a little easier, and hence yours goes easier." (HCA #2)

> "That's what it's about because then, at those times, that's when the resident may seem happy or . . . may say something nice to you or thank you. . . . That's what, at the end of the day, makes your job worthwhile. . . . The gratifying thing is thinking . . . that . . . their day was a little bit better because of a decision that you helped make." (HCA #4)

In summary, the connection between residents' quality of life and HCA work satisfaction comes through again in examining the relationship between following resident preferences and HCA work satisfaction. However for this element, there seemed to be more frustration and work dissatisfaction being expressed by HCAs because they could not honour residents' preferences as much as they would like to do this. And again, issues of the institutional constraint are evident. In chapter 2, the institutional context of the work of HCAs was emphasized and this context has broad implications for promoting resident-centered care from the perspective of HCAs.

Objective #3: Home-like environment and health care aide work satisfaction

The third objective spoke to examining the relationship between promoting a home-like environment and HCA work satisfaction. A home-like environment has both physical and psycho-social dimensions. As indicated earlier, in terms of physical structure, most PCHs were built following a "hospital model" where the design is tailored to meet the needs of staff. Typically, there are long corridors or "wings" and nursing "stations" positioned so as to have a view of these long corridors. For safety purposes, flooring has an even surface; it is usually industrial, high use, low maintenance flooring. Color scheme is usually

muted color or soft pastel and in some PCHs, the various wings may have unique wall colors in order to assist confused residents in the way finding. The resident rooms may be private with one resident, or shared with up to four residents in one room. For this research, resident rooms were either private or semi-private, that is shared by two residents. Sharing a room with another resident can be a source of conflict and discomfort for residents, as described by one HCA.

> "One time…at a meeting [the manager said], 'When people complain is it [because] they have to share a room? No, it's always about the care'... I felt like chiming in, 'They fight a lot because one wants television on, one wants television off. One wants to go to bed [now], one wants to go to bed then'. Of course, a lot of problems are that they have to share a room. It's a big one… But they're still sharing a room and it's their wish to have their own private room. . . . That would be the best home environment, but I'm working in a place where they share." (HCA#5)

There are common areas for mealtime and recreation activities and sometimes, residents leave the PCH to go to family events or events planned by the PCH staff.

In terms of psycho-social aspects, in most PCHs, residents are invited to bring personal belongings (photographs, bedding, curtains, etc.) and sometimes pieces of furniture (chair or dresser, for example) to provide a more familiar and home-like environment. This institutional support allows residents to contribute to their own home-like environment. One HCA described how residents made decisions that affected their unit or "neighbourhood."

> "The residents picked their own colors for their own stuff and they pick out whatever different things they have. I guess [by] a vote. . . . [They did this for their rooms] and the bathrooms, everything. The whole wing is theirs. It's their home. That's their neighbourhood, they call it." (HCA #6)

It would seem that honouring individual selections works best where residents have private rooms and more autonomy in making choices. But, some decisions can be voted on. A few PCHs have "in-house" or visiting pets, usually cats and dogs but also tropical fish or birds. These animals can lend a home-like atmosphere to the PCH. The presence of pets in PCHs has been associated with emotional and social benefits for residents in general and residents with dementia, specifically (Gammonley & Yates, 1991; Banks & Banks, 2002; Kongable et al., 1989).

Depending on the PCH, staff members may be required to wear uniforms or "scrubs." One of the PCHs allowed staff to wear "street clothes" within certain limits.

> "…like I say, even looking less institutionalized looking like we, we don't wear uniforms here. We're all in casual clothes as opposed to looking like a hospital atmosphere…and that's another big thing about home is the clothes we wear." (HCA #6)

Staff members can add to the home-like atmosphere by interacting in a social rather than a purely clinical way. Although it is possible for HCAs to promote the psycho-social aspects of a home-like environment, it is difficult for them to affect major changes in physical layout and structure. And generally speaking, physical-based home-like attributes in PCHs will always have to fit and conform with the more foundational aspects of hygiene, safety and security.

When asked about promoting a home-like environment as part of their work, HCAs related their role to having easy going, friendly interaction with residents, aside from their function of providing physical care.

> "And this is a business, whether you want to admit it or not. If I had my way, there would be more of us here so the residents would have more time with us. . . . If you stop and take the time to talk or joke with a resident, you have somebody down you neck like you're wasting time. . . . [It's] not only about the physical but also the mental and the emotional. For me, the physical [care] is met, but the residents like to talk and they like to joke, some people think you are wasting time. If I stand there and talk to someone, I don't think I'm wasting time or being idle." (HCA #2)

HCAs also talked about some of the special things that they might do for a resident to make them feel more at home. These special things might go unnoticed. One HCA provided two examples of things she has done to promote a home-like environment, one related to providing a quiet atmosphere and the other related to providing a respectful choice in bedspread color.

> "… I make sure their TV is on for them, or turn it off if it's loud… [Other] staff tend to go in crank everything up and walk [away], and the person's sleeping or agitated but . . . it's blasting, so make it [a] quiet atmosphere or . . . relaxing. . . . [It can be] even making the bed. I'm very petty about this one fellow. . . . Well, I always have a blue bedspread for him. When the staff put a pink one on, I have a problem . . . because he used to [be] a truck driver." (HCA#6)

HCAs also talked about some of the home-like features of the PCH that related to housekeeping. In one PCH, there were opportunities for residents to choose to help with household

tasks such as washing and drying dishes or sweeping the floor with a broom in common areas. When residents take advantage of this opportunity, it could add to the workload of HCAs.

> "Sometimes it's harder for us because we're cleaning all this stuff up. . . . We're picking up brooms. We're making sure they're not laying around [safety issue]...putting things back in that dresser after. Sometimes it can be more difficult for us…But I think in the long run, it's worth it." (HCA#2)

This HCA also spoke about involving residents, as they wish, in everyday activities that are taking place on the unit.

> "…They help us make the beds all the time…Routine things that they remember…we try to do as much of that as we can. We have…plants that they water. We have the animals that they help look after. It goes on and on, the more home-like things…My role in helping...it's just always been there. Get them to help me make beds. I do... Let them wash the dishes... Just encourage the activity, the thinking through." (HCA #2)

In relation to how residents might feel about a more home-like environment one HCA stated that this could lead to feelings of contentment.

> " … If you're going to have a more relaxed, less institutionalized atmosphere you're going to have happier residents. Hopefully, that's the purpose. . . . And I would think if the residents felt like it was their home, as much as they can, I would think that would make their life a lot more . . . for what it's worth, content." (HCA# 6)

Objective #3 was aimed at examining the relationship between promoting a home-like environment and HCA work satisfaction, and two themes became evident. Earlier, a quote from one HCA indicated that some attempts to promote a home-like environment, as in having housekeeping material available to residents may in fact, increase workload but as she said, "it's worth it" and this again confirms the primacy of resident quality of life and the importance of good relationships with residents. Similarly, the HCA who spoke about spending time to talk and joke with residents, indicated that time is a pressing, sometimes prohibitive factor, and the impression that this activity is "wasting time" ignores the value of this psycho-social activity. So, one of the themes is that promoting a home-like environment "adds to the quality of the HCA relationship with the resident" (even though, it may not be valued by managers or when it contributes to workload).

The second theme relates to work satisfaction directly. When HCAs described what they did to make residents happy and to improve their quality of life, it seemed that the link between resident satisfaction and HCA satisfaction again emerged. The second theme is that promoting a home-like environment "adds to HCA work satisfaction." One HCA noted her feelings of coming to work in relation to the pets in the PCH.

> "Myself personally. I love the idea that the animals are here. I really look forward to . . . seeing them in the morning." (HCA #2)

Another HCA spoke of times when two or more residents who must share a room, and when there are problems, things can become very upsetting. The HCA indicated that when residents are upset, it upsets her work. This is a negative example where that the lack of home-like environment contributes to work dissatisfaction. In this situation, there were two residents in a room and one was quite agitated, confused and vocal and this negatively affected the second resident who was having difficulty dealing with this behaviour.

> "But I mean depending on who your roommate is, it's awful for a resident. And then so I think … I mean it's awful hearing it from a few doors down or something. But I mean it would be so irritating for them and so upsetting for them. I mean it would naturally affect your work because it affects [the resident]." (HCA #4)

In summary, a home-like environment has physical and psychosocial dimensions. And while there is likely very little that HCAs can do with respect to the physical dimension, there are contributions that HCAs can make in the psychosocial dimension. Their relationship with residents does not always have to be purely clinical and can have elements of social interaction, such as joking and talking about everyday things. However, even this social aspect of interaction with residents may be frowned upon if it is seen as "wasting time or being idle." HCAs do special things related to providing opportunities for residents to participate in the PCH, such as contributing to household activities, if they wish to do so. Promoting a home-like environment has a positive effect on residents and similarly seems to have a positive effect on the work satisfaction of HCAs.

Objective #4: Permanent assignment to residents and health care aide work satisfaction

HCAs' work schedule rotates according to the pattern on their respective units and PCHs. The pattern can be daily, weekly, bi-weekly and monthly or tri-monthly. For example in a tri-monthly pattern, a HCA will work with the same group of residents for a three month period. After which, the HCA will work with a different group of residents for the next three month period. Longer rotations provide opportunities to build in-depth knowledge about residents' individual needs, likes and dislikes. The HCA team then becomes a vital resource of specialized knowledge about their residents for managers, nurses and other HCAs. The major disadvantage of long rotations is that the team maybe working for extended periods with heavy or stressful workloads. The advantage of shorter rotations is that if the workload is heavy or stressful, there is a break sooner rather than later. However, with a shorter rotation, HCAs develop more generalized rather than in-depth knowledge of the residents and their needs and preferences. This generalized knowledge is still valuable and when HCAs are replaced because of illness or leaving their place of employment, another HCA can step in and have this basic working knowledge of the residents in that particular grouping

Most often, two HCAs work together as a team and will provide care to a group of twenty-four or twenty-five residents. The number of residents varies in relation to their individual and overall needs. A HCA might be assigned to provide care to nine residents whose needs are high or complex whereas a HCA providing care to twelve residents might have residents with less acute care needs.

The nine HCAs in this research had various rotations from daily to tri-monthly. Yet, it was not clear if HCAs could be grouped according to rotation pattern in relation to how they saw their work and work satisfaction, and the residents' quality of life. Most of them seemed to acknowledge that the value of a longer rotation was the getting to know the residents and their usual care and preferences. Even those with shorter rotations identified the value of longer rotations. For example, one HCA who had a daily rotation spoke generally about the value of "stability" in rotations which seemed to refer to longer rotations. This HCA spoke with sincerity and frustration about being sent to other units and feeling at a loss.

> "And what we are looking for in our rotations was stability… and the residents would have the stability of the same faces for the week. They expected you. They know that you were coming and so on. It's just a lot easier. [Being sent to another floor and dealing with residents that you

> don't know]…Your stress level goes up. I am sure everyone's blood pressure goes up. [If you don't know the resident]… you'll have to find one of the regular staff and ask them, and…they're going to think that you're just stupid." (HCA #2)

Another HCA who had a biweekly rotation pointed out that just like family and friends, sometimes a person just needs to have break in contact. This HCA seemed to have the idea of balance, that is, permanent assignment is good because you get to know the resident and can tailor your care around preferences. On other hand, permanent assignment may be too much contact with a group of residents and a break in contact can be a healthy thing. Added to this is that there may be circumstances where a HCA and a resident simply cannot agree on care and preferences and permanent assignment with affect the resident's quality of life the HCA's work satisfaction.

> "I think it [permanent assignment] is the case to, to a great extent because then you get to know the residents and their like and dislikes. And things just become easier, you know, that it's not as frustrating for them. [But] sometimes, you need a break. And so if you take those things into account. I don't know if it [permanent assignment] would really be better for residents…You need to have a break….from each other. Just like you need breaks from your families and your friends." (HCA #4)

Similarly, another HCA identified the negative and positive aspects of permanent assignment for HCAs. She also expressed the idea that residents get used to certain HCAs providing their care. Sometimes residents will refuse care from a "non-familiar" HCA. A second HCA also spoke about other benefits to residents.

> "For the most part, people [HCAs] like it [permanent assignment]. They do… But I can tell you one thing. It's not always necessarily the best thing. People [HCAs] do get burnt out. They need a break… It can be six of one, and half a dozen of the other…Permanent assignment , the positive part of it is getting to know, getting your relationship built with the person [resident]…I think that's a good thing. And the residents for the most part, they really get used to certain people and they look forward to that. And if that person is not there… there's some who absolutely will refuse [care from another HCA]. So, you get that kind of thing getting out of hand too." (HCA #6)

> "Well I think the residents are more secure… They get very comfortable with the same staff. [When staff change]…you can really tell the difference. The agitation level, the aggression level will increase. They get comfortable because you know them, you know what they like." (HCA #3)

Objective #4 aimed to examine the relationship of permanent assignment and HCA work satisfaction. From what HCAs had to say, permanent assignment is a mixed blessing. On one hand it provides stability and in-depth knowledge of the assigned residents' care and preferences. There is a welcome familiarity and

consequential feelings of competence. On the other hand, there can be burnout and the natural need for a break in seeing the same people/residents each day is not an option. This can be frustrating and stressful for HCAs. On the whole, residents may like permanent assignment if the HCA who is assigned fits with their preferences and compatibility. Familiarity is secure and comfortable. If there is incompatibility, then permanent assignment will not benefit residents and will not contribute to their quality of life. So, the first theme is that "permanent assignment" is that it "adds to HCA work satisfaction" and the second theme is that permanent assignment "adds to HCA work dissatisfaction." Ultimately permanent assignment offers the quality of knowing what to expect and the positive challenge of not knowing what to expect. Both these sentiments were expressed by the two HCAs.

> "Well, I think because you . . . have the bond with the residents, and if you like the people you're working with, which you do or you would move to a different unit obviously. You work day is just much better. . . . You're more comfortable going in in the morning because you . . . know. . . . You don't know what's going to happen exactly but you . . . know what to expect. You . . . know what you're walking into." (HCA #2)

> It's just like when you change the rotation…it's like a challenge for you. ….you have to deal with another resident. Just like from the first day of the month, you have to do the other routine. I's just like you don't have to do the old routines, you have to do the new routine. …For me it's [a] challenge...It's a good thing for me, the challenge." (HCA#9)

In summary, permanent assignment seems to be a mixed blessing with aspects of work satisfaction and work dissatisfaction. Of interest here and something not mentioned in the literature is that HCAs seemed to recognize that providing care to the same residents for a prolonged period of time could or would lead to burnout.

CONCLUSION

This analysis of HCA work satisfaction has provided much information and much new information on what adds to it and what takes away from their work satisfaction. And a few things are noteworthy. The first thing is that the institutional context is a major factor and this includes written policies and procedures on resident-centered care and unwritten expectations of getting work done on time without wasting time. At times, HCAs are expected to offer residents flexible scheduling

of meals and bedtimes while maintaining their work assignment within a rigid schedule that is incompatible to resident preferences. The second thing is that the "people" aspect is most important and particularly the "residents" and their needs. HCAs seem to feel a bond with a resident that go beyond the provision of care and thus, contributes to their work satisfaction when the relationship with the resident is positive. The role of co-workers, nurses and managers varies in relationship to the work satisfaction of HCAs but there does seem to be a lack of connection or communication between nurses and managers and HCAs that takes away from their work satisfaction.

More specifically, the individual item analysis of the MMMS indicated more work satisfactions than work dissatisfactions, insofar as the items tapped the important elements of HCA work. The majority of HCAs indicated satisfaction with salary, benefits, work scheduling, working with nurses and other HCAs, opportunities for continuing education and overall job satisfaction. Dissatisfaction was related to a lack of compensation for working on weekends. Some items were not applicable to this group of nine HCAs, but the items that were most clearly missing were items on satisfaction on working with residents.

The open-ended questions on what added to and what took away from work satisfactions provided a wealth of information and to a great extent supported the literature on work satisfaction and HCAs and other health personnel (such as nurses). Not surprisingly some of the things that added to work satisfaction were identified as taking away from work satisfaction when they were absent. Relationships with residents, co-workers and management added to work satisfaction. Having opportunities to achieve personal and professional goals was also identified as adding to work satisfaction and the value of HCAs' maintaining their personal values in the workplace and having a fulfilling job seems underestimated in the literature. All in all, underlying the things that contributed to work satisfaction was the primacy of resident care and the value of good care, meeting needs and feeling valued for that care.

Relationships with residents, co-workers and nurses also took away from work satisfaction. And another group was identified, that of families who can be difficult, demanding and disruptive of

resident care. Family involvement in their relative's care seems an area of contention and warrants further investigation. HCA work dissatisfaction was associated with dealing with difficult residents, grieving their loss, dealing with difficult families, co-workers and management. Again, dissatisfaction often related to the things that impeded or negatively affected providing good care, meeting needs and be valued for the care provided. Of particular note, is what HCAs had to say about the loss of a resident either because of death or transfer to another PCH. The feelings expressed were like the loss of a friend or family member and this aspect of work satisfaction is not recorded anywhere in the literature.

Finally, the analysis on the four elements of resident-centered care (flexible scheduling of care, following resident preferences, promoting a home-like environment and having permanent assignment to residents) adds to our understanding of the relationship between HCA work satisfaction and resident-centered care. This is a relatively new area of inquiry. The analyses suggested that flexible scheduling of care and promoting home-like environment dually added to the quality of the HCA relationship to the resident and to HCA work satisfaction. While following resident preferences was seen as adding to residents' quality of life, it tended to add to HCA work dissatisfaction. This is largely due to HCA reporting that they are constrained by time and their own work schedules and cannot often meet resident preferences. HCA frustration was evident during the interviews and from the transcripts. The element of permanent assignment was a mixed blessing and it added to HCA work satisfaction and dissatisfaction. Permanent assignment allowed the HCA and resident to get to know each other but permanent assignment also contributed to HCA burnout and this is another area that is not clearly addressed in the literature. It was in discussing their work satisfaction and the four elements of resident-centered care that HCAs were most vocal about their concerns for institutional support for resident preferences and the other elements.

The next chapter will provide a discussion of the findings, including sections on limitations, implications for further research and conclusions.

CHAPTER FIVE – CONCLUSIONS

This research examined the relationship between resident-centered care and the work satisfaction of HCAs working with personal care home residents living with dementia. The specific objectives were to examine the relationship of four aspects of resident-centered care: providing flexible scheduling, following resident preferences, promoting a home-like environment, and providing consistent care through permanent assignment. This chapter presents a section on discussion of the findings, followed by a section on implications from this research to the PCH setting. The third section outlines limitations of the research and fourth section suggests future research. The final section is a summary.

DISCUSSION OF FINDINGS

Although this research examined the relationship between HCA work satisfaction and resident-centered care, it became clear that multiple contexts were in play as HCAs provided care to residents in the context of resident-centered care. For HCAs, these multiple contexts were: the institution; other health care workers, including other HCAs; and the residents, most of whom have some level of cognitive limitation, usually referred to as dementia. In chapter 2, theoretical emphasis was placed on the institutional context. It was suggested that when an institution, such as a PCH, develops and establishes a "vision" or mission statement of resident-centre care, the staff are expected to share and make manifest this mission in their daily work with residents. It was further suggested that adapting to a new model of care, like resident-centered care, can be a stressful experience. If the mission and the guidelines (policies and procedures) lack clarity or consistency, then there can be confusion and stress in attempting to implement the vision. In those circumstances, individuals tend to cope by attempting to manage the problem or by managing the stress that occurs.

Institutional Context

Institutional level data were not collected in this research. This was not one of the objectives. However, when examining HCA work satisfaction, it often related to the institutional context of "resident-centered care." From the perspective of HCAs, it became clear that the implementation of resident-centered care was flawed when it lacked institutional support of a substantive nature. HCAs seemed to be saying that there were incompatible messages, one which promoted flexible scheduling for residents and another that emphasized that their work had to be done in a set time frame. Flexible scheduling of resident care cannot be made manifest by HCAs in the absence of flexibility in their giving of that care. Similarly, promoting a home-like environment by attending to the psycho-social needs residents cannot be made manifest by HCAs who are viewed as "wasting time" and idle when they spend time with residents in a non-direct caregiving capacity.

As indicated earlier, most of the HCAs did not have a complete understanding of what resident-centered care meant. And it would seem that, if this is the philosophical approach in these PCHs, the notion of resident-centered care should be obvious and a guiding principle in every act of care and comfort. It may be that these PCHs took a relatively narrow definition of resident-centered care and emphasized, for example, the introduction of pets or the offering of alternate breakfast times. Both of these things are exemplars of resident-centered but resident-centered is much broader in scope and more holistic in presence.

Following resident preferences seemed particularly troublesome for HCAs. This may be because the range of resident preferences can be broad and difficult to deliver. The constraint of time was a factor here, as it was generally in things that took away from HCA work satisfaction. HCAs indicated that following resident preferences made their "routine" slower. It disturbed HCAs when they became the instruments of care that did not fit resident choice or that was given against resident choice. The words used by HCAs related to "jail," "force" and "losing rights and dignity." This is not resident-centered care. Resident-centered care is about empowerment of residents and similarly, the empowerment of the HCAs who provide the care.

Permanent assignment as an element of resident-centered care is a thorny one to analyze and discuss from the organizational context. It definitely is an organizational function to schedule the work assignments of HCA but it is not clear what the ideal work rotation period might be in relation to promoting resident-centered care. The message from HCAs is that the longer they provide care to the same group of residents, the better it is for the residents and themselves. However, the other message is that HCAs need a break, need refreshment and a change or else, burnout can take place. The quest is to find the optimal work rotation and change of resident assignment at an organizational level. It may be that tri-monthly rotation allows opportunity to get to know resident needs and preferences but also allows for a needed break.

Interpersonal Context

The second context is that of working with other staff and how this context relates to the provision of resident-centered care and HCA work satisfaction. HCA ratings on the MMSS indicated satisfaction with working with other HCAs (n=7) and working with nurses (n=5) but in the open-ended questions on what added to or took away from work satisfaction, the comments tended to be more critical. HCAs enjoyed working with supportive, competent co-workers but were more critical of those who lacked a teamwork spirit and action. HCAs were particularly critical of nurses who did not help out, when needed, who laboured with paperwork and who were so caught up in administering medications, that they missed “seeing” the real residents. HCAs indicated that supervisors were unsupportive when families complained about them and that some supervisors were not fulfilling their supervisory function. Most disturbing was a comment related to how nurses “look down on” HCAs and as one said, “make me feel inferior.” This co-worker context of work stress benefits no one and likely interferes with teamwork, communication and good care. Related to this, were HCAs expressing that they felt unappreciated and that they experienced a lack and of praise and encouragement from managers, who, in fact, are most often nurses. In relation to the questions on the four elements of resident-centered care, HCA responses seemed less contentious toward other HCAs and nurses.

Resident and Health Care Aide Interface

The third context is that of providing care to residents and overall HCAs spoke positively and caringly about their relationships with residents, even those who might be difficult or aggressive toward them. The MMSS did not ask about satisfaction with providing care or about the relationship with patients or residents, an omission not only for research with HCAs but likely also so, with nurses. But, in terms of the open-ended question that ask about what added to work satisfaction, the primacy of caring for residents became abundantly clear. HCAs spoke about feeling appreciated by residents and feeling a rewarding relationship with residents. This may balance out some of the feelings of not being appreciated by management, nurses and other staff. Certainly, the literature would support that statement. In describing how it was important to maintain personal values in the workplace, HCAs were talking about treating residents as they or their family members would like to be treated. In fact, in examining the categories and themes of "what adds to work satisfaction," all of these categories and themes are all grounded in ensuring that residents receive good care. For example, HCA work satisfaction is related to working with competent co-workers so that the end result is good care for residents. Dissatisfaction with co-workers seldom related to a personal problem or individual differences; it was most often grounded in concern for resident care. The one major message coming from these nine HCAs is that they do indeed care about their work and find most satisfaction within the context of the direct provision of care to residents.

Implications of this Research for PCHs

This research involved nine HCAs from four PCHs so there is always a likelihood of bias with a small number of subjects, who self-selected themselves into this research. However, that being said, the findings suggest two important implications that may be useful for PCHs as organizations to consider if they want to improve their resident-centered care and address HCA work satisfaction .

Given that the majority of HCAs could not express a complete understanding of what resident-centered care meant, the first step might be to outline clearly what this concept means and how it is made manifest in a PCH. Education for all staff members would be a necessary action. Making resident- centered

care a reality means identifying and implementing supportive features that ensure a healthy workplace for staff and home-like environment for residents where flexibility of scheduling care and respecting preferences are everyday expectations. This implication is simply stated, but to truly have resident-centered care as the "baseline" of care in a PCH requires wisdom, logistics and most of all, uncompromising commitment. Some would also add to the list, the influx of more budgetary resources.

A second implication relates the context of HCAs working with co-workers, specifically nurses. Although the MMSS indicated satisfaction with the immediate supervisor and other HCAs, an underlying tension with nurses seemed to reveal itself when HCAs were asked about what added to and what took away from their job satisfaction. Role differences in relation to scope of practice may be one part of this. But also, HCAs seemed to say that nurses were not always doing their jobs ("glorified ward clerks") and furthermore, that when they did do their jobs, they were not part of the team (not offering help with residents when they were needed) and their work did not benefit residents as "people" (giving medications without seeing the resident as person). Nurses as managers or supervisors were described as "not supervising" and not making decisions or setting priorities. Lastly, nurses were described as being absent or non-supportive to HCAs when a family complained about a HCA and their relative's care.

This tension and resentment seems again to be grounded in HCA concern for resident care, that is, in the notion that nurses who are not doing their jobs or who are doing their jobs badly are a problem because this affects the residents. The implication for PCHs is that when there is a division between nurses and HCAs, the workplace is not healthy and there may be consequential concerns for resident care.

Limitations

There are several limitations that must be acknowledged. Already mentioned is the limitation of a convenience sample. From all four PCHs, only nine HCAs who met the inclusion criteria were included in the study. These four PCHs together likely employed more than 100 HCAs. As indicated earlier, it would have been useful to have included a question that asked, "Why did you decide to participate in this study?" This is hindsight but it might benefit future research projects.

A second limitation is that data were not collected at the organizational level. This was not an objective of the research but as the interviewing progressed on what added and took away from HCA work satisfaction and more was said about institutional constraints on providing flexible scheduling, following resident preferences, promoting a home-like environment and permanent assignment, it became clear that organizational analysis might have been helpful. In selecting the four PCHs, the researcher sought out facilities that actively espoused a resident-centre care mission and could provide information on the mission statement and relevant policies. The goal of this research was not to validate the implementation or lack of implementation of resident-centre care philosophy into practice. However, the screening of PCHs as the first step in recruitment might have asked directors specifically about procedures and implementation strategies. Certainly after having completed this research several organizational context questions could be developed,

The final limitation is the use of MMSS. This tool contained some of the questions that were pertinent to HCA satisfaction and in fact, the relevance of most of these questions might suggest that factors associated with work satisfaction for HCAs may be similar to those pertaining to nurses. The major gap in this tool was the lack of questions on satisfaction with providing care to residents or satisfaction with relationships with residents. Again, the benefits of having completed this research mean that several questions of this type come to mind.

Future Research

There are several directions for future research that emanate from this research. First of all, theoretical development related to HCA work satisfaction in general, is lacking. This research used the model developed at the Quality of Nursing Worklife Research Unit at the University of Toronto and McMaster University with its identified internal and external factors. Future research might use this or another model and adapt it to fit the scope of HCA practice. Similarly, the limitations of the MMSS have been described and further research might be conducted on the development and testing of tool that is designed specifically to measure HCA work satisfaction. This tool could a dual use as a “administrative” tool

to assess and address HCA work satisfaction in PCHs and as a "research" tool to continue to examine aspects of HCA work satisfaction including the relationship between resident-centered care and HCA work satisfaction.

Two other areas already mentioned that seem appropriate for future research are permanent assignment and the working relationship between HCAs and nurses. Permanent assignment is clearly a mixed blessing for HCAs and it would be of practical benefit to get closer to learning more about the optimal rotation that will benefit residents and HCAs. The working relationship between HCAs and nurse seems a compelling next step. Certainly, improving working relationships would lend itself to a promoting a healthier workplace for all, including residents.

Finally, two other areas are possible next steps. First, although there were some positive comments from HCAs about families, most comments were negative, and listening to and trying to please families seems to be source of stress and work dissatisfaction for HCAs. The role of families in PCH is relatively long-term, for as long as their relative is a resident in that PCH. If families are difficult because they are unhappy with care, this needs to be addressed. If families have unrealistic expectations of the HCAs, then this also needs to be addressed and it certainly relates to the caregiving context between HCAs and residents but it likely also relates to the organizational and co-worker contexts. More research focusing on "family involvement" might try to learn more about the relationships between family involvement, quality of life for their relatives and the work of HCAs. Second, the HCAs identified that some resident (with severe cognitive limitations) are not capable of communicating a preference for care. There is a challenging area of research that could look specifically at resident-centered care and the special needs of residents with dementia.

CONCLUSION

This chapter intended to provide discussion of the findings and speculate broadly in relation to implications, limitations and suggestions for future research. The "context" of resident-centered care included organizational, co-worker and resident-based context that affected HCA work satisfaction and the

ability to provide resident centered care. The implications from this research to PCHs focused on the philosophy and practical implementation of resident-centered care as well as the work related tensions between HCAs and nurse. Three limitations of this research are the small sample size, the lack of data at an institutional level and the MMSS and lack of items on satisfaction with residents. Finally, the suggestions for future research are plentiful including more work on: theoretical and tool development, permanent assignment, work-related tensions between HCAs and nurses, family involvement in PCHs and the challenge of providing resident-centered care to residents with cognitive or communication limitations.

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APPENDIX A

APPROVAL CERTIFICATE

APPENDIX B

DATA COLLECTION INSTRUMENTS

WORK SATISFACTION QUESTIONNAIRE

INTERVIEW SCHEDULE

APPENDIX C

Box 4.1: THE COLLAPSED THE RESPONSES TO THE MMSS WITH RESPECT TO THE QUESTION "HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR CURRENT JOB?"

BOX 4.2: THE CATEGORIES AND THEMES OF "WHAT ADDS TO WORK SATISFACTION?"

BOX 4.3: THE CATEGORIES AND THEMES OF "WHAT TAKES AWAY FROM WORK SATISFACTION?"

BOX 4.4: THE CATEGORIES AND THEMES OF THE ELEMENTS OF RESIDENT-CENTRED CARE

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APPROVAL CERTIFICATE

20 March 2006

TO: **Anita Marcotte** (Advisor L. Guse)
Principal Investigator

FROM: **Stan Straw, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2006:024**
"Resident-focused Care and the Work Satisfaction of Health Care Assistants Working in Personal Care Homes"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Kathryn Bartmanovich, Research Grants & Contract Services (fax 261-0325), including the Sponsor name, before your account can be opened.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

APPENDIX B

DATA COLLECTION INSTRUMENTS

WORK SATISFACTION QUESTIONNAIRE

INTERVIEW SCHEDULE

INDIVIDUAL INTERVIEW QUESTIONS

Open-ended resident-centred care questions will deal with each of the four elements of resident-centred care.

1) Tell me what resident-centred care means to you. With resident-centred care, the emphasis is on flexibility. Tell me about how care to residents in this personal care home is scheduled? (Probe- is it flexible, structured to be completed at certain times or something in-between) (Probe – who decides if care can be flexible? Unit managers, Health care aides?) Tell me about how scheduling or changes in scheduling affect your work in providing care to residents? Has flexible care scheduling meant work satisfaction or work dissatisfaction? Why?

2) In resident-centred care, health care assistants are expected to follow residents' preferences. Can you give me some examples of times when you followed the resident's preference. What happened? What are some of the difficulties? Rewards? How does this relate to your work satisfaction?

3) Resident-centred care is also about creating as much as possible, a home-like environment. A home-like environment is thought to have an effect on resident's quality of life. Do you agree with this? Tell me how you help create a home-like environment for residents. What about a health care aide's quality of work life? Does creating a home-like environment improve work life and work satisfaction. What are your thoughts on this? Do you have some examples?

4) Sometimes, permanent assignments are part of resident-centred care. So, the same health care assistant provides care to the same residents. Everyone gets to know each other better and this may result in better care and quality of life for residents. Do you agree with this? What about health care assistants? How does permanent assignment relate to quality for work life and work satisfaction. Again, what are your thoughts on this? Do you have some examples?

5) Is there anything else that you would like to tell me about what adds to your work satisfaction?

6) What takes away from your work satisfaction?

7) Any other comments. Any other questions you think I should be asking.

Work Satisfaction Questionnaire

Please provide us with the following information that will help us better understand you and your satisfaction with your job.

Remember you are under no obligation to answer any or all of the following questions. Answer to the best of your ability. Please feel free to ask if there is something, you do not understand. There are no right or wrong answers.

You are not required to provide your name.

Thank you for your interest and your participation.

Please answer the following questions by writing the appropriate responses in the space provided. If you need more space, write on the back of this sheet.

Thank you.

Social and Work Characteristics:

Date of birth: _____ Place of birth: Canada _____ or _____

Ethnic group or background: _____ Level of highest education: _____

Other work-related training (courses, in-services, etc.): _____

Regular working schedule: _____ Days _____ Evenings _____ Nights

Health Care Aide training:

Formal training – Health Care Aide Certificate: _____

On-the-job training – no Certificate: _____

Where training obtained: _____

Year Certificate obtained: _____

Work experience:

Number of years working as a health care aide: _____

Number of personal care homes you have worked in: _____

Number of years working in this personal care home: _____

Resident assignment:

Number of residents regularly assigned: _____

Frequency of changing resident assignment: _____ daily _____ weekly

_____ monthly or every _____ months or _____

Please answer the follow questions by circling the most appropriate answer.

Please provide only one response per question.

The choice of answers are "5" for very satisfied, "4" for moderately satisfied, "3" for neither satisfied nor dissatisfied, "2" for moderately dissatisfied, and "1" for very dissatisfied.

Thank you for your time.

Work Satisfaction Questions:

How satisfied are you with the following aspects of your current job?

Please circle the number that applies.

	Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied
1. Salary	5	4	3	2	1
2. Vacation	5	4	3	2	1
3. Benefits Package (insurance, retirement)	5	4	3	2	1
4. Hours that you work	5	4	3	2	1
5. Flexibility in scheduling your hours	5	4	3	2	1
6. Opportunity to work straight days	5	4	3	2	1
7. Opportunity to work part-time	5	4	3	2	1
8. Week-ends off per month	5	4	3	2	1
9. Flexibility in scheduling your weekends off	5	4	3	2	1
10. Compensation for working weekends	5	4	3	2	1

How satisfied are you with the following aspects of your current job?

Please circle the number that applies.

	Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied
11. Maternity leave	5	4	3	2	1
12. Child care facilities	5	4	3	2	1
13. Your immediate supervisor	5	4	3	2	1
14. Your work with other health care aides	5	4	3	2	1
15. The nurses you work with	5	4	3	2	1
16. The delivery method used on your unit (e.g. resident-centred care)	5	4	3	2	1
17. Opportunities for social contact at work	5	4	3	2	1
18. Opportunities for social contact with your co-workers after work	5	4	3	2	1
19. Opportunities to interact with other disciplines (e.g. social workers, recreation therapists)	5	4	3	2	1
20. Opportunities for continuing education (e.g. workshops)	5	4	3	2	1
21. Opportunities to belong to department and workplace committees	5	4	3	2	1
22. Control over what goes on in your work setting	5	4	3	2	1

How satisfied are you with the following aspects of your current job?

Please circle the number that applies.

	Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied
23. Opportunities for career advancement	5	4	3	2	1
24. Recognition of your work from managers/ directors	5	4	3	2	1
25. Recognition of your work from other health care aides	5	4	3	2	1
26. Amount of encouragement and positive feedback	5	4	3	2	1
27. Opportunities to participate in research	5	4	3	2	1
28. Opportunities to participate in union activities	5	4	3	2	1
29. Your amount of responsibility	5	4	3	2	1
30. Your control over work conditions	5	4	3	2	1
31. Your participation in organizational decision making	5	4	3	2	1
32. Your overall satisfaction	5	4	3	2	1

Comments: _____

_____

_____

Thank you for your time and for your participation.

APPENDIX C

Box 4.1: THE COLLAPSED THE RESPONSES TO THE MMSS WITH RESPECT TO THE QUESTION "HOW SATISFIED ARE YOU WITH THE FOLLOWING ASPECTS OF YOUR CURRENT JOB?"

BOX 4.2: THE CATEGORIES AND THEMES OF "WHAT ADDS TO WORK SATISFACTION?"

BOX 4.3: THE CATEGORIES AND THEMES OF "WHAT TAKES AWAY FROM WORK SATISFACTION?"

BOX 4.4: THE CATEGORIES AND THEMES OF THE ELEMENTS OF RESIDENT-CENTRED CARE

Collapsed Responses to the MMSS

How satisfied are you with the following aspects of your current job?

Items	Satisfied	Satisfied/Dissatisfied	Dissatisfied
1. Salary (E)	**5**	2	2
2. Vacation (E)	**6**	1	2
3. Benefits package (E)	**7**	0	2
4. Hours that you work (S)	**8**	1	0
5. Flexibility in scheduling hours (S)	**5**	2	2
6. Opportunity to work straight days (S)	**5**	3	1
7. Opportunity to work part-time (B)	4	3	0
8. Weekends off per month (S)	3	3	2
9. Flexibility in scheduling weekends off (S)	**5**	0	3
10. Compensation for working weekends (S)	2	1	**5**
11. Maternity leave (B)	1	7	0
12. Child care facilities (B)	0	**5**	3
13. Your immediate supervisor (A)	**7**	0	2
14. Your work with other HCAs (C)	**7**	2	0
15. The nurses you work with (C)	**5**	3	1
16. The delivery method use on your unit (resident-centered care) (I)	4	2	3
17. Opportunities for social contact at work (I)	4	4	1
18. Opportunities for social contact with co-workers after work (I)	3	**5**	1
19. Opportunities top interact with other disciplines (I)	4	1	1
20. Opportunities for continuing education (P)	**5**	1	3
21. Opportunities to belong to departments/ workplace committees (P)	4	4	1
22. Control over what goes on in your work setting (R)	4	1	4
23. Opportunities for career advancement (R)	0	**6**	3
24. Recognition from managers/directors (A)	3	3	3
25. Recognition from other HCAs (A)	4	3	2
26. Amount of encouragement and positive feedback (A)	4	1	3
27. Opportunities to participate in research (P)	1	4	4
28. Opportunities to participate in union activities (P)	4	**5**	0
29. Your amount of responsibility (R)	4	1	3
30. Your control over work conditions (R)	4	1	4
31. Your participation in organization decision making (R)	2	3	4
32. Your overall satisfaction	**6**	1	2

Box 4.1: The collapsed responses to the MMSS with respect to the question "How satisfied are you with the following aspects of your current job?"
Note: Rows do not add up to "9" because of missing values.

Scale:	
A=	Praise and Recognition Subscale
B=	Balance of Family and Work Subscale
C=	Co-workers Subscale
E=	Extrinsic Rewards Subscale
I=	Interaction and Opportunities Subscale
P=	Professional Opportunities Subscale
R=	Control and Responsibility Subscale
S=	Scheduling Subscale

Categories and Themes of "What Adds to Work Satisfaction"

Relationships with residents
1) Rewarding relationships with residents
2) Putting the needs of residents before mine
3) Meeting residents' social and emotional needs

Relationships with co-workers
1) Supportive work relationships
2) Working with competent co-workers

Relationships with management
1) Having input into decisions involving my work
2) Being treated with respect and acknowledgement

Having opportunities to achieve personal and professional goals
1) Maintaining personal values
2) Having a fulfilling job
3) Maintaining good physical and mental health

Box 4.2: The categories and themes of "What Adds to Work Satisfaction?"

Categories and Themes of "What Takes Away from Work Satisfaction?"

Relationships with residents
1) Dealing with difficult residents
2) Residents quality of care
3) Residents quality of life
4) Grieving the loss of a resident

Relationships with family
1) Dealing with difficult families

Relationships with co-workers
1) Relationships with HCAs
2) Lack of teamwork
3) Relationships with nurses

Relationships with Management
1) Lack of adequate resources
2) Lack of praise and encouragement
3) Lack of good supervision
4) Heavy workload

Box 4.3: The categories and themes of "What Takes Away from Work Satisfaction?"

Elements of Resident-Centred Care: Categories and Themes

Flexible Scheduling
1) Adds to HCA work satisfaction
2) Adds to the quality of the HCA relationship with the resident

Following Resident Preferences
1) Adds to HCA work dissatisfaction
2) Adds to the residents' quality of life

Promoting a Home-Like Environment
1) Adds to the quality of the HCA relationship with the resident
2) Adds to of HCA work satisfaction

Permanent Assignment

1) Adds to HCA work satisfaction
2) Adds to HCA work dissatisfaction

Box 4.4: The categories and themes of the elements of resident-centred care.