

**Discovering and Dreaming:  
Long-term Care Healthcare Aide Perceptions of Structural Empowerment**

by

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### Abstract

**Background and objective:** Chronic and emergent care challenges have led to diminished quality of care in many long-term care (LTC) facilities during the COVID-19 pandemic and beyond. Healthcare aides (HCAs) occupy a strategically important role in achieving improved resident care outcomes yet continue to experience disempowerment through authoritarian working conditions. The aim of this study was to develop a robust description of HCA perceptions of how organizational structures empower them and the desired dream state for such structures. **Approach:** This study used a qualitative descriptive research design informed by Kanter's theory of structural empowerment within an appreciative inquiry (AI) framework. AI was chosen for its optimistic egalitarian approach towards organization change; it provided a platform for HCA voices to be heard, protected, and valued. Sampling used volunteer participants and involved convenience and snowball sampling. Ten HCA participants were recruited from four Winnipeg LTC sites. Semi-structured virtual interviews were used to gather rich descriptive data, allowing for an understanding of participant perspectives. **Findings:** Two main themes emerged from the data: i) What is Important to Healthcare Aides; and ii) Challenges. These participants care about their residents, their job satisfaction and team functioning but experience numerous challenges in their work. They lack access to opportunities for education, resources (i.e., staffing and time), and support from managers and organizations; they also endure difficult, stressful, and dangerous working conditions and retention is inadequately prioritized by the LTC sector. Modifiable organizational structures have the potential to improve resident care by empowering healthcare aides and may be mediated by the functionality of teams and the use of regular healthcare aides. **Conclusion:** Empowering healthcare aides is a means to improve the well-being and satisfaction of these essential workers and represents a strategy for ensuring these workers have what they need to provide quality care to residents.

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### **Dedication**

**Dedicated to E & T.** May you be bold in dreaming and in pursuing your dreams. May the barriers to post-secondary that existed for me be non-existent for you.

**Dedicated also to all long-term care healthcare aides, including my mother.** May you never experience burnout and always be full of care and compassion for your residents. May you know the value you bring and have brought to residents in your care and to society as a whole. May you be seen, appreciated, and supported. May you be given and take chances to learn and grow. May you always be respected and heard.

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## Chapter 1 – Background

### Background & Canadian Context

#### Characteristics of Long-term Care Residents: A Complex and Vulnerable Population

Adults aged 65+ are the most rapidly growing segment of the global population, with the 85+ aged group growing the fastest both in Canada and globally (Bloom, 2020; United Nations, 2019). As the older adult population continues to increase, so too does the volume of individuals with dementia and other co-morbid conditions (Alzheimer's Association Report, 2020; Chatterji et al., 2015; McGilton et al., 2016). These demographic and health profile changes within the older adult population have and continue to converge with healthcare restructuring to influence the characteristics and needs of long-term care residents. Health restructuring in the last four decades has gradually shifted care of older adults out of institution-like settings with the aim of keeping these individuals living longer independently in the community (Vasunilashorn et al., 2012). For example, in Manitoba, this restructuring is largely centred around the province's *Aging in Place* initiative (Health Seniors and Active Living, n.d.). Therefore, long-term care residents today possess increasingly complex care needs (Estabrooks et al., 2020; Fahey et al., 2003). Chronic conditions such as moderate to advanced dementia, diabetes, stroke, chronic obstructive pulmonary disease, heart failure, cancer, and schizophrenia are common in long-term care residents; multimorbidity of such conditions and polypharmacy for their management is also common in this population (Hirdes et al., 2011; Ng et al., 2020). For example, over half of Ontario long-term care residents have five or more chronic conditions while nearly two thirds have been prescribed nine or more medications (Ng et al., 2020). Resident morbidity is associated with high levels of frailty and dependence – two other common characteristics in individuals who reside in residential long-term care settings (Muscedere et al., 2016). Finally, of the 7% of Canadian adults aged 65+ who reside in residential long-term care settings, 55-72% are female

(Garner et al., 2018; Hirdes et al., 2011), a statistic most pronounced in the 85+ age group, where 33.4% of Canadian woman reside in long-term care settings compared to only 21.5% of Canadian men (Statistics Canada, 2012).

### **Characteristics of Long-Term Care Healthcare Aides: A Disempowered and Vulnerable Population Caring for a Vulnerable Population**

Healthcare aides provide 80-90% of direct resident care in residential long-term care settings (Price Waterhouse Coopers, 2001). As unregulated professionals, individuals occupying healthcare aide positions are often subject to low pay, minimal non-standardized education, lack of adequate continuing education, high burden of work, and little to no professional authority or autonomy (Armstrong et al., 2015; Estabrooks et al., 2015; Zysberg et al., 2019). In Canada healthcare aides tend to be middle-aged or older women from ethnic minorities (Chamberlain et al., 2019; Estabrooks et al., 2015). Furthermore, these workers are managed using top-down authoritarian practices, while enduring hostile work environments and high rates of work-related injuries (Anderson et al., 2003; Hewko et al., 2015; Quinn et al., 2016). The compounding effect of these social and structural issues predispose long-term care healthcare aides to high levels of job dissatisfaction, burnout and turnover rates between 60-170% annually (Cooper et al., 2016; Donoghue & Castle, 2009).

### **Ageism, Ableism, Sexism, and Racism**

Although resident morbidity and age contribute to mortality in the long-term care population during the COVID-19 pandemic, epidemiological and demographic vulnerabilities of these individuals are not the only contributors to the problem (Canadian Institute for Health Information, 2015; Centers for Disease Control and Prevention, 2020; Faghanipour et al., 2020; Gordon et al., 2020; Ouslander & Grabowski, 2020). The long-term care sector in Canada functions within a sociopolitical context in which the devaluation of aged and disabled

individuals intersects with sexist and racist structures and values (Faghanipour et al., 2020). Such bias acts to shape the delivery of care in these complex adaptive systems in dynamic and emergent interconnected ways and is at the forefront of the Canadian consciousness during the COVID-19 pandemic (Faghanipour et al., 2020; Greenhalgh & Abimbola, 2019). The long-term care workforce represents one such interconnected influencer of quality care profoundly shaped by these biases.

Prevailing ageist and ableist neoliberal capitalist ideologies assign value to humans based on their economic contribution, viewing older adults as having outlived their usefulness and deprioritizing care of such individuals, perceiving such work to be “low-skilled” work reserved for unskilled labourers (Faghanipour et al., 2020). Such ageism and ableism intersect with sexism and racism to further devalue older adult care work in residential long-term care settings, where most individuals in need of care are women and most healthcare aide caregivers are women, particularly women of colour. Biased structures and values impact the care and work environment of residential long-term care settings beyond the organizational level and extend to the levels of the provincial and federal governments. For example, Canadian government policies organize and fund healthcare in ways that do not prioritize the long-term care sector. The exclusion of residential long-term care from the Canada Health Act or other equivalent national legislation is the most obvious case in point of our nation’s de-prioritization of this sector. As a result, the long-term care sector is chronically underfunded directly contributing to chronic understaffing, inadequate staff skill mix, and under education of staff in long-term care settings (Armstrong et al., 2015; Armstrong et al., 2020; Estabrooks et al., 2020; Shields, 2006). Such inadequacies influence staff knowledge and attitudes (Estabrooks et al., 2020) – an important consideration because staff with hostile attitudes and insufficient education are less likely to adhere to evidence-based practices, directly influencing quality of care (Grimshaw et al., 2012;

Tacia et al., 2015). The volume and intensity of duties to which long-term care staff are subjected are compounded by understaffing issues and also contribute negatively to staff well-being and resident outcomes (Maben & Bridges, 2020; McGarry et al., 2020; Stevenson, 2021).

Existing in a climate of broad systemic ageism, ableism, sexism, and racism, the long-term care sector perpetuates these biases against long-term care healthcare aides and those to whom they deliver care. It does this by placing healthcare aides in charge of the vast majority of direct care received by residents, while paradoxically undermining them and their contributions. Long-term care healthcare aides and the work that they do are devalued through low pay, precarious employment, low career opportunity, unsafe and exploitative working conditions, inadequate staffing, inadequate education, and placement on the bottom rung of a well-established healthcare hierarchy. Together these act to limit the opportunity for such workers to draw attention to their plight or create change (Faghanipour et al., 2020). Moreover, the disadvantages and racism experienced by long-term care healthcare aides actively excludes them from participating in decisions about the care of residents (Lightman, 2021). The hierarchical healthcare ladder meanwhile impedes the contributions of these healthcare team members by devaluing their expertise and perspectives in the delivery of care even though they are often optimally positioned to understand the specific preferences and values of the residents for whom they provide care. These paradoxes compromise the wellbeing of the long-term care healthcare aide workforce and ultimately act to diminish this sector's capacity for consistent, quality relational care for Canadian long-term care residents.

### **Turnover, Quality Care, and Empowerment**

Strong interplay exists between the work and care conditions of long-term care settings and staff turnover rates. Turnover causes and is caused by high workloads and poor working conditions and vice versa (Castle & Engberg, 2006; Collier & Harrington, 2008). Turnover

negatively influences quality of care; for example, turnover is associated with substantial increases in infection rates and hospitalizations (Zimmerman et al., 2002). Improving resident outcomes must necessarily consider the requisite need to interrupt damaging work-and-care-condition-turnover cycles by creating environments that are structurally empowering. Studies demonstrate that better quality of care is associated with residential long-term care settings which foster cognitive diversity, creativity, communication, and team-based approaches to care (Brabant et al., 2007; Forbes-Thompson, 2007; Zheng & Temkin-Greener, 2010). Long-term care staff who experience empowerment perform their jobs better, have improved quality of work life and job satisfaction, while being more devoted to their work, more dedicated the aim of optimizing resident care, more likely to provide improved quality of care, and more likely to sustain quality improvement changes (André et al., 2014; Barry et al., 2005; Cranley et al., 2018; Hamann, 2014; Squires et al., 2015; Yeatts & Cready, 2007). Evidence that long-term care staff desire greater empowerment is, therefore, unsurprising (Hamann, 2014).

### **The Problem and Purpose**

#### **Statement of the Research Problem**

Addressing the paradoxes embedded in this sector's treatment of long-term care healthcare aides is both a means and an end in itself; bridging ongoing evidence-practice gaps has the potential to meet the moral and ethical obligation of organizations to provide healthy work environments while improving quality of care provided. While researchers and practitioners in Canada and beyond are using promising implementation approaches to close this gap (Cranley et al., 2018; Cranley et al., 2011; Norton et al., 2013), the iterative creation and use of new knowledge to support these ongoing efforts is needed within the area of healthcare aide perspectives of empowerment structures in long-term care facilities. This study has been designed with this need in mind.

Sufficient understanding of the use, availability, and relative importance of empowerment structures from the perspectives of healthcare aides is necessary to optimize stability and effectiveness of the long-term care healthcare aide workforce. Use of a theoretical framework coupled with a qualitative exploratory approach is well-suited to addressing these evidence gaps. Examining structural empowerment from the perspectives of this typically disenfranchised and disempowered group of strategically placed essential healthcare workers is a necessary starting point to address the empowerment needs of this worker population. Moreover, such work has the potential to not only reveal the priorities and values of this group of healthcare workers, but to contribute to the development of enhanced policy, governance, and structuring of the residential long-term care healthcare aide position and eventually, to the optimization of care delivery in residential long-term care settings.

### **Purpose and Research Questions**

The purpose of this study was to develop a rich description of the structural factors which support the empowerment of long-term care healthcare aides. Specifically, this study aimed to understand the relationships, relative importance, promising practices, and ideal state of organizational structures for optimal healthcare aide empowerment. This study was guided by the following research questions:

1. What organizational structures (i.e., power, opportunity, and proportion structures) do long-term care healthcare aides have access to and use?
2. What is the relationship between organizational structures (i.e., power, opportunity, and proportion structures) in residential long-term care settings and healthcare aide empowerment?
3. What is the relative importance of organizational structures (i.e., power, opportunity, and proportion structures) in influencing healthcare aide empowerment?

4. What are the organizational structures (i.e., power, opportunity, and proportion structures) already in use in long-term care settings that work well at empowering healthcare aides?
5. What is the ideal state of organizational structures (i.e., power, opportunity, and proportion structures) in long-term care settings to optimize healthcare aide empowerment?

### **Definitions**

#### **Healthcare aide**

A term “often used synonymously with Personal Support Worker (PSWs)...home support workers, health care aide, hospital attendant, long-term care aide, nurse aide, nursing attendant, patient care aide, psychiatric aide, and resident care aide” (Berta et al., 2013, p. 1). Their role is largely supportive and involves assisting with activities of daily living (ADLs) “such as bathing, dressing, meal preparation and other ‘light’ household tasks” but may also comprise of more complex functioning including delegated tasks such as catheterization and injection (Berta et al., 2013, p. 2).

#### **Regular Healthcare Aide**

A healthcare aide who works at least on average of 15 hours per week on a specific long-term care facility's unit.

#### **Non-Regular Healthcare Aide**

A healthcare aide is deemed non-regular when work on any long-term care organization's unit that less than an average of 15 hours per week. They could be a regular healthcare aide on one unit (where they work on average 15 or more hours per week) and non-regular on another unit. The term ‘non-regular healthcare aide’ encompasses agency, casual, and float healthcare aides except when they work an average of 15 hours or more per week on the long-term care organization unit being discussed.

**Agency Healthcare Aide**

A healthcare aide who is employed by a private health care staffing corporation (i.e., agency) and is contracted through the agency by long-term care facilities to fill staffing vacancies.

**Casual Healthcare Aide**

A healthcare aide who is employed by a long-term care organization but does not have a position or guaranteed hours. Casual healthcare aides have the flexibility to only take shifts that they want (assuming they are available).

**Float Healthcare Aide**

A healthcare aide who is employed by a long-term care organization with a position in the organization's 'float pool'. Float pools help organizations to address fluctuating staffing and resident needs.

**Long-term Care Facilities**

Residential long-term care facilities which provide "room and board, as well as management of chronic medical conditions and 24-hour assistance with ADLs in [residents] who are physically and/or cognitively impaired" (Sanford et al., 2015, p. 182).

**Racialized Healthcare Aide**

A healthcare aide who identifies as a race other than the dominant norm (i.e., White) (Mooten, 2021).

**Non-Racialized Healthcare Aide**

A healthcare aide who identifies as a race that is the dominant norm (i.e., White) (Mooten, 2021).

**Theoretical Framework****Empowerment**

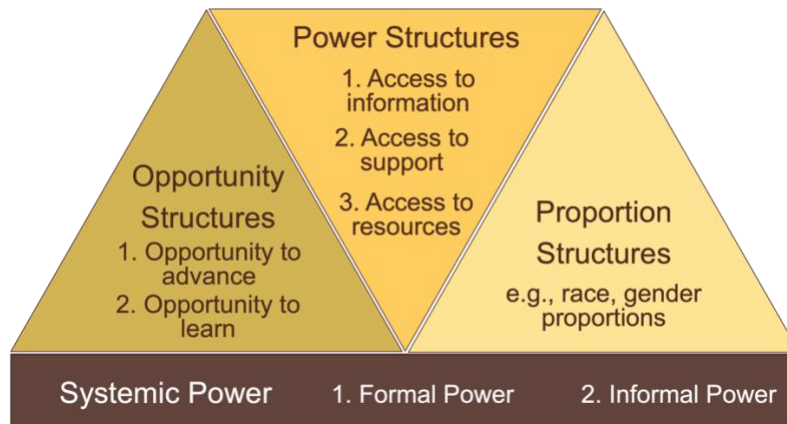
Structures and customs are known to influence evidence adoption (Greenhalgh et al., 2004). Empowerment structures have the capacity to influence both. Heterogeneously

conceptualized in the literature, work empowerment can be organizational (i.e., through empowerment structures) or individual (i.e., psychological empowerment) (Caesens et al., 2020; Kanter, 1993; Spreitzer, 1995; Travis & Oliver, 2017). Kanter's theory of structural power in organizations provides a framework of idealized work environment conditions which lead to staff empowerment. A complementary concept, psychological empowerment encompasses employee responses to their work environments and is defined as a belief that one can influence and affect their work; this perception is motivated by a sense of meaning, competence, self-determination, and influence in their role (Spreitzer, 1995). Structural empowerment in nurses serves as an antecedent to psychological empowerment and both directly yield a positive influence on job satisfaction and negative influence on job strain (Cummings et al., 2010; Kanter, 1993; Laschinger et al., 2001, 2002). Given the direct and indirect influence of structural empowerment upon nursing staff and the evidence supporting the concept as a requisite for psychological empowerment in nursing staff, the study presumes psychological empowerment to be an outcome of organizational empowerment structures through internalization of such empowerment by staff. Therefore, the focus of this study is on the environmental conditions in long-term care facilities and the ways in which healthcare aides perceive such organizational structures to be empowering or disempowering.

### **Kanter's Theory of Structural Empowerment**

Kanter's (1993) theory of structural empowerment provides a framework useful for understanding and improving employee quality of work life and organizational effectiveness through structural empowerment. In this theory, Kanter posits that the effectiveness of employee work attitudes and behaviours are influenced by structural factors such as an individual's organizational position and circumstances significantly more than they are by individual traits (Kanter, 1993). Three structural factors are said to influence structural empowerment, namely

power, opportunity, and proportions (see Figure I, p. 11). Power is defined as “the ability to get things done, (and) to mobilize resources” (Kanter, 1993). It is embedded systemically within organizations and is categorized by Kanter as formal and informal power. Formal power is found in jobs which are visible, central to the purpose of the organization, and allow for discretion in decision-making (Laschinger, 1996). Informal power is found in relationships with superiors, peers, and subordinates (Laschinger, 1996). The formal and informal power structures which an employee has access to, influences the access they will have to job-related empowerment structures, namely information structures, support structures, and resource structures (Laschinger, 1996). Organizations with high levels of access to information, support, and resources are synonymous with a flattened organizational hierarchy, and result in enhanced workforce opportunity and empowerment. In contrast, organizations which monopolize power offer workers poor access to information, support, and resources, while upholding employee accountability structures, causing staff to experience powerlessness. Opportunity structures encompass the opportunity for workers to advance within the organization, and the opportunity to develop knowledge and skills. Proportion structures refer to the social composition of workers in similar work roles and encompass, for example, gender and race. All three organizational structures are influenced by feedback loops in which embedded structures shape employee behaviours and facilitate or impede access to power, opportunity, and enhanced proportions. For example, when opportunities to advance within an organization are provided to workers they are more highly committed to the organization and more highly motivated to perform in ways which benefit the organization and advance their careers.

**Figure I***Kanter's Theory of Structural Empowerment***Summary**

When crossing the long-term care sector's evidence-practice chasm, requisite attention must be paid to the perspectives and empowerment needs of frontline healthcare aides who provide the bulk of resident care. Such an approach employs theoretical and empirical evidence from across the literature and carries with it the potential to yield direct and indirect improvements upon this segment of the healthcare workforce and the residents for whom they care. This study has elicited novel findings on the perspectives of long-term care healthcare aides' empowerment and can help to shape the way long-term care organizations are structured. It also has the potential to iteratively inform ongoing implementation research being done in Canadian long-term care settings by highlighting relationships, relative importance, promising practices, and the ideal dream state of organizational structures from the perspectives of care aides while providing a rich description of the factors influencing the accessibility, use, and opportunities surrounding these.

## Chapter 2 – Literature Review

The review of the literature on healthcare aide empowerment and related populations and terms for this study used a combined narrative/descriptive review process (King & He, 2005). Such a review provides a clear understanding of the state of the literature on the topic, delineating strengths, weaknesses, and gaps in the existing body of research and rationale for the study (De Los Reyes & Kazdin, 2008). Guidance was obtained from Polit and Beck (2017) on proper deployment of search strategies. To ensure reproducibility of this literature search, a clear description of the search strategy deployed is provided.

### Search Strategy

Searching was limited to English language documents with the timeframe of studies left open. Three databases were accessed: CINAHL, PubMed, and EMBASE (Appendix A). Three concepts were identified: empowerment, healthcare aides, and residential long-term care settings. Table I shows that each concept was searched for using as many terms as possible.

**Table I**

#### *Identified Concepts and their Accompanying Terms*

Concept #1: Empowerment	Concept #2: Healthcare Aides	Concept #3: Residential Long-term Care Settings
empower*	support worker* nurs* aide* unlicensed aide* unlicensed attendant* nurs* attendant* care aide* care attendant*	long term care residential care nursing home* care home* aged care facilit*
*Note: Truncated words with asterisk indicates terms with various endings were searched to maximize search results (e.g. nurs* aide* indicates the following were included in the search: nurse aide, nurse aides, nurses aide, nurses aides, nursing aide, nursing aides).		

General database search strategies were employed. Assistance with developing this strategy was sought and provided by health sciences librarians. General database searches

returned 107 records. Preliminary screening of articles excluded 77 records (58 duplicates). Full text screening resulted in another four records excluded for a total of 26 full text articles identified and included in the literature search. Lastly, references of included records had their bibliographic databases searched. Historical reference list searching yielded 6 records, all of which were included after preliminary and full text screening. Altogether, 32 articles met the literature review's search criteria and were included.

### **Earlier Research**

Most of the existing literature on the work and working environment of long-term care healthcare aides has centred on examining workplace stressors, job satisfaction, and turnover (Brannon et al., 2002; Castle & Engberg, 2006; Castle et al., 2007; Collier & Harrington, 2008; Dill et al., 2010; Donoghue & Castle, 2009; Kuo et al., 2014; Lerner et al., 2011; Parmelee et al., 2009; Stearns & D'Arcy, 2008). Some of these findings are discussed in the previous chapter. While some understanding of workplace stressors, job satisfaction, and turnover in long-term care healthcare aides has emerged, less is understood about structural empowerment and the perspectives of long-term care healthcare aides in relation to it.

The bulk of the research on structural empowerment is situated within the nursing literature and focuses on hospital nurse empowerment (Cicolini et al., 2014; Goedhart et al., 2017; Greco et al., 2006; Laschinger et al., 2001, 2002; Laschinger et al., 1999). This makes transferability of findings to long-term care healthcare aides challenging and somewhat limited, owing to differences between groups (i.e., between nurses and healthcare aides) and/or settings (i.e., between hospitals and long-term care facilities). Nonetheless, a brief examination of the insights offered by structural empowerment studies using Kanter's (1993) model in hospital nurses and long-term care staff is beneficial in understanding the current state of the structural empowerment literature and delineating further rationale for the study.

Structural empowerment in nurses is closely linked to the empowering behaviours of their leaders (Greco et al., 2006; Laschinger, 2008; Laschinger et al., 1999); for example, leaders who enhance the meaning and value of work, enable participative decision-making, foster goal accomplishment, express confidence in high performance, and provide autonomy from bureaucratic constraints are associated with significantly higher levels of empowerment, increased work effectiveness, and decreased job tension in nurses (Laschinger et al., 1999). Leadership empowering behaviours also have a direct influence on nurse burnout (Greco et al., 2006). In a scoping review by Goedhart et al. (2017) greater access to empowerment structures in hospital nurses positively influenced quality, effectiveness, safety, efficiency, and patient-centredness. For example, greater access to support, resources, and the opportunity to develop knowledge are highly correlated with individual nurse and unit level effectiveness. Urban tertiary nursing staff also report that the most empowering structures in their workplaces are good relationships and access to opportunity to learn and grow in the job (Laschinger, 2008).

Like other empowerment literature, the evidence on empowerment of healthcare aides working in long-term care is conceptually vague and/or heterogeneous (Barry et al., 2005; Hagerman et al., 2017; Hamann, 2014; Yeatts & Cready, 2007). It also often fails to examine healthcare aide empowerment separately from other long-term care staff (Caspar & O'Rourke, 2008; Hagerman et al., 2017; Hamann, 2014). Nonetheless, some studies using Kanter's (1993) construct of structural empowerment reveal positive relationships between long-term care staff structural empowerment and increased provision of person-centred care approaches and service quality (Caspar & O'Rourke, 2008; Hamann, 2014), as well as positive relationships between structural empowerment of leaders and staff (Hageman et al., 2017).

### **Literature Search Findings**

Regarding long-term care healthcare aides, the literature review found that the term *empowerment* was conceptualized in three different ways, namely as *empowerment (undefined)*, *psychological empowerment*, and *structural empowerment*. Conceptually, varying degrees of overlap could be inferred within studies depending on the use of the word. It is worth noting that over half – 17 of 32 – of included studies were conceptually vague and did not define the term at all. A further seven of included studies utilized the term to mean psychological empowerment. The remaining eight studies used the theoretical underpinnings of Kanter's (1993) work and examined structural empowerment.

Support was found for Kanter's (1993) theory that structural, not individual, factors were more strongly associated with structural empowerment of healthcare aides (Chaudhuri et al., 2013). Findings from the literature on residential long-term care healthcare aide empowerment were divided into two broad categories, namely *Fit with Kanter's Theory* and *Related Concepts*. As appropriate, subcategories were created to further delineate key themes that emerged from the literature within each of these categories.

#### **Fit with Kanter's Theory**

A study examining long-term care staff and resident family empowerment found that most staff working in the 33 American long-term care facilities examined were low in empowerment scores (Hamann, 2014). However, not all studies included in the literature review shared these findings. Some studies found healthcare aides were moderately empowered and possessed similar empowerment levels to nursing staff (Caspar & O'Rourke, 2008).

Some specific structural factors were identified in the literature as contributing to long-term care healthcare aide empowerment or disempowerment. These factors were subcategorized to align with key concepts within Kanter's (1993) theory of structural

empowerment, creating a road map of structural conditions that long-term care facilities should seek to espouse or avoid when seeking to empower these invaluable members of the healthcare team.

### ***Systemic Power***

Because access to formal and informal power structures influences the access that employees have to job-related empowerment structures, understanding systemic formal and informal power structures embedded within the long-term care sector's healthcare aide position is foundational to understanding the empowerment needs of long-term care healthcare aides.

**Formal Power.** Healthcare aides working in long-term care lack formal power. Work roles that are visible possess formal power (Kanter, 1993). Long-term care healthcare aides, though present nearly everywhere in healthcare, remain largely invisible (Hewko et al., 2015). However, when healthcare aides' work is seen and appreciated, they experienced greater empowerment (Karmacharya et al., 2023).

Work roles that are linked to the central purpose of their organization also possess formal power (Kanter, 1993). Long-term healthcare aides, however, may be poorly linked to the central purpose of their organization because of the highly task-oriented view of their work role. Furthermore, work roles that contain decision-making power possess formal power (Kanter, 1993). The studies examined confirmed findings that long-term care healthcare aides often practice in a rigid medical hierarchy where their views and opinions are not heard or trusted equitably (Andersen & Spiers, 2016), and where they commonly lack decision-making power (Hamann, 2014; Perreira et al., 2017). Lack of decision-making power was further evidenced in studies which demonstrated long-term care healthcare aide perceptions that they possessed limited power to initiate change (Chaudhuri et al., 2013; Howe, 2014), lacked autonomy, and were endued with inflexible and expansive work responsibilities (Andersen & Spiers, 2016;

Chaudhuri et al., 2013). In healthcare aides whose formal power ratings were high, however, greater person-centred care was able to be provided (Caspar & O'Rourke, 2008). This makes sense because decision-making power – part of formal power – is needed to provide the type of individualized care approach that constitutes quality person-centred care; this type of care is also more likely to align with organizational purpose and values – another tenet of formal power.

**Informal Power.** Lack of teamwork was frequently found in the literature (Chaudhuri et al., 2013; Howe, 2014; Perreira et al., 2017) and represents a lack of access to informal power for long-term care healthcare aides since relationships with colleagues are considered a source of systemically derived informal power (Kanter, 1993). In a study examining the value of “empowered (healthcare aide) work teams”, Yeatts and Cready (2007) found that those working in such teams rated themselves as more highly empowered than healthcare aides in other care homes using traditional work strategies. These highly empowered long-term care healthcare aides better cooperated with, coordinated with and supported their nurse and healthcare aide colleagues than those who were less empowered (Cready et al., 2008; Yeatts & Cready, 2007). This finding supports Kanter’s theory which posits that strong interprofessional relationships provide a source of informal power for employees, leading to greater levels of empowerment for them (Kanter, 1993; Yeatts & Cready, 2007). It also supports Kanter’s theory which states that empowered staff behave in ways which benefit their organization, creating a positive feedback loop (Kanter, 1993).

Empowering healthcare aides to collaborate with other members of the care team and become more involved in decision-making resulted in increased perceived healthcare aide autonomy, impact and competence (Yeatts & Cready, 2007). This study also found improved work performance, psychological empowerment ratings, quality of resident care, and decreased

turnover. These findings support Kanter's (1993) theorization that the quality of working relationships has a direct influence on quality of work performed by staff (Kanter, 1993).

### ***Power Structures***

Power structures encompass three theoretical components within Kanter's theory. These are (a) access to information, (b) access to support, and (c) access to resources.

**Information.** Lack of information was disempowering for healthcare aides according to studies (Andersen & Spiers, 2016; Chaudhuri et al., 2013; Howe, 2014). For example, in a qualitative focused ethnography study examining the perspectives of 22 long-term care healthcare aides in Canada, participants shared how lack of information about a resident's change in health status or about the rationale for a client procedure caused them to feel distressed and disempowered (Andersen & Spiers, 2016). In this study and two other American studies, healthcare aides perceived a lack of information came from their managers (Andersen & Spiers, 2016; Chaudhuri et al., 2013; Howe, 2014). As with power, when healthcare aides had access to information, greater provision of person-centred care was achieved (Caspar & O'Rourke, 2008). Without adequate information about the values and preferences of residents, quality person-centred care cannot be delivered, making person-centred care and access to information complementary concepts.

**Support.** Long-term care healthcare aides perceived a lack of managerial support or concern for them (Chaudhuri et al., 2013; Howe, 2014; Kostiwa & Meeks, 2009) and perceived themselves to be less supported than healthcare aides working in the community setting (Perreira et al., 2017). In a study of healthcare aides in 11 American long-term care facilities where structural empowerment was defined as the ability to autonomously decide and execute an appropriate action within their work role, long-term care healthcare aides had significantly more autonomy in their decision-making when supported by their supervisor (Chaudhuri et al., 2013).

This finding supports Kanter's (1993) theorization that support is vital for staff empowerment. Of all measured variables of structural empowerment, support was the one most significantly related to improved perceived access to structural empowerment in long-term care healthcare aides, demonstrating the vital role that those who lead and manage healthcare aides have in empowering them (Caspar & O'Rourke, 2008). In a study by Wang et al. (2024), long term care facilities with supportive leaders empowered healthcare aides to take proactive leadership roles which helped them optimize resident quality of care through such approaches as effective collaboration with fellow healthcare team members (Wang et al., 2024). In addition to providing them with sufficient resources, leaders in this study supported healthcare aides by providing psychological support and communicating openly with them. Moreover, access to support for healthcare aides was also associated with improved person-centred care (Caspar & O'Rourke, 2008; Iaconi et al., 2024; Wang et al., 2024).

**Resources.** Kanter's (1993) theory posits that resources are essential for staff empowerment and that without adequate resources staff are unable to perform their job. These include adequate time, staff, and access to physical resources. Adequate resources correlated positively with structural empowerment in long-term care healthcare aides and improved provision of person-centred care (Caspar & O'Rourke, 2008; Cready et al., 2008) and time to care for residents was positively associated with psychological empowerment in healthcare aides (Iaconi et al., 2024). Nonetheless, inadequate resources were a common finding in studies (Andersen & Spiers, 2016; Kostiwa & Meeks, 2009; Kuo et al., 2008). For example, healthcare aides report inadequate time to do the work assigned to them (Kuo et al., 2008) particularly when management staff locked up certain supplies required by healthcare aides in their work caring for residents (Andersen & Spiers, 2016). Resources were found to positively influence the impact of support on person-centred care (Caspar & O'Rourke, 2008). This finding fits with other studies

which also demonstrated that staff felt unsupported by their superiors when they are not given enough resources (Andersen & Spiers, 2016; Kuo et al., 2008).

### *Opportunity*

In Kanter's (1993) theory, opportunity pertains to prospects, mobility, and professional growth. Specifically, upward and lateral job mobility, and education are sources of opportunity which empower staff. None of the included studies examined the effect of upward or lateral mobility. However, in the literature review by Gruss (2007), she cites Franke (2001) and Jette et al. (2000) and links programs for advanced education to Kanter's theory. As a next step in mobility, these programs encourage healthcare aides who complete the education to progress by teaching other healthcare aides or pursuing nursing education (Gruss, 2007). Some studies included in Gruss' literature review found that younger healthcare aides tended to demonstrate less commitment to their jobs as they intended to or were actively pursuing education to become a regulated nurse. The literature did not otherwise indicate that formal mobility mechanisms exist within long-term care healthcare aide positions.

Access to opportunity structures positively correlates with improved empowerment, work performance, and provision of person-centred care (Caspar & O'Rourke, 2008; Häggström et al., 2009; Jones et al., 2024; Yeatts et al., 2010). Three studies examined the impact of education on long-term care healthcare aide empowerment. A study in Sweden examined psychological empowerment and a 9 month education series on role awareness; participants developed increased feelings of self-worth, empowerment, and more active, less dependent work roles (Häggström et al., 2009). A Taiwanese study examined healthcare aides who were immigrants and found that teaching these individuals about empowerment without actually addressing empowerment structures had the opposite effect – it was disempowering for them as they came to recognize ways in which they lacked power (Wu et al., 2005). An American study examined the

perspectives of healthcare aides on the impact of having access to education whenever it was needed found this type of opportunity positively influenced both healthcare aide performance and empowerment, further confirming Kanter's (1993) theory's applicability in this population (Yeatts et al., 2010). In this study, healthcare aides indicated positive increases in both participating and autonomy in decision making, with much greater increase in the former than the latter (Yeatts et al., 2010).

### ***Proportions***

The study by Chaudhuri et al. (2013) examined the differences between Black, White, and Non-White healthcare aides and found that Black healthcare aides were less prone to autonomous decision-making than White care aides, while Non-White healthcare aides were the most likely of the three groups to display autonomous decision-making. This finding supports Kanter's (1993) theorization that proportions are important considerations for employee empowerment. The concept of proportions is not expressly examined within studies examining structural empowerment using the CWEQ II. However, demographic data are frequently assessed for relationships with other empowerment structures and otherwise confirm Kanter's (1993) theorization that structural factors, not individual factors, account for the root sources of employee empowerment and behaviours.

### **Related Concepts**

Several studies within the literature review examined the relationship between empowerment and other concepts. Sometimes these studies examined psychological empowerment and not structural empowerment. Owing to a paucity of studies examining structural empowerment relationships in long-term care healthcare aides, these were also included. Other concepts identified in the literature were job satisfaction, turnover, and quality of care.

### *Psychological Empowerment*

Psychological empowerment refers to an individual's belief that they can influence their work. The presence of organizational empowerment structures (i.e. structural empowerment) is a necessary precondition for the individual worker to experience such a response to their work environment. The conceptualization of structural empowerment as a requisite for psychological empowerment is supported in relation to long-term care healthcare aides (Gruss, 2007). In a study by Gruss (2007) healthcare aides' self-reported structural empowerment scores were significantly positively associated with their self-reported of psychological empowerment scores. In examining the components of structural empowerment more closely, Gruss (2007) found that resources and opportunity were significantly positively correlated with psychological empowerment, while support was only marginally associated with the concept and the relationship between psychological empowerment and information was not significant.

In a study examining behaviour directed toward improving the organization (namely organizational citizenship behaviours), creativity, innovation, task performance, and proactive work behaviours were all associated with increased psychological empowerment (Perreira et al., 2017). These were also associated with improved quality of work life (Perreira et al., 2017). Psychological empowerment also was found to correlate positively with the job satisfaction of long-term care healthcare aides (Gruss, 2007; Perreira et al., 2017). Another study examined the organizational context elements associated with psychological empowerment in this population found that culture, leadership, evaluation, social capital, time, informal interactions, and space were all positively associated with the concept (Iaconi et al., 2024); formal interactions, structural resources, and staffing, however, were all negatively associated with the concept. For example, authors of this study found that "social capital" was associated with 49% fewer missed care tasks and concluded that teamwork and time work together to influence care delivered to residents.

Some studies found long-term care healthcare aides were disempowered. However, Kostiwa and Meeks (2009) found the psychological empowerment scores of participants were comparable to their nursing staff counterparts. While healthcare aide scores were lower, the difference was not statistically significant and demonstrated that the majority of healthcare aide and nursing staff in the American long-term care facilities sampled were empowered (Kostiwa & Meeks, 2009). In this study healthcare aides drew meaning from their work and rated themselves well on competence while rating themselves lower on self-determination and influence. An urban Western Canadian study by Song et al. (2020) found that healthcare aides frequently worked short-staffed, regularly missed essential care tasks for residents, regularly experienced responsive behaviours from residents, and most participants (70%) reported moderate to high risk for indicators of burnout. Participants were also infrequently involved in team meetings or family conferences. Nonetheless, participants reported high levels of psychological empowerment and professional efficacy (Song, Iaconi, et al., 2020).

### ***Job Satisfaction***

Job satisfaction is a measure of worker affect towards their job. This concept has been extensively examined in long-term care healthcare aides within the literature. Low levels job satisfaction in this population have been linked to reduced work ethic, attendance, and resident outcomes (Castle et al., 2006; Chou et al., 2002). Long-term care healthcare aides, however, report job satisfaction levels that are significantly lower than other members of the care team (Kostiwa & Meeks, 2009).

Empowerment and job satisfaction are closely related. A systematic review of job satisfaction in long-term care healthcare aides found that psychological and structural empowerment were important for achieving job satisfaction (Squires et al., 2015). Healthcare aide empowerment is strongly and positively associated with job satisfaction (Cready et al., 2008;

Gruss, 2007; Hamann, 2014; Kostiwa & Meeks, 2009; Kuo et al., 2008). For example, Gruss (2007) found that psychological empowerment in healthcare aides was significantly positively associated with their job satisfaction. She also found that structural empowerment accounted for 9% of the variance in job satisfaction, while 21% of the variance was accounted for by structural empowerment and psychological empowerment together. Meanwhile, Kostiwa and Meeks (2009) found that in conjunction with healthcare aide reports of service quality, empowerment accounted for nearly 46% variance in job satisfaction scores for these healthcare workers. Additionally, Kuo et al., (2008) reported that resources, opportunity, and informal power were more strongly predictive of job satisfaction than information, support, or formal power in long-term care healthcare aides in Taiwan. Finally, in a study that examined the impact of education provided to long-term care healthcare aides on the behavioural and psychological symptoms of dementia and a subsequent one year quality improvement initiative in which educated healthcare aides were supported to work as a peer mentor and resource to colleagues on person-centred care, increases were seen in healthcare aides' job satisfaction and in the meaning they assigned to their work (Jones et al., 2024).

### ***Turnover***

Reducing turnover of healthcare aides in long-term care settings has important implications for resident quality of care. Notably, a study in the literature review revealed that high healthcare aide retention rates are associated with improved social and medical outcomes for residents in long-term care facilities (Barry et al., 2005). Long-term care healthcare aides who are empowered are less likely to quit or report intention to quit (Barry et al., 2005; Berridge et al., 2020; Cready et al., 2008; Yeatts & Cready, 2007). For example, organizations with empowered leaders and staff were shown in a study by Berridge et al. (2020) to retain 76-90% of healthcare aide staff for one year, compared to a 0-50% retention rate in comparative organizations.

Similarly, Cready et al. (2008) found that healthcare aides who experience high levels of psychological empowerment were more likely than those who reported medium or low empowerment scores to report decreased burnout and increased job commitment. In an American study which purposively selected long-term care facilities, assisted living facilities, and home care agencies that were high performing in the areas of family satisfaction and staff retention, consistent work culture themes focused on worker empowerment were identified (Karmacharya et al., 2023). These included recognizing and appreciating direct care workers in formal and informal ways, providing them with financial incentives, and career advancement opportunities. Other work culture elements identified in this study which aided in worker retention were direct care workers feeling supported by their leaders and coworkers, autonomy in decision-making, leaders who used participative leadership approaches, and effective communication of information.

### ***Quality of Resident Care***

Findings across studies demonstrate that healthcare aide empowerment and quality of resident care are intrinsically linked (Barry et al., 2005; Caspar & O'Rourke, 2008; Caspar et al., 2009; Cranley et al., 2018; Cready et al., 2008; Doupe et al., 2022; Hamann, 2014; Ransom, 2000; Wu et al., 2018; Yeatts & Cready, 2007). To optimize the quality of care received by long-term care residents, the empowerment needs of healthcare aides must therefore not be overlooked. Quality of resident care can be measured in diverse ways. Therefore, heterogeneity was evident across included studies. Some studies examined the provision of person-centred care (Caspar & O'Rourke, 2008; Cready et al., 2008; Hamann, 2014; Yeatts & Cready, 2007). Others examined a specific measurable health outcome such as pressure ulcers (Barry et al., 2005; Ransom, 2000). A final group of studies within the literature review examined the initiation of a quality improvement intervention (Cranley et al., 2018; Doupe et al., 2022; Wu et al., 2018).

Given the different aspects of quality care, a brief discussion about each is provided in this section, as it relates to healthcare aide empowerment.

**Person-centred Care.** Care delivery in long-term care settings has historically been based upon the medical model (Caspar et al., 2009). More recently these settings have shifted towards more social models of care in an aim to prioritize the delivery of care which is person-centred (Caspar et al., 2009), viewing those receiving care as individual residents living in what, for many, will be their home until they die. Referred to heterogeneously in the literature, person-centred care attends to the specific care needs and values of the resident. Structural empowerment – and all of its attendant parts – have a statistically significant positive effect on the provision of person-centred care for both nurses and healthcare aides (Caspar & O'Rourke, 2008; Hamann, 2014; Yeatts & Cready, 2007). Access to resources, informal power, and support most strongly predict staff perceptions on the provision of person-centred care (Caspar & O'Rourke, 2008).

The importance of nurse empowerment in quality of resident care may be less significant in long-term care settings than the empowerment of healthcare aides – or, at least, it is according to the family of residents (Hamann, 2014). This perspective is likely because healthcare aides, not nurses, provide the bulk of direct care in long-term care settings. Further, the ability of empowered healthcare aides to influence decisions and advocate on behalf of their residents, in conjunction with increased self-efficacy, all contribute to the enhancement of quality of service received by residents. Empowering healthcare aides to participate in team meetings, for example, allows them to be better informed regarding the unique preferences and needs of their residents, which improves quality of care by enabling healthcare aides to make whatever adjustments are necessary for them to offer residents choice around the timing of when certain care activities were performed (Yeatts & Cready, 2007).

Improvements in the provision of person-centred care when healthcare aides are empowered is a finding shared from the perspectives of diverse stakeholders (Caspar & O'Rourke, 2008; Cready et al., 2008; Hamann, 2014; Jones et al., 2024; Yeatts & Cready, 2007). Residents' families report that healthcare aides who are empowered provide improved quality of care to residents (Hamann, 2014; Yeatts & Cready, 2007). Healthcare aides who are more empowered score themselves higher on work performance, for example, possessing more "effective work procedures" than their less empowered counterparts (Cready et al., 2008). Their nurse colleagues also agree, reporting that these individuals perform their jobs better than nurses whose healthcare aide colleagues had medium to low levels of empowerment (Cready et al., 2008).

***Culture Change Models.*** Culture-change models in long-term care tout empowered staff and person-centred care for residents. A study by Caspar et al. (2009) comparatively examined three culture change models and no culture change model to determine what relationship culture change models may have on staff perceptions of structural empowerment and delivery of person-centred care. The study found that registered nurses' empowerment and provision of person-centred care were not influenced by the presence of lack of culture change model. Healthcare aides who worked in long-term care facilities which used the GentleCare model – a care model focused on staff education and consultation which has been endorsed by the British Columbia Ministry of Health (Gnaedinger, 2003; Jones, 1996, as cited in Caspar et al., 2009) – or a facility specific social model of care were found to not only experience greater structural empowerment, but were also more able to provide person-centred care to residents (Caspar et al., 2009). However, while healthcare aides who worked in long-term care facilities with the Eden Alternative model – a model concerned with the psychosocial challenges facing residents and promotes a flattened staffing hierarchy, staff and resident decision-making, and "humanizing"

nursing work (Caspar et al., 2009) – reported greater empowerment than those working in a facility with no culture change model, they rated their ability to provide person-centred care as lower than those working in the latter type of facility (Caspar et al., 2009). Therefore, while culture change models are lauded as strategies for reform in long-term care facilities, culture change models were not shown to impact either quality of person-centred resident care or access to empowerment structures (Caspar et al., 2009). Nonetheless, this study identified what the most empowering feature of culture change models was: the amount of time caregivers had to spend with residents; a feature which also had the greatest influence on the provision of person-centred care (Caspar et al., 2009).

**Specified Health Outcomes.** Access to opportunity structures and informal power negatively influenced the incidence of pressure ulcers (Barry et al., 2005). Greater access to empowerment structures among healthcare aides is also associated with a lower incidence of pressure ulcers and improved social engagement (Barry et al., 2005; Ransom, 2000). Use of an education program on dementia care for healthcare aides and subsequent healthcare aide-led quality improvement strategies resulted in decreased anti-psychotic medication use and increased provision of person-centred care (Jones et al., 2024). Other healthcare aide-led quality improvement interventions demonstrated improvement in resident outcomes as well. For example, one such study reported decreased pain and mobile dependency (Wagg et al., 2023).

**Quality Improvement Interventions.** Long-term care facilities that were more successful at implementing a quality improvement change, measured higher on staff empowerment (Cranley et al., 2018; Doupe et al., 2022; Wu et al., 2018). Empowering healthcare aides to lead teams for quality improvement projects required support and facilitation from their leaders, and gives healthcare aides a voice as well as added meaning and satisfaction to their work (Cranley et al., 2018; Ginsburg et al., 2024; Jones et al., 2024; Wagg et al., 2023).

Empowerment and satisfaction with quality of work life decreased across professional groups with time in Cranley et al.'s (2018) study, however such decreases were slower in empowered healthcare aide groups. Improved resident outcomes were seen in nearly all long-term care facilities that empowered healthcare aides to lead a quality improvement project (Doupe et al., 2022; Jones et al., 2024; Wu et al., 2018)

### **Rationale for the Study**

Historically the literature has focused on nurse empowerment, especially in hospital settings. Even within long-term care settings, studies often exclude healthcare aides or use a mixed staffing sample. While the empowerment of nurses and other staff within the long-term care setting are important, it may be of lesser significance in this setting because long-term care healthcare aide empowerment is more closely linked than nursing empowerment to resident quality of care (Hamann, 2014).

Most of the studies examining long-term care healthcare aide empowerment were quantitative survey studies and/or theoretically vague in their use of the term empowerment. As such, a gap remains in the literature. Some crucial work examining healthcare aides and their work environments in long-term care settings has been done; for example, investigating the influence of healthcare aides leading care teams, and identifying healthcare aide empowerment and comparing it to nurse empowerment and other concepts. However, the age of much of this work makes applicability in the post-pandemic era beyond 2023 somewhat challenging. Further, no work to date was located with the aim of identifying idealized empowerment structures from the perspective of these essential healthcare workers. The few qualitative studies identified looked at the present working conditions of healthcare aides, failing to ascertain a dream state for the structures in which they work. This study adds to our understanding of the structural empowerment needs of long-term care healthcare aides by using a strength-based approach,

namely appreciative inquiry approach, to yield evidence fundamental in facilitating this sector's movement towards workforce and quality care solutions, helping to solve systemic structural empowerment challenges embedded within the sector.

### **Summary**

The inconsistent empowerment levels found in various studies indicate that empowerment structures in long-term care are likely organized variably by organizations. While some long-term care facilities may have achieved significant success in empowering their workers and achieving other important organizational outcomes such as high-quality person-centred care, other facilities lag behind. This study helps to address this variability by looking beyond the current state of empowerment structures in long-term care organizations. By exploring the dream state of empowerment structures for healthcare aides from their perspectives, this study provides fresh understanding on this sector and organizations within it should undertake systemic change to address empowerment barriers for healthcare aides.

### **Chapter 3 – Methodology, Methods, and Ethical Considerations**

#### **Methodology**

To elucidate healthcare aide perspectives of structural factors which support and impede their empowerment, a qualitative design is selected. Qualitative research is capable of providing rich descriptions of phenomena from the perspectives of participants (Polit & Beck, 2017) and is therefore ideally suited to the purpose of this study. Qualitative research is also philosophically bound within the naturalistic paradigm (Polit & Beck, 2017). It values holistic over reductionist thinking as it seeks to understand the whole of complex phenomena and is well suited to the needs of the study to acquire an in-depth understanding focused on the entirety of a phenomenon (i.e., structural empowerment) within a specific context (i.e., long-term care) based upon the lived experiences of participants (i.e., healthcare aides) (Polit & Beck, 2017).

Of the diverse qualitative methodological approaches available, qualitative description was selected for the study owing to usefulness in gathering comprehensive, direct understanding of the lived experiences of participants on a given phenomenon, as well as for the cost and time effectiveness associated with this approach (Neergaard et al., 2009; Sandelowski, 2000). Additionally, the manner in which qualitative descriptive research allows the researcher to obtain rich descriptive data, stay close to the words of the participant, and obtain a “straight” description of phenomena under study, further enhanced the suitability of this approach for this study (Sandelowski, 2000, p. 339; Willis et al., 2016).

This study is also based upon the appreciative inquiry framework. Appreciative inquiry is an organization development process and approach which intentionally seeks an organization's strengths with the goal of building further success on existing successes achieved within the organization (Cooperrider et al., 2008). Appreciative inquiry is the antithesis of a deficit-based approach most often used in organizational development and views the strengths of an

organization as the optimal starting point to elicit positive change, by creating “energy, excitement and a desire to move toward a shared dream” (Cooperrider et al., 2008, p. 3). This method, through its optimistic egalitarian approach, creates opportunity by engaging in the early steps necessary for organization change by itself empowering healthcare aides through provision of a platform from which to reflect, create, and influence an optimal future organizational state (Cooperrider et al., 2008; Hung et al., 2018). Such a view, itself, challenges the prevailing hierarchical power ideology and positionings embedded in residential long-term care settings and further positions this method as meritorious for this study (Hung et al., 2018).

The appreciative inquiry approach uses a “4-D Cycle” of discovery, dream, design, and destiny. For the purposes of this thesis-based study, only the first two – discovery and dream – were used owing to practical limitations of the project (i.e., time, funding). The ability of this study to engage all relevant and interested individuals – a defining process characteristic of this method – was limited (Cooperrider et al., 2008). Nonetheless, the discovery and dream phases of the appreciative inquiry approach assisted in developing a rich understanding of the stories, themes, and high points of participants, while eliciting an understanding of perceived possibilities for organizational change. Within the appreciative inquiry framework, there are three concepts used to guide the development of interview guides and fulfill its phases. These guiding concepts are: best experience (past), values (present), and wishes (future) (The Center for Appreciative Inquiry, 2025). The appreciative inquiry approach and its attendant guiding concepts were well-suited to the aims and purpose of the study. Additionally, the use of descriptive and explanatory data produced by these approaches met the research objectives of determining how organizational structures have or currently act to empower healthcare aides and the desired future state for such structures to optimize healthcare aide empowerment.

### **Setting**

This study took place at four long-term care facilities in Winnipeg, Canada; a single participant did not disclose the long-term care organization in which they worked. This setting size was selected for its ability to yield the sample size required for this study.

### **Sample Characteristics**

A sample of healthcare aides who worked in their current role (i.e., as a healthcare aide) at their current long-term care facility for at least 6 months was obtained. Exclusion criteria included those who were unable to speak English fluently, worked less than an average of 15 hours per week, did not consent to being audio-recorded, and/or did not have access to a computer or handheld device with a speaker/microphone and internet access or telephone.

Other important considerations used in determining the study's sample were its size (i.e., the number of participants) and composition (i.e., the ability of the sample to provide rich description of the phenomenon being investigated). Adequacy of both were ensured to achieve sample adequacy (Vasileiou et al., 2018).

### **Sample Size**

Determining sample size in qualitative research is not as straightforward as following fixed rules (Polit & Beck, 2017). Instead, data saturation should guide qualitative researchers in determining sample size (Polit & Beck, 2017). Data saturation occurs when redundancy occurs within the data set and new information is no longer obtained (Polit & Beck, 2017). Achieving data saturation is influenced by diverse factors, including quality of data, scope of study, and study design (Morse, 2000). For example, the more rich and useful the data collected, the sooner data saturation can occur and the fewer participants will be required (Morse, 2000). Up to 15 participants is a typical sample size recommended for a relatively homogeneous sample of

participants (Cleary et al., 2014). A sample size of ten participants was sufficient to meet data saturation requirements.

### **Sample Composition**

Sampling began with volunteer participants using convenience sampling. This sampling method was efficient and allowed for a diverse sample (Polit & Beck, 2017). Snowball sampling was also used for less than half of the study's participants, as convenience sampling failed to return an adequate quantity of participants. This sampling strategy involved asking early participants to refer others to participate in the study and is a practical and cost-efficient way to recruit participants (Polit & Beck, 2017). Sample diversity and data saturation were both sufficient, therefore the study did not require other emergent purposive sampling strategies (e.g. maximum variation sampling) (Morse, 2000; Polit & Beck, 2017).

## **Data Collection**

### **Demographic Data**

After obtaining consent, demographic questions (Appendix G) developed by the researcher for the purpose of this study were administered to participants, providing contextual and descriptive information enhancing understanding of participant perspectives. The responses received also assisted to determine the role of proportions in the structural empowerment of long-term care healthcare aides. These questions were administered prior to the onset of the semi-structured interview.

### **Semi-Structured Interviews**

A 60-75 minute semi-structured interview was utilized to gather rich descriptions and understandings of participant perspectives on how organizational structures have or do empower them and the desired future dream state for these structures (Appendix H) (Polit & Beck, 2017). The use of interviews within qualitative description study design is commonplace (Kim et al.,

2017; Willis et al., 2016). Interview questions using this methodological tradition are formed from a structured theoretical or conceptual framework (Willis et al., 2016). For this study, concepts within Kanter's (1993) theory of structural empowerment formed the basis of each research question posed and rationale is explicated in bracketed italics under each question within the interview guide. How each question satisfied the theoretical concepts within Kanter's theory and the appreciative inquiry framework is also outlined in Table II. As suggested by Hsieh and Shannon (2005) and Willis et al. (2016), the interview guide for the study was framed by open-ended questions with targeted prompts and questions developed from the relevant theoretical framework. The interview guide was merely that – a guide – and participant responses dictated iterative changes throughout the interview process (Willis et al., 2016). Interviews were done via Zoom video teleconference and audio-recorded.

**Table II**

*Theoretical Underpinning of Interview Guide Questions*

Theoretical Concept	Q #2	Q #3	Q #4	Q #5	Q #6	Q #7	Q #8	Q #9
(SE) Power	X							
(SE) Formal Power		X						
(SE) Informal Power			X					
(SE) Information				X				
(SE) Support					X			
(SE) Resources						X		
(SE) Opportunity							X	
(SE) Proportions								X
(AI) Best Experience	X	X	X	X	X	X	X	X
(AI) Values	X	X	X	X	X	X	X	X
(AI) Wishes	X	X	X	X	X	X	X	X
NB: Concepts from the theory of structural empowerment are indicated with (SE); those from the appreciative inquiry framework are indicated with (AI).								

**Memos, Field Notes, Reflexive Journal, and Descriptive Summaries**

Throughout the course of the study, *memos* were used to keep track of and preserve decisions (Willis et al., 2016). For example, because the process of data collection and analysis in

qualitative description research is iterative, changes made to the interview guide were documented in memos, creating an audit trail of changes (Willis et al., 2016). *Field notes* were utilized to capture observations made during the interview process, improving transparency (Willis et al., 2016). *Reflexive journaling* was used to self-examine the effect the researcher has upon the research collection, analysis, and interpretation, helping to delimit subjectivity (Polit & Beck, 2017). Studies using interviews within the qualitative description design should use summaries to provide details of analysis and observational data findings (Willis et al., 2016). *Descriptive summaries* were therefore used in this study to provide a descriptive summary of findings as indicated.

### **Data Analysis**

Digital recordings of interview conversations were transcribed by the student principal investigator (JE) reviewed and utilized for data analysis. In qualitative description research, when interviews are the primary source of data, data analysis should begin upon completion of the first interview iteratively informing and influencing the further development of future interviews (Willis et al., 2016). This approach was difficult to implement for this study owing time consuming nature of transcribing interviews. Therefore, data analysis was not formally undertaken until all interviews had been conducted. Data was coded iteratively into categories and themes eventually encompassing all interviews and the entire data set, with meaning described at the level of the obvious (Willis et al. 2016).

### **Trustworthiness**

Reliability and validity of the study's finding were ensured in a number of ways. Firstly, constant comparative analysis was used to construct and iteratively analyze data through empirical inquiry, ensuring findings accurately represented participants' views (Leavy, 2014; Noble & Smith, 2015). Categories and themes were identified, followed by an iterative

comparison across all interviews, notes, and the entire data set, further adding credibility to the findings (Leavy, 2014). Critical reflection, accounting for personal biases, and careful record keeping to clearly delineate decision-making were also used (Noble & Smith, 2015). Finally, the student principal investigator's (JE's) work was overseen and independently analyzed by the student advisor (JS) who has extensive experience with qualitative research (Creswell & Poth, 2018; Willis et al., 2016).

### **Ethical Considerations**

This study obtained approval from the University of Manitoba Research Ethics Board 1 (REB1) (University of Manitoba, 2020) and ensured that consent processes were adhered to. Participation in the study was voluntary, and participants were notified that they could withdraw at any time without fear of reprisal. Participation in this study had no additional risk of harm than everyday life.

In seeking to access the study population, a brief presentation was made at a meeting for directors of Winnipeg long-term care facilities (Appendix B). A sign-up list was used after the meeting to gather the contact information for sites that were interested in participating. Printed recruitment posters and recruitment letters were provided at the time of sign-up. The student principal investigator (JE) was invited to attend to one facility to engage in in-person recruitment but was unable to recruit any participants. Subsequently, emails were sent to directors of long-term care facilities who had signed up to disburse digital recruitment posters (and recruitment letters). These were then emailed to staff at their discretion. Letters and posters outlined details of how to contact the student principal investigator (JE) for follow-up questions or to enrol.

When potential participants contacted the student principal investigator (JE) – either by phone or email – they were assessed for eligibility (Appendix E). Consent was emailed to participants and obtained from them via email. An interview was scheduled after the signed

consent form was received (Appendix F). Participants chose to have a copy of the consent form mailed or emailed to them – all chose to correspond via email. Interviews were audio-recorded and transcribed for data analysis. As a sign of appreciation, participants were provided with an honorarium of a \$50 gift card.

### **Summary**

This study used a qualitative description research design informed by Kanter's (1993) theory of structural empowerment within an appreciative inquiry framework. Appreciative inquiry encompasses an optimistic egalitarian approach towards organization change and, within this study, provided a platform for healthcare aide voices to be heard, protected, and valued. Sampling used volunteer participants and involved other emergent snowball sampling. Ten healthcare aides from four long-term care facilities, who had worked in their current role for at least 6 months were recruited to participate. Semi-structured interviews were used to gather rich descriptive data and allowed for an understanding of participant perspectives of organizational structures and empowerment.

## **Chapter 4 – Findings**

The purpose of this study was to explore the perspectives of long-term care healthcare aides on the structural factors which support their empowerment. This study aimed to understand the relationships, relative importance, promising practices, and ideal state of organizational structures for optimal healthcare aide empowerment and was guided by the following research questions:

1. What organizational structures (i.e., power, opportunity, and proportion structures) do long-term care healthcare aides have access to and use?
2. What is the relationship between organizational structures (i.e., power, opportunity, and proportion structures) in residential long-term care settings and healthcare aide empowerment?
3. What is the relative importance of organizational structures (i.e., power, opportunity, and proportion structures) in influencing healthcare aide empowerment?
4. What are the organizational structures (i.e., power, opportunity, and proportion structures) already in use in residential long-term care settings that work well at empowering healthcare aides?
5. What is the ideal state of organizational structures (i.e., power, opportunity, and proportion structures) in residential long-term care settings to optimize healthcare aide empowerment?

### **Recruitment and Participant Characteristics**

Recruitment of participants occurred over approximately 4 months during the winter of 2023/2024 and occurred as outlined in the previous chapter. Snowball sampling aided in expediting the recruitment process – though less than half of the participants are estimated to have been obtained through this process. A total of eleven participants were recruited and

interviewed. One interview was excluded from the study as the participant (P05) was ineligible (i.e., did not work in long-term care) but did not disclose this during the eligibility screening process. The remaining ten participants met eligibility criteria and did not withdraw from the study and their interviews were therefore included.

As shown in Table III (p. 41), the participants in this study were long-term care healthcare aides ranging from 26-51 years of age. Of the ten participants, one identified as non-binary; the rest identified as female. Participants' work experience as a healthcare aide ranged from 7 months to 13 years. Participants reported working in their current job from 7 months to 11 years. Six participants worked part-time, three participants worked full-time, and one participant did not indicate whether they worked full- or part-time. Five participants did not indicate whether they worked in a term position, permanent position, or as a casual employee without a position. Of the remaining five participants, three indicated that they were in permanent positions, while two indicated that they were employed on a casual basis. Four of the ten healthcare aides worked second jobs – two for another long-term care facility, one for an assisted living facility, and one for a private agency. The minimum level of education acquired by participants was a college certificate – which two participants reported having. Another three participants reported acquisition of a college diploma, while the remaining five possessed a university degree. Three participants reported being non-racialized (i.e., European or White). The remaining seven participant identified as racialized: five Indian, one Black, and one Chinese. Though not a demographic form or interview question, it was learned through later interview questions on proportions that at least three of the ten study participants were immigrants to Canada; one participant reported being born and raised in Canada. The remaining six participants did not volunteer whether they were immigrants or Canadian born.

**Table III***Participant Demographic Data*

Characteristic	n	Characteristic (continued)	n
Age		Years in Current Job	
21-30 years	2	0.5 – 5 years	7
31-40 years	4	6 – 10 years	1
41-50 years	3	11 – 15 years	2
51-60 years	1	Part-time or Full-time Hours*	
Gender		Part-time	6
Female	9	Full-time	3
Non-binary	1	Unknown (did not respond)	1
Race		Employment Status	
White/European	3	Permanent	3
Indian	5	Term	0
Black	1	Casual	2
Chinese	1	Unknown (did not respond)	5
Highest Level of Education		Employed in One or Two Jobs	
College Certificate	2	Employed in One Job	6
College Diploma	3	Employed in Two Jobs	4
University Degree	5	* <i>NB</i> : In cases where participants worked more than one job, part-time or full-time hours referred to hours worked in the primary long-term care facility in which they were employed.	
Years as a Healthcare Aide			
0.5 – 5 years	6		
6 – 10 years	1		
11 – 15 years	3		

**Data Analysis & Interpretation**

After recording participant interviews, the student principal investigator (JE) transcribed the audio recordings to ensure accurate transcription and to become immersed into the data. After listening carefully and often repetitively to interviews, the student principal investigator read and re-read transcripts to become further immersed in the data. Themes were identified using an iterative analytic process that involved coding the data, writing reflective notes, and engaging in constant comparative analysis across interviews. While Kanter's (1993) theory and the appreciative inquiry framework provided some sensitizing concepts (e.g., resources: Time and Staffing; values: What is Important to Healthcare Aides), data analysis was inductive, allowing concepts to emerge from the data (e.g., workload and role challenges). Two main themes

emerged from the data: i) what is important to healthcare aides; and ii) challenges. Table IV contains a summary of all the themes and subthemes of this study. The themes that were identified capture the experiences of participants and subthemes, on occasion, use their words to reveal their thoughts and priorities. While the findings in each theme are reported separately, they interact with and relate to one another and are, therefore, best understood together.

**Table IV**

*Themes and Subthemes*

Theme #1: What is Important to Healthcare Aides	Theme #2: Challenges
Residents and their Quality of Care <ul style="list-style-type: none"> <li>○ Caring for Residents with Empathy and Kindness</li> <li>○ Providing Holistic Care</li> <li>○ Providing Appropriate, Evidence-Informed Care</li> </ul>	Workload and Role Challenges <ul style="list-style-type: none"> <li>○ Volume of Workload</li> <li>○ Residents' Needs</li> <li>○ Residents' Behaviours</li> <li>○ Resident Deaths</li> <li>○ Residents' Families</li> <li>○ Getting Help Wherever Possible</li> </ul>
Job Satisfaction <ul style="list-style-type: none"> <li>○ Intrinsic Rewards: Drawing Personal Meaning and Joy</li> <li>○ Extrinsic Rewards: Feeling Appreciated and Supported</li> </ul>	Access to Opportunities Staffing <ul style="list-style-type: none"> <li>○ Inadequate Baseline Staffing Ratios</li> <li>○ Staffing Shortages</li> </ul>
Teamwork <ul style="list-style-type: none"> <li>○ Why Teamwork is Important</li> <li>○ Competencies of Functional Teams</li> </ul>	Time Fellow Healthcare Aides <ul style="list-style-type: none"> <li>○ Regular Healthcare Aides</li> <li>○ Non-Regular Healthcare Aides</li> </ul> Feeling Devalued <ul style="list-style-type: none"> <li>○ Micro Level: Residents and Nurses</li> <li>○ Meso Level: Managers</li> <li>○ Macro Level: The System</li> </ul> Difficulty Dreaming

At times during the interview process participants were asked to rank the relative importance of concepts they identified. This rank order data is provided with relevant findings. Lastly, participants sometimes referred to residents as 'patients'; for consistency in reporting, all instances of this have been edited to reflect the term 'residents.'

### **What is Important to Healthcare Aides**

The long-term care healthcare aides who participated in this study varied in the manner and detail with which they articulated what was important to them but focused significantly on the importance and value of the residents for whom they provided care, and the quality of care residents received. This constituted one subtheme within the theme of *What is Important to Healthcare Aides*. A second subtheme that emerged from the data was job satisfaction. Finally, teamwork was a third subtheme identified and viewed as important to participants because it allowed healthcare aides to optimize the efficiency and efficacy of their work, thereby optimizing participants' ability to provide high quality care to residents.

#### ***Residents and their Quality of Care***

Participants viewed providing high quality care to their residents in ways that prioritized resident comfort and well-being, as highly important.

*For me, my [resident] care is most important for me...that my [resident] is comfortable, my [resident] is feeling ok. This is the first thing for me. (P09)*

To participants, quality resident care encompassed three key tenets: i) caring for residents with empathy and kindness; ii) providing holistic care; and iii) delivering care in appropriate, evidence-informed ways.

**Caring for Residents with Empathy and Kindness.** Participants were emotionally and socially invested in the work they did as they created relationships and bonds with the residents to whom they provided care in empathic, kind ways.

The deep care and respect that participants had for their residents was noted in how they described the, oftentimes challenging, disease states or behaviours of residents with understanding and empathy. For example, some participants expressed empathy for their residents with dementia.

*It's not their fault. The disease is so big that they don't know what's going on. (P04)*

*It's not their fault their brains are sick. (P06)*

Others expressed empathy for their aggressive residents. Empathy extended beyond an emotional or cognitive understanding of the residents and their conditions and encompassed a desire to provide care to residents despite the challenges participants often faced.

*Even if I see a resident being so aggressive, even though he is hurting me, after that, I still want to try to help him. (P11)*

Caring for residents meant participants tried their best and often went 'above and beyond' what was required of them.

*I always go above and beyond and I just wanna try. (P06)*

Building relationships with residents was one of the ways that participants cared for residents.

While one participant reported that they preferred to maintain emotional distance while caring for their residents, this was not the norm among study participants.

*I have to maintain a healthy boundary...and not to get too attached to the residents. I find that's very important. I like that distance. (P01)*

Every other participant described being bonded with their residents – albeit to varying degrees.

One participant stated that it was difficult for her not to form close relationships with the residents for whom she cared.

*I find I form such strong bonds with [the residents], even though we're told in school sometimes to try not to do that. But it's hard not to. (P06)*

Participants shared specific stories about residents they had cared in the near or distant past, describing their close relationships with residents. Indeed, relational bonds were so close that sometimes residents missed participants when they were away from the long-term care facility for a period.

*Some of the residents they notice when I'm not there...they actually tell me that they missed me... 'Oh, I missed you,' and then [the residents will] want me to give them a hug...That makes me happy. (P06)*

Residents also noticed when their favourite healthcare aides were at work and would request to be cared for by them.

*There's one resident, though she has passed on now, on evening shifts once she noticed I was around, she wouldn't want anybody else to give her care. She wanted me to give her care. So even if I was not on her unit, I will just switch places with someone – like, "You do this [other resident's care] while I do her [care]. (P08)*

Participants missed residents and grieved when they died. Participants also described the perceived link between the close relationships they had with residents and their ability to provide quality care to them. For example, one participant described how her underlying relationship with a resident allowed her to help him to eat.

*When I talk to [a certain resident], I say, "Let's go eat. That's your food," he would open his mouth for me, but he wouldn't open his mouth for his family. (P11)*

In addition to building relationships with them, making residents 'happy' and 'comfortable' was important to participants. These two words were used recurrently by participants in describing how they wanted their residents to feel.

*I want them to be happy. I want them to be comfortable. (P06)*

*I always provide good care. I make sure they are comfortable. (P08)*

Providing 'kind and loving' care was also viewed as crucial in caring for residents and providing them with quality care. One participant reported she gave quality care by caring for residents "in a kind and loving way" (P06). Another participant reported quality care was provided by herself and other healthcare aides "by just being kind to [residents]...by providing their needs. It's by

*providing their basic needs of care. It's just by being there and being a caring, compassionate worker” (P10).*

**Providing Holistic Care.** Participants in this study viewed providing quality care to residents as encompassing the provision of holistic care which entailed: i) meeting the physical needs of residents; and ii) meeting the social and emotional needs of residents.

***Meeting the Physical Needs of Residents.*** Meeting the physical needs of residents was viewed as an essential component of caring for residents and providing high quality care. It meant healthcare aides' work could be viewed as highly task-based and entailed “*activities of [daily] living like bathing [residents]...feed[ing residents] ...dress[ing residents] ...help[ing residents] with walking” (P07) and more.*

***Meeting the Social and Emotional Needs of Residents.*** While some participants were focused on the task-based nature of their roles, nearly every participant discussed their desire to provide care to residents that did not just meet their physical needs. Participants sought to meet the social and emotional needs of residents and viewed this as an essential component of high quality care for residents, frequently detailing the ways that high quality resident care was holistic in nature.

Ensuring the social and emotional well-being of residents was important for participants, who recognized the loneliness of many of their residents.

*Without family our residents, they're just miserable, and they're lonely. A resident care home could be very lonely without family. (P01)*

Insufficient time to provide high quality care to residents that went beyond their immediate physical needs was a recurrent theme in the data. Nonetheless, participants did what they could to meet the social and emotional needs of residents.

*There are some [residents] that really need attention...Maybe they are lonely or something – they just need someone to talk to. So, whenever I'm less busy, I sit with them and chat with them, and they feel happy about that. (P08)*

In addition to sitting and talking with residents, meeting their social and emotional needs were facilitated through their attendance at social or recreational programs, playing an instrument for them, or even something as simple as bringing residents together so they could socialize with one another.

*I, personally, try to take all of them to the dining room so they can be together and talk to each other. (P07)*

At other times, addressing the social and emotional needs of residents meant de-escalating agitated or aggressive residents.

*There was a scenario...when I came in the evening [the healthcare staff] said [a resident had] been calling nonstop...and they didn't know what was really wrong with her. So, when I came – during that period it wasn't really busy – so I just had some time to spend with her...I noticed she was lonely. She wanted someone to talk to, maybe walk together, because she was indoors in her room, and she was bored. So, we both came out...we just walked around a little. Then I took her back to her room, and that was it. She stopped calling. (P08)*

The care felt for and given to residents extended beyond their immediate well-being. It also encompassed the residents' home (i.e., their long-term care facility).

*Treat them like this is their home cause it really is. (P01)*

Another participant identified that this tenet of quality resident care was embedded within the organization's purpose.

*My organization's purpose is about the residents living there and feeling like it's their home. (P02)*

Organizations did this, for example, by hosting families and Christmas parties.

*They really like to bring in the family and have Christmas parties and really involve the family if they can. (P01)*

Participants aimed to make the facility comfortable and home-like, for example, by keeping it clean and organized much the same way they would their own home.

*I feel like my family is living here, so I try to clean everything there. (P02)*

Participants also reported that spending time with residents was important because it made them feel like they were at home.

*We spend quality time with them so then they feel at home. (P09)*

This idea of creating a 'home-like' environment for residents emerged in the word choice of participants as well. In Manitoba, long-term care facilities are called personal care *homes* (emphasis added); nonetheless, there was meaning to the linguistic choice participants used to refer to their facility, most often as a 'care home'. Finally, making continual improvements to the facility that residents called home was also important to participants.

*We want to make this facility a better place for the residents. (P06)*

**Providing Appropriate, Evidence-Informed Care.** It was important to healthcare aides that residents were provided with appropriate care.

*I feel like I'm doing a good job because I'm providing the care to the [resident] the right way. (P02)*

Embedded within the concept of providing appropriate care was the participants' desire to always meet the safety needs and minimum care needs of residents no matter the situation. This was particularly true when caring for agitated residents with whom there was a safety risk involved;

participants reported that they did what they could to always ensure minimum safety and care needs were met. Examples of this included speaking to the nurse about administering medication to help calm an agitated resident; separating an agitated resident from other residents; changing an agitated resident's wet brief after they had calmed down; or, if safe to do so, changing an agitated resident's wet brief and then leaving them to calm down and rest safely in bed.

*There have been incidences where we just try and get their brief changed, so at least they're clean for the most part, and [then we] just tuck them in bed and then make sure they're safe that way. (P06)*

Providing appropriate, evidence-based care also included the provision of person-centred care to residents by honouring the individual preferences, needs, and choices of the residents for whom they cared.

*[The organization and healthcare aides] try and make sure [residents] are comfortable; whatever [residents] need [the organization and healthcare aides] provide for them. [Residents] are independent, respected, and all that. (P08)*

Participants believed that the requests of residents should be respected and accommodated.

*I feel like we have to respect them so whatever they request...we just do that. (P11)*

Some residents preferred healthcare aides of a certain gender only which was also accommodated.

*They want the [healthcare aide with the same gender as them], so we have to do an exchange. [Male healthcare aide] to the [male resident], a [female healthcare aide] to the [female resident]. (P11)*

Some residents had preferences around timing of care delivery, which was also accommodated.

*If they don't want to do it, if they say, 'I'll dress later', we just leave them...We give them time as much time as they need. (P03)*

The unique physiologic needs of residents were also recognized and accommodated.

*Everyone's different with their specific routine. Some people have to go to bed right after supper...and then other people, they stay [up]. (P10)*

Allowing resident to be autonomous with their care, when they were able, was another way that participants sought to provide appropriate, evidence-informed care.

*We help [the residents]. Like washing in the morning...bathing and dressing up...we give [residents] everything, and we just stand by and watch if they are able to do things by themselves. (P07)*

Another way that participants ensured that residents received appropriate, evidence-based care was by reporting concerning findings to nurses.

*Whatever I observe, [even] little things in the [resident's] health, I always tell my nurse. Doesn't matter if it's common, doesn't matter if it's major...I always convey the small thing to my nurses when I work with them. "Oh, that's what I noticed. Can you go and check? I don't know if this is new or it was here before because, I wasn't here the last 2 days or 3 days." (P09)*

Participants also reported that they strove to anticipate care needs.

*I try and watch and see if there are things [residents] need that I can help with. (P08)*

### **Job Satisfaction**

A second sub-theme emerged from the data in the theme *What is Important to Healthcare Aides*, pertained to the value assigned by participants to finding satisfaction in the work they did.

Rewards for their work were either intrinsic or extrinsic in nature.

**Intrinsic Rewards: Drawing Personal Meaning and Joy.** Creating emotional and social bonds with residents allowed participants to draw personal meaning and joy from their work

caring for residents. A participant emphasized that she did not just enjoy her work but truly loved it.

*I love, I love my job. I've been doing it for over 11 years now. I really, really love my job.*

*I mean, at times it can be stressful, but for the most part it's very rewarding. (P06)*

While no other participants expressed their enjoyment of their work so strenuously as this participant, it was nonetheless apparent that they drew personal rewards from their work as helping others and genuinely caring about residents generated positive feelings for them.

*I'm so glad to take care of them...This is my feeling: when I'm working, I use my heart as I'm working. That's why I feel good. (P11)*

*The good thing about this work is I feel good to help people. (P04)*

Moreover, participants enjoyed the people for whom they cared and the relationships they formed with them. For example, participants explained how talking with and listening to residents was appreciated by residents and rewarding for them.

*I love old people. I like to talk to them. (P07)*

*What I find rewarding is how much, even just a small conversation...even just taking that extra little bit of time and listening to them tell you a story and how much they appreciate that. (P06)*

The personal meaning participants assigned to their work varied. A few participants likened their care work to caring for family – specifically parents or grandparents. One participant became tearful when she shared that she took a job as a healthcare aide after the death of her father and wondered who was taking care of her parents at their home in another country.

*My dad passed away. That's why I chose this job. Because when my dad passed away <cries> ...<voice breaking> ...I was just thinking, when my parents are getting old, who is taking care of my parents? (P11)*

Participants wanted to do the work they did because of the personal meaning they assigned to it and contributions they felt they were making.

*I find that I'm a blessing to them...I just want to be there for them. (P06)*

Participants believed that they were making a positive difference to residents by reassuring and caring for residents.

*I find that I'm making a difference by just reassuring them that they're cared for. (P06)*

**Extrinsic Rewards: Feeling Appreciated and Supported.** Participants reported that feeling appreciated by residents, coworkers, managers, and organizations was another source of satisfaction for them in their work. Feeling supported by managers and organizations also brought about positive feelings for participants.

***Appreciated by Residents.*** Participants experienced satisfaction when they were noticed and appreciated by residents. Residents often took note of the care they were given and expressed gratitude in different ways. In addition to joy, participants felt valued and appreciated by residents when they received these diverse expressions of gratitude. For some residents, a small gesture such as a smile conveyed their appreciation.

*I'm doing this job because when I see the resident there smiling, I feel good. (P04)*

*A lot of them [appreciate you] and that's the part that warms my heart...some of them always say 'Thank you' when you help them. When you can make somebody smile, at the end of the day it's a good feeling. (P06)*

For others, gratitude was expressed via compliments, tips, and words of appreciation directed towards participants.

*A lot of times [residents] show appreciation...They're always telling me like, "Oh my god, you are doing very good job." (P02)*

*Sometimes they give you like \$5 as a reward... if it's less than \$10, you can take it. So sometimes, if they like your job then they offer you a reward. So that's a good thing that they notice...that feels good. (P04)*

*Some of them, they are expressive. They are like, 'Oh, thank you so much, 'whatever' you're doing for us.' They always say thanks.'" (P07)*

The satisfaction that participants received from these expressions of gratitude from residents was also apparent at times in the ways participants smiled or were more excited as they recounted these details during their interviews.

***Appreciated by Co-workers.*** Participants received expressions of gratitude from co-workers (specifically from fellow healthcare aides, nurses, charge nurses, physicians, and physiotherapists) as well as from managers. Being called 'hardworking' or a 'hard worker' was a common compliment participants received from their co-workers.

*I've had lots of coworkers saying to me 'you are so hardworking' and that they love to work with me. (P03)*

This made them feel valued.

*My coworkers say I'm a hard worker, so I feel that I'm valued. (P10)*

Participants reported that co-workers also expressed gratitude for them by missing them when they took a different position, or by asking them to pick up shifts to work with them again.

*My evening shift coworkers, they liked me so much that when I [went] back to [a dayshift rotation], they started hugging me and saying, "We miss you. You are such a nice person. You're always helpful." (P04)*

*When we finish our work... they usually say, "When are you coming here next?" with a smiley face. "Oh, pick up more shifts. We like you here. Come back next time." So, you know they really appreciate your work. (P08)*

This type of recognition brought them happiness.

*It makes me feel happy, like at least I'm doing my job, and it's still recognized. (P08)*

***Appreciated and Supported by Managers and Organizations.*** For participants to feel appreciated by managers or organizations, small gestures were often all that were needed.

Examples included complimenting participants, greeting or acknowledging them, and expressing gratitude for the hard work of the team on a busy shift.

*When I [went] back from evenings to days, my manager ... said to me, "Happy to see you in the morning," so that feels good to me. (P04)*

*My manager, my supervisor, they also appreciate my work – not only my work but all my coworkers. There have been lots of times when the floor was getting so crazy – lots of call lights and lots of lifting and everything. At the end of the day, the manager appreciates us and says like, "Thank you for all you guys are doing." (P03)*

Feeling appreciated by managers was important beyond improving participants' job satisfaction.

It also made participants want to "do more and more work" (P03) and contributed to their retention.

*I think people have worked there for 30 years and this is because of the management.*

*They are always ready to help you, and always ready to hear you. (P04)*

Staff appreciation meals provided by organizations also helped participants to feel appreciated.

*Our facility values us, I feel. We often get staff lunches...we've been given...free lunches or free suppers, and they have a lot of food. They have really good staff appreciation at my work, [and] I love [that] about where I work. (P10)*

Feeling appreciated by managers was not the only important way for participants to experience enhanced job satisfaction. Feeling supported was also important to participants. This

entailed things like listening to and valuing the input of participants, prioritizing the safety of participants, and following up on participant concerns.

*The management is good. They understand. Even if you think that somebody is not good with you, you can report to the management, and they will understand, and they will talk to the person. They will not just let it go. Because even if you report nurses or anybody else, they will talk to them. So that makes me feel good. I work there because I feel like management is good there. (P04)*

Support from management was important because it made participants feel satisfied and made them enjoy working in their long-term care facility. One participant shared another example of how her manager supported her and made her and her team 'feel good' by coming onto the floor and answering calls from residents during busy periods.

*Sometimes, our manager, if it is getting busier, sometimes they answer one or two calls. It's amazing. We feel good. (P03)*

Another vital way that participants shared that they felt supported by managers was through encouragement and accommodation to pursue nursing studies. A number of participants were actively pursuing such studies which demonstrated that this support not only was appreciated by participants but actively enabled them to take this step. Encouraging participants or other healthcare aides to pursue nursing education and helping them to navigate their work options (e.g., taking a leave from their position or lowering the number of hours in their position) were the two key ways that participants shared that their managers and organizations supported them in pursuing nursing education.

*If we wanna grow ourselves as a healthcare aide, they always encourage us if we wanna study something...If you want to study, [our long-term care facility] helps them to get that*

*little bit [of] time off for their education. Then they hold their positions, or sometimes, they arrange a lower position for them so they can study at home. (P09)*

*Recently I was going for my studies for registered nurse, and for that I needed some time off from my job. They helped me with that, my manager. She helped me a lot during that time. Like whenever I needed vacation, like one month, 2 months, they helped me. They were guiding me [around] what I can do, what I cannot, what will work for them, what will work for me. That was good. (P03)*

### **Teamwork**

*Teamwork* was a third and final subtheme that emerged from the data within the theme of *What is Important to Healthcare Aides*. Having proper teamwork was viewed by participants as foundational to them being able to effectively do their jobs.

*It's teamwork that makes it or breaks it. (P10)*

**Why Teamwork is Important.** Teamwork was a requisite to optimization of healthcare aides' work efficacy and efficiency according to participants and occupied a requisite role in optimizing the delivery of quality care to residents. Without teamwork, there was too much work to do according to participants. Participants and their fellow coworkers compensated by helping each other out.

*We're both helping each other with our [residents], because you cannot do everything by yourself so we try to help each other as much as we can. (P03)*

Working in pairs (i.e., 'the buddy system') to wash, dress, turn, toilet, and transfer residents who required a two-person assist for lift transfer was preferred by participants.

*The buddy system is ideal. (P01).*

Teamwork was viewed as important by participants because of its perceived role in reducing the burden of work placed on a single individual, for example, when turning a resident in bed alone,

the task was 'hard'. Doing the same job with a partner, however, made the task more manageable.

*If [we use] teamwork, then it's not too much burden because it is a difficult job...and it's hard if you're doing it by yourself...[but] I think if there's teamwork, then it's not too much burden on one healthcare aide. (P04)*

In addition to being less burden, participants aligned with their belief that working in pairs was better than working alone because this approach also reduced healthcare aides' fatigue levels, so they went home less exhausted than if they tried to work alone.

*The good thing is you're working together so when you go home, you are not too tired. This is what I like about this job. (P04)*

A participant shared how one organization embedded the practice of working in pairs when caring for residents who required a two-person assist into policy after “*some incidents happened*” (P04), implying that using teamwork when providing care reduced risk of injury to residents/healthcare aides. Standard practice before this policy was implemented at their facility according to a participant, was for healthcare aides to wash, turn, and dress residents on their own before calling for help to transfer their resident into their wheelchair. In addition to this former approach being more burdensome on individual healthcare aides, and unsafe for residents/healthcare aides it also created inefficiency. Participants shared that they had to wait for someone to come help with a resident transfer before they could move the resident which sometimes took several minutes and wasted valuable time, especially during periods of peak busyness.

*Sometimes when we put the staff assist on [to call another staff for help], [the other staff] are also taking care of the other residents, so it's hard for them to come right away, and sometimes we are waiting for 5 minutes, sometimes 10 minutes. In the mornings you*

*cannot wait because you need to get every resident up. So that's why I think it's good...I work in the morning and now they changed it to 2 people working together so it's easy.*

(P04)

Using teamwork when delivering care enhanced safety and reduced risk of injury in other ways as well. For example, participants shared the challenges of moving or turning a heavy resident alone, dealing with agitated residents, and injuries sustained at work and how teamwork minimized risks and safety concerns.

*We do teamwork. Even our nurse will see the residents starting to get aggressive and will either give the medication right away or otherwise ask us to separate the residents. We always do teamwork.* (P11)

Teamwork was especially important for staff safety on units with a high concentration of residents who could be violent.

*If you work by yourself – no – you'll die there. <Laughing>* (P11)

Working in teams also allowed participants to be more effective by helping them to be more organized and work quicker without rushing residents. It also helped a participant who identified as neurodivergent, with their time management – an area of difficulty for them.

*I can be super organized, and I can be out in 10 minutes with a resident if I have that buddy there...I can just dress one half, one side and my partner dresses the other side. We can make the bed while the resident is in the bed. My partner does the other half, and I do one half. And then it's just like that, it just clicks like a puzzle. And I find that's very helpful with my time management.* (P01)

Another way that teamwork was reported by participants to make their work more effective was that it transformed the work and care environment for the better – a necessary

requisite for the delivery of quality care. For example, supporting and respecting one another was perceived by participants to improve the work environment and reduce stress for healthcare aides.

*I just think that it would make the work environment better. You wouldn't be as stressed, because you don't want that to affect your job. You want to be comfortable with your coworkers. You want to have a good relationship, and you want to work as a team. My most important thing is working as a team. (P06)*

According to participants, residents noticed these changes in work and care environment whether they were cognitively impaired or not.

**Competencies of Functioning Teams.** In addition to being important to healthcare aides, participants reported that teamwork was an underlying tenet of their work roles.

*We're here to do a job together. It's the reason we call it the healthcare team. (P01)*

Participant interviews also provided detail into the components of the teams they worked in during their interviews. As these components emerged from the dataset, it became evident that participants were identifying competencies of functional teams. Five competencies identified were: i) complementary roles and functions; ii) support and respect; iii) shared values and goals; iv) open communication; and v) shared decision-making. While each subtheme contained enough detail and difference to warrant its own category within the coding process, overlap and interdependence nonetheless existed between domains.

***Complementary Roles and Functions.*** Participants discussed three key components within this competency: i) knowing their role and value; ii) knowing the roles and value of others; and iii) functioning in complementary ways.

Knowing their role and value. Participants in this study discussed their individual strengths and the ways that these contributed to the delivery of quality care to residents.

Individual strengths were as varied as the individuals who participated in this study and included

prioritizing the mental health of residents and staff, possessing physical strength, and being effective at de-escalating agitated residents. Individual strengths were often a source of pride for participants:

*One day, one of the [residents] she got mad ...and she didn't want anyone with her but...I talked with her calmly, and the way I talked to her...she was really happy, and she started to talk with other people...That day I still remember because she got mad but then I made her calm. (P03)*

Other individual strengths identified by participants involved taking the time to go above and beyond in delivering care to residents and included playing an instrument, noticing subtle non-verbal cues in residents, treating the long-term care facility like a home, listening to and visiting with residents, and giving good baths. A participant talked about how important the small things were and the pride they gave her and others in the care team to provide these:

*Giving them that extra time to soak in the tub. Rather than giving them a quick wash, letting them have an extra 5 minutes to soak in that tub. I've heard even nurses express, "Oh, [Participant 06] gives the best baths," ...they're always just so happy to have that extra time in the bath. And then when they're sitting there soaking in the tub, I keep on adding hot water for them to make them more comfortable. (P06)*

In addition to individual strengths, participants clearly possessed expertise regarding their roles, the unit routines as well as knowing individual residents.

*We're assigned groups of people to [give care to] and we follow our lists of groups of people...we each have a wing to work on, and we have a partner, and we work together and the ones that we can [give care to] that are one-assists [we give care to] on our own. (P10)*

*My role as a healthcare aide is to provide care for the elderly residents, to make sure all their...personal needs are met. Not only personal needs, but to make sure they have someone to listen to them if they need to talk, to form personal relationships. So, I do that...You're the one providing care. You're one that's with them most of the time, and you know their personalities, and you know what works. (P06)*

In conjunction with knowing what their roles were, participants shared what they believed were boundaries to their role responsibilities. In response to being asked to restrict visitation for specific members of the public to residents, a participant stated

*That shouldn't be my job. My job is to take care of the resident. (P06)*

Knowledge about their roles, their unit, and the individual residents assigned to them was largely acquired on-the-job.

*A lot of us have been there for a long, long time. And we know the routine. We know everything that we're doing. (P06)*

This expertise translated into quality individualized care for residents as these participants sought to adjust their care routine in ways that optimized resident experiences.

*If we know the [resident] really prefers to [have a cup of coffee] before they get up in the morning, we prefer to give them care in their way. (P02)*

*I start a little bit later, so my resident is more comfortable. (P09)*

Another benefit of their expertise in understanding the resident and their care needs, coupled with their role as direct caregivers was that they were able to act as the 'eyes and ears' for the rest of the healthcare team.

*We're the eyes and the ears for the nurses, if we have any concerns about sores, or the way they're behaving, or stuff like that then we're their eyes and ears to report issues like that. (P06)*

Understanding and acting on this element of their role, was something these workers prioritized and placed significant value on, as they recognized that a resident's condition could change in a moment. Further, participants recognized the limitations of their role and associated scope of practice limitations. Their discussions about involving other members of the care team revealed their ability to think critically, rationalize, and act as capable decision-makers.

*If I saw a nurse, if I saw a doctor, or if its physiotherapist related, I just convey the message [regarding a change in a resident's health status] to them right away. I don't hold it until the end of the day...the medical health can change anytime. [The medical health] can change within an hour or two. [The medical health] can change anytime.*

(P09)

The decision-making expertise of these essential workers emerged elsewhere. Participants discussed their ability to rationalize as they exhibited autonomy in decision-making regarding timing and distribution of care, as well as their capacity to incorporate resident preferences into the unit routine in ways that considered both the individual and the group.

*When we start in the morning, we always think about which residents we have to spend more time on, which residents we have to spend less time on. We always do our heavy [residents] earlier. Heavy means they need total care in bed; to be changed, get dressed or whatever. We do them first, because then they don't have to wait until 9AM or 9:30AM.*

(P09)

Decision-making capacity was underpinned by an ability to adapt to the constraints placed upon them by changes in resident care needs and the care environment, as well as by an ability to appropriately prioritize the diverse needs of the residents for whom they were providing care.

*We are very short staffed some of the days, and sometimes it's hard to complete all the tasks but we try to do our best. It goes by priority. Whatever is very important, we do. But,*

*for example, some of the days, we are not able to make them walk, so we skip it, and it can happen on the next shift. That's how we adjust. (P07)*

The expertise of participants in understanding their role, the unit routine, and the needs and preferences of individual residents gave them confidence – “*I'm confident working there*” (P11) – and led to a desire to be trusted to have autonomy in decision-making. This pertained to tasks participants had experience with performing safely and competently.

*If what I'm doing is going to work, and it has been working before then I should be allowed to do it how I see fit as long as I and the resident and my coworkers are safe. (P06)*

Nonetheless, it was apparent that a few participants downplayed the value of their knowledge and expertise, even referring to it as ‘common sense’.

*It's common sense, like if the person is a heavy wetter and they are on water pills, that person can soak through within half an hour again. (P09)*

The healthcare aides who participated in this study further demonstrated their expertise as they discussed the ways they held themselves accountable for the well-being of the residents that they cared for.

*I have to take care of it, and I have to notice. (P09)*

This sense of accountability for the residents was shared by a participant as she reflected on a challenge she identified when working with staff who were not able to complete their duties. She highlighted that her care and accountability extended beyond those residents to whom she was assigned, to encompass all the residents on her floor. Rather than going home and leaving things undone for residents, she worked harder on her shift to make sure that care needs for residents were met.

*I want to get everything done before I go home...cause I can't leave the [residents]. Even though they are not on my team, it doesn't matter... whatever work is left when my coworker goes for break, I have to do all the duties, whatever she was assigned...I can't ignore it. (P07)*

Knowing the roles and value of others. Participants highlighted the need to report concerns to nurses or other healthcare professionals on the healthcare team and demonstrated an understanding not only of the limits of their role and scope of practice, but also an understanding of the roles of others on the healthcare team. They recognized that nurses had a different role than the healthcare aides. Firstly, nurses were viewed as the leaders of the healthcare team.

*How do I see it? It's like our nurse is in charge and we are the team there. We are the eyes for her. (P11)*

Thus, the nurse was the person to report complaints or concerns to.

*I've complained to the nurse. (P06)*

*If I see a problem, I have to tell the nurse and the nurse checks. For example, the resident today was not eating like usual...so I will tell my nurse. (P11)*

Because of the leadership role assumed by nurses, participants asked nurses for permission if required or if they were not sure about something. For example, if they wanted to leave someone in bed for supper or if they wanted to look in a resident's chart.

*Once in a while I will look on their chart, and I will see what are they diagnosed with.*

*And I've made this very clear to the charge nurse, like I asked, 'Is this okay? Can I?*

*Where's my boundaries? Can I do this?' And so far, they're okay with it. (P01)*

Participants framed the differing roles between nurses and themselves another way: nurses performed cognitive work, whereas healthcare aides performed physical work.

*I have to be active with the physical work, they have to be active with the mental work.*

*The nurses are working with the medication. The nurses have to notice their health and have to prep so many things. (P09)*

The requirement of nurses to give medications, as well as do dressing changes and charting was highlighted by a number of participants. Participants displayed not only a cognitive understanding of the roles of others on the healthcare team but also an empathic understanding of the added workload that these tasks could sometimes present.

*Nurses have their own job. They have more paperwork, they have to do the pills, and dressings. So much stuff they have to do. (P07)*

Being understanding that they were not the only ones who were busy or working hard emerged as an important part of understanding the role and value of others on the healthcare team.

*I understand that if I have work on my plate, they could have more work on their plate, too. With the medication, with the [interprofessional notes], with the charting, and then testing, and all that. Sometimes they have a blood transfusion, and they have to do it. Sometimes a [resident] is going out for an appointment, and they have to prep everything. (P09)*

Nurses were also viewed by participants as sources of information, keeping staff up to date and explaining things when participants had questions.

*If I don't know anything I will ask my nurse, and they will let me know. Like the first time when the [resident] is admitted, at that time they will tell us everything about the [resident]. (P02)*

*They keep us updated. The nurses keep us updated in the report very well. (P10)*

This information influenced their care delivery so their approach could be individualized to each resident's care needs.

*Sometimes nurses explain to us how we can reach out to the [resident]...if they have a mental or physical disability. (P09)*

Participants also acknowledged situations where role overlap occurred with nurses, for example, with transferring residents.

*I think for the most part the nurses just do the medications, but they will help with transfers and whatnot. (P06)*

Functioning in Complementary Ways. A final tenet of the component of team functioning entitled *Complementary Roles and Functions* was participants learned to function with fellow healthcare aides and with other members of the healthcare team in ways that were complementary. For example, a participant recognized the direct-care role of healthcare aides made her better suited than nurses to assess residents' skin on a daily basis.

*Nurses don't have that much time. They can't observe their skin every single day because we do lots of peri-care and we do the bathing. (P09)*

Complementary functioning also entailed capitalizing on one another's individual strengths.

*I can see that [another healthcare aide is] better at some things where I'm not so I can say, "How about you do 'Job A' because you're really good at that, and I'll do 'Job B' and we'll come together." (P01)*

A vital part of complementary functioning was working together as a team, which encompassed helping each other out.

*We always work in a team. We are always helping each other. (P03)*

This relationship was described as 'give and take'.

*It's give and take. If I'm doing things for them, they always do things for me too. (P07)*

Another example of complementary functioning and working together was provided by another participant and described as dividing the workload.

*We have to give them water and other things ...so we divide the duty. Like one staff will go to fill the water. One staff will collect the breakfast trays. One staff will give the breakfast. (P03)*

Participants remarked that when the team was functioning well, everyone gave their assistance.

*Nurses are also helping. And then the healthcare aides, everybody's helping. Like I said it's teamwork so that it's not more [work] on one person. (P04)*

Nurses assisted more in facilities where policy mandated that they assist healthcare aides.

Moreover, in the facility with this policy, nurses extended more assistance than was required by the policy, thereby enhancing team functioning.

*In [long-term care facility #2], there is a policy that nurses also help transfer but in [long-term care facility #1] the nurses just do their job – medication pass – and that's it. But sometimes I think healthcare aides also need the nurses help to transfer but the nurses don't want to do it so it's hard...In [long-term care facility #2] there's a policy that tells the nurses that they need to help with the lifts and the transfers. They also help with feeding. What I feel is that they will never feel that you are less educated [than they are] so they always work as a team. What I feel is they work more as a team as compared to those who are just doing their own job. Which I feel is more helpful for us as well. (P04)*

Another participant shared that her manager participated and helped during busy times. This type of help offered by a formal leader had a positive impact on the healthcare team.

*Our manager, if it is getting busier, sometimes they will answer one or two calls [from residents]. It's amazing! We feel good. (P03)*

Another feature of working together was that participants believed that they could ask for help, and that in doing so, assistance would be provided.

*Honestly, if I ask my partner who was on the floor with me for help, they always help me.” (P02)*

Working together also meant recognizing when someone else needed help. For example, participants reported cases where nurses would offer to help without being asked.

*Nurses offer to help if we need help sometimes. Like if I'm short and I need help with a transfer, the nurse will help me. (P10)*

They also reported times when fellow healthcare aides would help them, for example, when they were falling behind.

*My coworkers, especially, they are helpful when you are behind with your tasks. (P07)*

Helping each other out extended beyond helping with catching up and offering to help without being asked. It also included helping staff who were physically less capable of doing their work and exchanging shifts with each other when someone needed a shift off.

*When I was pregnant, it was really hard for me, doing all the lifts so some of them, like if [a resident is] one-assist, they say, 'Okay, you do that. I know you can do that.' Though I can do the lift but just because I was pregnant, they really wanted to help so when it's time for us to do the transfer, they just said, 'Oh, don't worry about that, we will help you. We'll help you do the transfer.' They were really helpful. (P08)*

*With regard to work, if I need a shift exchange or something, my co-workers are always helping me with them. (P02)*

Another feature of working as a team was having an 'us/we' mindset and viewing responsibilities as shared. Shared responsibility encompassed viewing their responsibility as extending beyond their work assignment to encompass those of other healthcare aides.

*We have 22 [residents] on one floor – so 11 [residents] in my team, 11 [residents] in my coworker's team – but I'm not looking after only my team. My coworker always gives me*

*a helping hand. They're always helping. We're both helping each other with our [residents]. (P03)*

*We have to weigh people every week. I don't care if that person is not assigned to me.*

*Whenever I have time, I always get ready to do things for others – all the people. (P07)*

This type of approach helped ensure residents were provided with care when they needed it even if the healthcare aide assigned to care for them was busy or on break.

*Sometimes [residents] wait because another person is on break. We will help that resident, although [that resident is] not [assigned to us] ...We will help everybody. Our job is to get the residents up if they're on our list. That's the only part which we do by ourselves. Then, if they are up, I can help other residents with feeding...or [if] they want to walk...with the rest, we will help each other. (P04)*

A sense of shared responsibility encompassed nurses as well; an example was highlighted by a participant when she described a challenge faced by healthcare aides on her unit.

*We have one resident; she just follows you. She just holds you. You can't do anything if she doesn't have a companion. (P11)*

This participant further explained how the team addressed this by sharing responsibility for the resident so healthcare aides could continue to help other residents.

*The nurse will come and take her with her, even though she is doing the meds, she still has her walking with her. (P11)*

In functional teams, a sense of shared responsibility extended beyond the staff with whom they worked directly to the staff on the next shift. In particular, during less busy shifts – usually the night shift – staff helped organize or get things ready for future shifts.

*I tried to make it easier for the dayshift when they start, because, as I told you, they have lots to do in their dayshift. (P09)*

For example, in some facilities, night staff were responsible for putting out briefs, washcloths, and other essential resources needed to perform their jobs. In other facilities, night healthcare aides would write out the important information for the residents assigned to the day shift healthcare aide on a piece of paper.

*The night staff make a copy on nights for the next day so when we start in the morning, we have that paper, and then we can look after the residents and have information about...everything. (P02)*

Another tenet of working as a team was information sharing. Participants shared that they capitalized on the expertise and knowledge of more experienced healthcare aides to optimize team functioning and performance.

*Those who are more experienced than me, who have been there longer, it's nice that they they're very open to sharing their information with me and their experiences. (P01)*

Information sharing was particularly important in cases where staff had been away from work for a time, or new residents came to live in the long-term care facility.

*For example, you're off for a while and you go back to work. Then you are kinda lost where to start. [Fellow healthcare aides] are the ones I go to. "Okay, so how's things going? What do we start with first?" [Fellow healthcare aides] are the ones explaining, "Okay, this person is new. If you wanna do him first, or her first, or this person wears a brace". These things, they explain to you. (P07)*

Another time information sharing occurred when it was essential; when there were changes in a resident's health status, particularly if it was a safety issue.

*We communicate about what's going on today. They report to me if something has changed. (P11)*

*Let's say the particular resident, she's independent – she walks on her own. On our new shift, we just got information that she had a fall. Now she's using a lift...Now we know the care plan has changed. We don't have to walk her anymore. We have to use the machine for her. (P08)*

This information sharing happened most comprehensively at shift change but was also done as needed throughout the shift and extended to all members of the care team.

*The resident today was not eating like usual. I have a partner, so I said, “I don't know Mrs. Jones. Today she only ate 30% of the food. She is not happy” ...I will tell my nurse. (P11)*

### ***Support and Respect***

A second component of high-functioning teams in long-term care was reciprocal support and respect. Participants could expect to be treated without bias or disrespect and offered the same courtesies to their colleagues when teams were functioning well.

*We are all are treating each other the same way. (P02)*

This helped participants to perform their jobs.

*They help me to do my job by...we get along so well, all of my coworkers and I. We get along very, very well. (P06)*

*I never have an issue, even with the healthcare aides. My teamwork is very good. I don't have any teamwork problems. And my nurses, they are the best. Yeah, they are the best. (P09)*

Giving and receiving support and respect were viewed as positive feedback loops. For example, if fellow healthcare aides valued and appreciated the work that participants did, they were more willing to do more in return for them. One participant discussed what it was like to

work with fellow healthcare aides who were “retirement age” (P04) and had difficulty performing the physical functions within their role, leaving more work for her.

*It's little bit hard but if the [healthcare aide] is nice with me, I'm okay. Yes, because if they understand what you are doing for them and they are thankful too, then I'm okay with that. (P04)*

Participants felt supported and encouraged in their work when others helped them out.

*When I do get somebody to come and assist with me...it is definitely a morale booster there and supportive. (P01)*

### ***Shared Values and Goals***

A third component of high functioning teams was possessing shared values and goals; that is prioritizing residents, and the quality of care delivered to them.

*We all agree that we're there for the residents. We're there to take care of the residents' needs (P06)*

### ***Open Communication***

Open communication was used throughout the participants' work in diverse ways. Participants used open communication for information sharing. Keeping members of the healthcare team apprised of residents' status and reporting concerns to nursing staff is an overlapping part of functioning in complementary ways within the competency of complementary roles and functions.

*We watch [the residents] and we see and tell our nurse how they are doing. (P07)*

Another important aspect of open communication that contributed to the functioning of participants' teams was ensuring a common understanding with their partner(s) of who was doing what. This ensured all the tasks that needed to be done were being completed by the team.

*We find that communication is the best thing. Usually, we work in a team of three on one side, so like, "Oh, I'm going here. Do you want to do the bath?" (P06)*

There was an underlying presumption in the participants' work structure that those who needed help would ask for it and that others would respond positively to these requests. This open communication strategy was used by both nurses and fellow healthcare aides.

*With regard to [resident] care, if I have lifting, like a 2-assist [resident], I'm gonna ask [another healthcare aide] before starting the shift [to help]. They will help me with that. And my nurse also, if I ask her for help, anytime they help me. (P02)*

Participants reported that this type of help was also a "big support" (P02). Though less common, participants stated that there were times when newer staff were unable to help when asked because they had not completed their own care duties.

*Mostly I have good co-workers, and if I ask for help, they come and help. But some of them, they are really busy with their team. They are not able to finish...their duties...sometimes they're new...It's very hard. (P07)*

Participants highlighted the ways that regular staff on highly functional teams did not always have to communicate as frequently as when newer staff joined the team, for example, with regular staff, communication sometimes was not necessary – unit practices created routines that became ingrained.

*If [I'm working with staff that is] regular, we know the routine. We know what time we go to Mr. Jones. We don't need to call each other. We meet each other by the door at the time. We know that. But for the agency you have to call "Hi, where are you?" (P11)*

As highlighted previously, within the competency, *complementary roles and functions*, reporting changes in resident status to other team members was an essential part of team functioning and

was another way that participants used open communication to optimize their functioning and the care that they delivered.

*We do the rounds with my day shift co-worker. We communicate about what's going on today. They report to me if something has changed. (P11)*

Open communication was also deployed by participants as a strategy to address misunderstandings or conflict. A participant reported that to assist a new healthcare aide on her team, she communicated directly about the care needs of residents. However, when this was not well received by the new team member, she and the new healthcare aide were able to work together to remedy the issue.

*I said [to the new healthcare aide], "...We can fix this problem...Whenever you are not comfortable with the resident, you come to me. I will tell you the tip for caring for this resident." So right now, we are okay. Whenever [the new healthcare aide] comes to our floor she will ask me, "What are you doing for that one? Who should I do first?" "Okay, I will give you a list. I'll write down the things. You follow that." Now she is happy. (P11)*

In addition to confirming the diverse ways that open communication is used by participants to optimize team functioning, this participant's perspective confirmed that open communication was especially important when there was a new member on the team as team dynamics and interactions were affected by differing understandings and expectations.

Lastly, open communication was vital for voicing concerns.

*"If I don't like something, or don't feel comfortable with something, I will say it" (P10)*

For example, when healthcare aides spoke a foreign language together at work, participants asked them to speak in English. Non-confrontational approaches, however, were more common among participants. For participants dealing with the challenge of foreign languages spoken by coworkers, they addressed this less directly by saying *"What? I didn't hear that"* (P07) to

offending healthcare aides and bringing concerns to management – particularly when resident care was affected.

*I went to my manager a few times...when someone is talking in another language at the bedside. (P07)*

### ***Shared Decision-Making***

Shared decision-making was the fifth and final competency identified within this rich data set. Open communication and shared decision-making were more likely to occur when the previous three competencies – complementary roles and functions, support and respect, and shared values and goals – were already in place. Without knowing how to function in a complementary manner that was supportive and respectful of one another, it was difficult to establish the trusting rapport necessary to communicate openly or engage in egalitarian shared decision-making. Further without shared goals and values, it was difficult to engage in shared decision-making.

Shared decision-making took different forms depending on the composition of the team and work required. Firstly, participants often employed shared decision-making strategies with their healthcare aide partners.

*When we need to change them, and when we have to do their lifts, we – both of us, me and my co-worker – ...we decide. (P09)*

There were times where participants recognized the value of involving and being involved with their nurse counterparts in the shared decision-making processes and were happy to facilitate this.

*We are the eyes for [the nurse]. We see something, we tell the nurse right away, and then [the healthcare aides and the nurse] can decide what we do for the next step. (P11)*

The shared decision-making process employed by nurses and healthcare aides also demonstrated that healthcare aides in high functioning teams knew the limits of their role and the roles of others (i.e., in this case, nurses) on the healthcare team and functioned together in complementary ways.

### **Challenges**

A second theme that emerged from the data was *Challenges*. Subthemes within this category were: i) workload and work role; ii) access to opportunities; iii) staffing; iv) time; v) fellow healthcare aides; vi) feeling devalued; and vii) difficulty dreaming. Whenever relevant, the perceived impacts of these challenges upon residents and healthcare aides are also discussed within each subtheme.

### ***Workload and Work Role***

Participants consistently reported that their work, while rewarding, was immensely difficult for a few reasons. Firstly, the workload faced by participants challenged them physically, putting them at risk of injury or pain and constraining them in their ability to provide quality care to residents. Secondly, participants reported that their work had an emotional and psychological impact upon them. The impact of these upon participants was said to be cumulative. The workload and work role challenges faced by participants were i) volume of workload, ii) residents' needs, iii) residents' behaviours, iv) resident deaths, v) residents' families, and vi) getting help wherever possible.

**Volume of Workload.** A challenge faced by participants was the high volume of residents for whom they were asked to care in a time constrained environment.

*That is my struggle there: to do seven residents, and I have... 10 to 15 minutes for their morning routine for each of those residents, and then to do breakfast service. That would be my constraint, is the workload. (P01)*

Participants also shared that there was a high level of responsibility, and they were asked to do 'a lot' in their roles.

*A lot is expected for from us. People expect so much from us. (P10)*

When obliged to work with less experienced non-regular healthcare aides (i.e., float, casual or agency employed), participants reported that greater expectations were placed on them than their counterparts.

*Even your charge nurse and everyone, they're expecting more from you. They're like,*

*"Oh, this a float so he doesn't know much about the floor. You're regular here." (P07)*

**Residents' Needs.** Balancing the diverse needs of residents was a challenge identified by participants. The needs of the individual resident were often juxtaposed with the needs of another resident, the needs of the many, or in some cases, the needs of the long-term care facility.

*Lots of [residents] are calling at a time, like three or four call bells, and sometimes they get upset. We cannot provide care to them right away. Yes, it's difficult sometimes to make everyone comfortable at one time. (P03)*

*There's always limitations, absolutely. They're running a care home, which is the business end of it. And then you got residents who treat it like a home. So, you're in the middle.*

*Figure it out, and so it's always challenges. (P01)*

Balancing these needs was more difficult for participants when they had less time or staff at their disposal.

*Sometimes at nighttime we have only one staff on the floor at that time. It's very hard to help everybody. When my nurse is on break and I'm working all by myself, and [there are] 22 [residents], sometimes they would like to use the washroom. Some people they would like to change their brief. At that time, it's really hard to provide the care to everyone together. (P02)*

The high degree of care required by their residents was another challenge for participants.

*It does not happen all the time, but sometimes we have lots of [residents] who need more care – like lifting and everything. (P03)*

The care needs of residents increased over time.

*I find that since I started back in 2014, that the [volume] of dementia [residents is] a lot higher and care is a lot heavier. (P06)*

For example, turning and transferring heavy residents risked compromising the physical well-being of participants when they had to perform these tasks alone.

*“When the resident is heavy and then you need to turn them, it's hard for one person”  
(P04)*

The physical cost borne by healthcare aides was echoed by a number of participants.

*[A healthcare aide's job is] a job that's very taxing on the body. It's hard on your body, physically, with lifting people, with everything. That's the thing. A lot of people that do our kind of work eventually, it wears and tears at your body. It's a very physical job. That's our job. We work very hard physically. (P10)*

Indeed, a few participants specifically reported on the back pain they lived with because of the physical difficulty of their work.

*Oh, my back is so bad! (P11)*

One participant viewed continuing in their current role as healthcare aides to be physically unsustainable over the long term and returning to school to become a nurse was viewed as a way out.

*Physically, I'm 39, but I don't know if I want to be doing this in ten years from now...I'm already contemplating things because I started some school a couple years ago, but I may*

*have to just push through it and go back and do what I have to do, because I feel that this is just such a hard job. (P10)*

Meeting the needs of residents was not just physically difficult for participants. It also had an emotional and psychological cost on participants.

*There's just so many things to take on. Sometimes it's physical and depending on the floor, it's mental. It has all these things that you take on. (P10)*

The 'stress' of their work was frequently discussed by participants.

*It's very stressful, it's heavy and it's not balanced. (P10)*

*You might even have a little PTSD [(post-traumatic stress disorder)] at the end of the shift, depending on how it goes. (P01)*

Participants reported they took both the physical pain and exhaustion of their work, as well as the emotional and psychological stress of their work home with them.

*Sometimes I feel stressed, and the stress comes home, and I just stress my husband. (P11)*

**Residents' Behaviours.** Many of the challenges presented by participants in their interviews centred around the increase in dementia and responsive behaviours of residents and the care needs attached to those behaviours.

*They are aggressive and also, they have dementia. They forget things. That's the challenge. (P11)*

Residents engaged in behaviours such as screaming, wandering, and acts of aggression towards fellow residents and staff which required close monitoring and intervention from participants and their colleagues. For example, one participant discussed how residents who wandered sometimes would not stay in bed at night.

*We try our best to put all the residents to bed but some just get up. (P11)*

Another participant shared how easy it was for some residents to become upset suddenly and how this could impact care.

*I do remember one day, one of the [residents], she got mad because she has dementia.*

*Suddenly she got upset at one of the staff and she didn't want anyone with her. (P03)*

Other participants discussed the risks an agitated resident could pose to other residents and staff.

*Some residents are fighting. Some have dementia so they don't know. Sometimes they start chasing you. (P04)*

Participants tried their best to deliver care in ways that kept themselves and others safe and injury-free.

*If I see the resident today is aggressive at this moment...we wait for a for a while...because we ...don't want him hurting us. (P11)*

*If you feel like you're in danger of getting hurt then you have to walk away and then come back later once they've calmed down...For our safety and for their safety - coming back once they've calmed down, is the really one of the best options. (P06)*

Despite the participants efforts to keep themselves safe, they reported that on units with a high concentration of aggressive or violent residents, everyone incurred some type of injury every day from residents and that working in this type of environment was stressful for participants.

*Sometimes, it's really stressful for us because my floor is for mental problems and some residents' behaviour is so aggressive. Yesterday I got hurt from a resident. She was just holding me so tight, after my wrist was red...Everyone...gets a bruise...each [day]. (P11)*

To manage, some participants reported they avoided picking up shift on floors that were more stressful for them.

*When [my mental or physical wellbeing suffers], I tell my scheduler, that floor [that stresses me out], I just refuse it. I've just refused it to do it on a regular basis. That's how I*

*take care of my mental and physical health, because when I go there, I'm always stressed out. (P10)*

Participants also used formal reporting strategies caused by unsafe and/or aggressive residents to report injuries and unsafe working conditions. Nonetheless, participants also shared that these behaviours were so severe sometimes that a 'code white' had to be called, and a resident sent to a hospital for unmanageable aggressive behaviours.

*We have called a code white and sent [a resident] to the hospital. (P11)*

In one case when a resident was too unsafe to be cared for in a particular long-term care facility, a participant shared how the resident was moved to a new facility that could safely manage their care after incident reports were filed.

*We had to take her out of [the long-term care facility] for everybody's safety. (P06)*

Unsafe residents in their facility were "kind of scary" (P06) for participants. Taking care of residents when they were agitated or aggressive made it more challenging to deliver quality care.

*That would probably be more of a time when you can't really give as good of care as you would like to because of their emotional state. (P06)*

Certain residents were consistently aggressive, making it an ongoing challenge to deliver quality care to them, even with multiple care providers present.

*[It happens] often a few of our residents are so aggressive. Like our one resident is really very aggressive. We can't do the care, even with four people, five people. Very, very challenged there. (P11)*

**Resident Deaths.** The death of a resident had a profound impact on participants' emotional and psychological state. A participant choked back tears during her interview when she recounted the impact of resident deaths upon her.

*I'm so emotional about that. (P11)*

She also shared how difficult it was to go on vacation as she worried that a resident that she cared for would die during her absence.

*It's really hard. Sometimes you take care of the resident and then you go, like when I'm on vacation...when I come back my favourite is gone so I thought, 'Oh, my god! My heart's broken! ...I know it's life, but I'm so sad.'* (P11)

**Residents' Families.** Lastly, the family of residents were sometimes listed as challenges for participants. Two specific scenarios were provided. In the first instance, family members pressured participants to deliver care to their loved one ahead of another resident; however, participants had identified other care needs on the unit should be prioritized at that time. The second scenario related to restricting access to residents by family members who had been deemed unsafe for the resident; this made participants feel uncomfortable.

*A family member, for example, is not to be allowed access to a particular [resident]...because of financial issues or abusive issues... [The long-term care facility] give[s] us notice...not to allow them to have any association with that particular resident which, honestly, kind of makes me uncomfortable.* (P06)

**Getting Help Wherever Possible.** Participants reported that when their workload was too much to manage, they would sometimes request additional staff from their manager.

*Sometimes, we have to tell [managers] that we really need help with the...heavy workload.* (P03)

These requests were often granted, particularly for transient changes on the unit or for certain resident-specific care needs, for example, when there were infectious disease outbreaks on the unit, or for high-risk residents (e.g., fall or flight risk) or bariatric residents. However, for long-standing challenges, workload relief had to be found in relying upon non-staff to meet residents'

care needs. For example, volunteers were relied upon to ensure all residents could be fed at mealtime because of the volume of residents requiring assistance with feeding.

*In the floor on which I'm working there are a lot of [residents who need assistance with feeding], so there are some volunteers there and we need them...I think there are 16 [residents who need assistance with feeding], so it's hard. (P04)*

Participants also reported a reliance upon the companions (private paid non-medical support workers) that some residents or their families had hired.

*Our floor also has some companions, and some companions are also helping us...Some [residents] have one-on-one [companions] to take care of them. That's a big help too...If the companions are not there, sometimes you can't [do your job]. (P11)*

The use of companions was recognized as inappropriate by some participants. The inappropriate use of companions coupled with caring for wandering residents without adequate staff was perceived as stressful for healthcare aides.

*What's stressful about it is because there's not enough staff to watch the people that wander and then sometimes there's companions there, and then [the other healthcare aides] expect us to get the companions to help us. But that's not [the companions'] job. (P10)*

Not all participants, however, recognized that using companions to assist them was inappropriate, and willingly sought them out to assist in providing care to residents beyond those to whom they were being paid.

*We have other companions [with other residents] so [we] just ask them to give [a different resident] a little bit company there, so I can change a [resident], or help [a resident] who needs to go to the toilet or something. (P11)*

### *Access to Opportunities*

Participants were eager for opportunities to learn and grow professionally but these opportunities were mainly confined to the organization's limited education offerings according to participants.

*Apart from those educational opportunities they give to us, no, [there is] nothing else.*

(P08)

As a result, organizational education offerings were usually viewed as inadequate by participants.

*[Our long-term care facility] offering us classes to improve our skills, I think that would be really beneficial. I don't think we're really offered that too much...I would like more classes and teachings on [dementia]. Like how to deal with residents in certain situations.*

(P06)

If other opportunities existed, participants were not aware of them.

In addition to being eager for more opportunities to learn and grow, participants viewed the pursuit of additional education as important for growth.

*The learning opportunity is a good opportunity so you can grow. We can grow ourselves.*

(P02)

The learning opportunities provided by organizations were therefore well utilized by participants.

*I took the Parkinson's disease seminar, and I always do the [online learning] as well. I like to study. (P04)*

As there were limited opportunities for education through their long-term care facilities, several participants pursued their own education and growth endeavors by embarking on education to become a nurse. Though there were no interview or demographic questions directly aimed at ascertaining whether participants were pursuing additional studies, three participants disclosed that they were actively pursuing nursing education – at least one of which was engaged

in studies to become a registered nurse. Another participant was completing her grade 12 studies with the aim of pursuing nursing after she completed these pre-requisites. A fifth participant had previously started attending college to become a licensed practical nurse and withdrew from the program; she was, however, considering reapplying and resuming her studies. Moreover, participants reported that they knew co-workers who were working towards becoming nurses.

*Right now, at least, two or three [staff] on my floor, they are going to be [registered nurses] right now. They were healthcare aides. (P09)*

The underlying reason for at least one of the participants to pursue nursing was to escape the challenges embedded in the healthcare aide role she occupied.

*I'd like to go...finish my [nursing] school, because I see how hard this is...right now, realistically speaking, probably it's better to go back to school again. (P10)*

A lack of knowledge on how to pursue opportunities outside of their long-term care facility existed for one participant; nonetheless she reported that she was eager to learn and pursue any opportunities afforded to her.

*No, I never get that. But yeah, if in future I will get it, I will prefer to go there. (P02)*

### **Staffing**

Working short staffed and working with a full complement of staff were two concepts that participants discussed at length. When asked to rank the relative importance in relation to the provision of quality care, working short staff was identified by most participants as the concept which provided the greatest interference with the provision of quality care. Closely related, working with a full complement of staff ranked only behind teamwork in terms of importance, as a requisite to the provision of quality care to residents; some participants rated it as the most important.

*The first thing I think [I need to give good care] is not working short staffed. (P11)*

Inadequacy of staffing of healthcare aides was said to originate from two places: i) baseline staffing levels; and ii) staffing shortages.

**Baseline Staffing Ratios.** Participants asserted that baseline staffing levels were sometimes inadequate to facilitate the delivery of quality care to residents. For example, a participant described the ways that a high-need unit in her long-term care facility lacked adequate staff.

*There's this one floor, and it's a locked unit and on that floor, a lot of – me and other coworkers – we say, “Oh, that's a special floor,” because it requires a lot and it's people that wander, and that floor is never adequately staffed to support the care needed...They have five, but it should be six on that floor because there's residents that wander into other people's rooms. (P10)*

This participant also reported that when working with insufficient healthcare aide to resident staffing ratios, she felt that her expertise and skill set were not fully utilized.

*That's the one floor where I don't feel that I can use my skill to my full potential, because there's just not enough staffing to watch everyone. (P10)*

The sentiment that staff to resident staffing ratios were insufficient was echoed by participants beyond units caring for high-risk residents. In the face of inadequate baseline staffing ratios, participants shared that their best efforts were not enough to ensure quality care was delivered to residents.

*I have tried to do my best, but I think they need to be the number of residents to staff needs to be reduced. (P04)*

Participants also shared that under current staffing ratios, nurses were often too busy to help them out when they needed it.

*[The long-term care facility] said that nurses can help in transferring, but they're also busy in passing out medications so they also don't have time. (P04)*

*Nurses are helping in the evening but they also do have to do their stuff like medicines and everything so we cannot expect that much from them. (P03)*

Moreover, participants believed that if baseline staffing ratios were improved, they would be able to deliver better individualized quality care to residents as they would have more time for residents and would not have to rush.

*I think if I get the chance, if I could have less residents, then I would be able to [spend more one-on-one time with my residents]. (P04)*

Utilizing staffing models that were flexible and increased during peak times of busyness was a solution offered by one participant to this challenge. She stated that in the busiest times – which were usually the mornings – it would be helpful to have one more staff assigned to the team or, in the very least, an extra staff to come and help out for that period of time. She reiterated later in her interview that this type of flexible staffing arrangement should exist beyond the morning shift and extend to all times that were predictably busy and difficult to manage.

*Sometimes we have lots of [residents] who need more care – like lifting and everything. So yes, we need one extra staff I would say, or else somebody can help us during that busiest time. Mostly it happens in the early morning...In evening, they can give us two healthcare aides or two nurses, one extra nurse, whatever works for them. It would be good...Or sometimes for nights it's hard if the patient is trying to get up, and whoever is the high risk for falls. (P03)*

When this type of staffing model was mentioned by the interviewer to two other participants who identified lack of time/staffing as challenges, both agreed that this type of solution had merit.

*Yeah...If [an extra healthcare aide] can [work] 7AM to 11AM as a float, they can help [with the morning rush]. (P02)*

*Yeah! [If a staff came who did a bath or two and that was their shift, that] would be good! Coworkers have said this. They should have this as well. These are good ideas. But we don't have a healthcare aide that just does baths. (P10)*

**Staffing Shortages.** Staffing shortages occurred for a variety of reasons including sick calls, family emergencies, and staff not showing up for their shift.

*People call in sick. Someone has a family emergency, and someone doesn't show up. (P07)*

Participants also reported that staffing shortages were commonplace.

*Oh, yes. very much so...Just short staffed everywhere. (P06)*

Staffing shortages contributed to poor quality care for residents.

*At times when we are short, we don't have that time to sit and chat with them. You see them calling, and we're having a busy day, so the whole thing will just be messed up. (P08)*

For example, some residents were left in bed on mornings when there were insufficient staff to get everyone up in time for breakfast. Those residents ate breakfast in their rooms instead of communally and participants reported that working short made rush, which was more 'pressure' and 'burden' on them.

*It's not good being short staffed. It's too much burden on us, and then it's not good care for the resident. Because then we will get up some residents in morning, and some we will give breakfast in the room and then get up later. We do our job, but the thing is we have no time, and we are like rush, rush, go, go, more pressure, more burden. So yeah, being short staffed is not good. (P04)*

Although participants resented and were burdened by working short staffed, it was not something they had control over.

*When we're short [staff] – like in [long-term care facility name] in the evening, we are five healthcare aides, so we might be short with one healthcare aide, and we are four [healthcare aides now]. We have to do the job for the fifth person, which is an additional work for us. It's really hectic, but we have to just do it. We can't leave those jobs undone...You won't be happy about it but there's nothing you can do. (P08)*

Use of non-regular staff was a solution sometimes employed by long-term care facilities to address the short staffing challenge. This included the use of float or casual staff from within the long-term care facility, or the use of private agency employed staff.

Staffing shortages also occurred on some units because of toxic staff or dysfunctional team dynamics which resulted in staff from within the long-term care facility refusing to pick up extra shifts on those units. As a result, sometimes agency filled the gap.

*If a nurse is not good, the healthcare aides say they don't like to pick up on that floor. And that's not good for the resident, because then sometimes they call agency people to work there. I think that's not good. (P04)*

A participant who worked as an agency healthcare aide reported that lack of support and respect towards her from regular healthcare aides, made her work more difficult. She also noted that if staff dynamics were poor at a certain long-term care facility, she was hesitant to return.

*There are some places you go to [work as an agency healthcare aide], the staff might not be nice to you, so it makes work difficult for you. So those places, I find it difficult to go back there. (P08)*

*Use of Non-Regular Healthcare Aides.* Agency healthcare aides, in particular, were viewed with disdain by participants who posited that agency healthcare aides did not help lessen the load of regular staff, and in fact, contributed to increasing their workload in a variety of ways.

*Sometimes they send people from agencies to cover for sick calls. But these people from agencies, some of them don't know anything and it's like you're doing twice the work anyways...I'm not a big fan of having [agency healthcare aides] come and help us at our work because I've had bad experiences where I end up doing their work. (P10)*

### **Time**

For the most part, participants reported that they had enough time to do their job.

*Most of the time we do [have enough time]. We finish our things – whatever we have to do – on time. (P03)*

Nonetheless, inadequate time emerged from the data as a consistent challenge encountered by participants and emerged as the second biggest hindrance to the provision of quality care to residents. Participants reported they needed both sufficient staff and time to provide good care to residents.

*I need enough time to do accurate stuff to provide better care to my resident and I need ...enough manpower to complete the task. (P07)*

Inadequate time was linked to inadequate staffing as inadequate staff led to inadequate time for participants who then had to 'rush' to do their job. Rushing residents during care was the antithesis to the provision of good quality care.

*I've done my best job when the residents...were satisfied and very happy and they were very content with not being rushed. (P01)*

*We try not to rush the clients. With the [residents], we cannot say, "Oh, hurry up! Hurry up! You have to do it right now" ...We give them time as much time as they need. (P03)*

Despite the importance placed on providing holistic care that met the social and emotional needs of residents, participants reported it was something for which they often did not have time. For example, one participant compared her work as a companion to her work as a healthcare aide and stated she could provide better care for the resident as a whole person in her companion role in contrast to her rushed and busy healthcare aide job.

*I also do sometimes companion work. In that job I help them more compared to [my job] as a healthcare aide, because in companion work...we can do coloring, I can start showing them their [old] pictures...I can ask, "Who is this? Who is this? Oh, you're looking so nice," and they feel happy. But in my healthcare aide job we don't have enough time to do that...No, because we are so busy. (P04)*

Participants also shared that the amount of time allocated for some tasks was unrealistic; all they could do was provide basic care, meeting just the minimum of physical care needs of residents.

*The important thing to mention is sometimes it's not enough time to do everything they are expecting us to do. For example, we have to wash all of [the residents] – ten or eleven people – and dress them up and take them to the dining room within 30 minutes. You have only 30 minutes! You start your shift at 7:30AM, and I don't know why [the long-term care facility] can't make breakfast a little bit later – 15 minutes? Make it a quarter after eight at least... [Some of our nurses] are expecting us to take everyone to the dining room in 30 minutes and it's impossible...and I don't want to rush and leave things not done properly. That's how it is. There is, sometimes, not enough time...you have to do at least basic things quickly. Put the clothes on, and brief on, this and that...Sometimes...there's not enough time to do things. [The long-term care facility] needs to make adjustments. Especially, I find with the meals, especially with breakfast. Cause that's the start of the*

*day and you start your shift, and you don't have enough time to dress up everyone and take them to the dining room unless you get extra help. (P07)*

Not having enough time meant that corners were cut; not just reducing care to only basic things, but also delaying morning care for some residents, as previously mentioned, and leaving them in their rooms alone for breakfast.

*Sometimes, especially in the morning, we don't have the time to get up everybody together, so we [don't finish getting residents ready] until [much] later. The care [will] be done by like 11:30AM or something – before lunch. (P02)*

Participants also shared that other care was missed, such as baths, due to insufficient time. For example, a participant refused to bathe a resident when she believed it left her with inadequate time for other responsibilities and would have been unsafe to leave other residents.

*They increased the baths to everyone getting a bath twice a week on that floor. It's a nice idea but...it's too much...it's a lot of conflicts on that floor...I even refused a bath to the nurse, because, I said, "I can't handle this. This is too much at once being thrown at me." ...I just found it to be not enough time to complete my tasks. They increased the baths on that floor, and it's just it's a nice idea. But it's not a realistic plan. (P10)*

Inadequacy of time was reflected in the words of participants not just when they stated that they did not have enough time but was also reflected in word choices such as having to 'run', 'rush', or 'go, go, go', and as being 'busy'.

*Usually as healthcare aides we're running back and forth, back and forth cause usually we're so busy, or we're short staffed. (P06)*

Peak times of busyness were often predictable and aligned with times when more direct care needed to be delivered to many residents in a constrained period: mornings when waking

residents up and getting them ready for breakfast; evenings when getting residents back to bed; nights, when working alone and/or covering for breaks.

*Mornings are busier than evenings and nights. Mornings are like, go, go, go. Because in [the] mornings we need to get up the residents, so we need to do our job quick, and then make sure that the resident is safe. (P04)*

Evenings were remarkably busy as well because staffing ratios were curtailed and residents still had significant care needs related to their evening and bedtime care routines.

*It gets busier after supper because most of the [residents] want to go to bed and some want to walk. In the evening, on our floor, we just have one healthcare aide with 22 [residents] and two nurses so it's really hard for us during evening shifts. (P03)*

On night shifts the complement of staff to residents dropped further, which made it challenging to find enough time to provide quality care on this shift as well. These challenges were even more pronounced during the COVID-19 pandemic.

*Especially in the night shifts – evenings and nights – we just have one healthcare aide and during COVID, it's really hard because we have just one nurse and one healthcare aide. If the nurse is on break and we have four or five call lights, in COVID, we have to put on the N95, change everything again. Same thing, we have to don all the PPE, donning and doffing. It was hard. (P03)*

Participants admitted that in these types of situations, they were unable to provide quality care.

*At that time, I'm not providing good care to [residents], honestly. (P02)*

In an attempt to avoid these untoward outcomes, participants did everything they could to meet the care needs of residents, even missing breaks.

*If it's not busy, we can take a second break, however if it's really busy, it's crazy, then we can't take a break, and we still watch [the residents]. (P11)*

***Fellow Healthcare Aides***

A few challenges arose for participants when working with fellow healthcare aides. Specific concerns resulted from regular as compared to non-regular healthcare aides and challenges have been divided into subgroups within those two categories.

**Regular Healthcare Aides.** Challenges that surfaced with regular healthcare aides were less common or significant than those that arose from working with non-regular healthcare aides and were co-worker specific.

*I feel like it depends upon the co-worker. Some are really good, but some are, no. Some, they just want to do their own residents and that's it. So, it depends. (P04)*

These challenges emerged from 'lazy' healthcare aides, 'personal' problems, and speaking a foreign language. With the former two (i.e., 'lazy' healthcare aides, and 'personal' problems) not everyone on the team helped others even though it was part of their assigned role.

*They know their duty but sometimes they don't wanna do it. (P07)*

Whether working with individuals who were perceived to be 'lazy' or who had 'personal' problems with another coworker, participants reported that working with a fellow healthcare aide who did not complete their duties made it extremely difficult on them since they had to perform not only all of their own tasks but also all those left behind by the other healthcare aide.

*It's very hard. It's very hard for, I don't know about others, but for me, it's very hard because I want to get everything done before I go home .... whatever is left...I have to do all the duties...It's more work for the person who is working harder. (P07)*

**'Lazy' Healthcare Aides.** Two participants described some healthcare aides as 'lazy', and as individuals who "don't want to work...they are just there... [because] they want the money, but they don't wanna do their job" (P07). Participants reported that working with these

underperforming individuals contributed to a greater workload, and, at times, injury or pain for them.

*One night shift the healthcare aide that I worked with, she was just talking nonstop... instead of...working...so that gave me an extra job to do...The work both of us are supposed to do, I'm trying to do it so that we make it in the time we have. So, the work became extra work for me, and I was having back pain. Some staff like that they are kind of lazy so if you're working with some lazy staff, it's hard. (P08)*

One participant recounted an example of a healthcare aide whose assignment included giving baths and helping other teams with their residents. She reported that even though this team member was not helping her or other healthcare aides with their residents and left them with more work, she felt that she could not communicate her concerns to the offending healthcare aide.

*Sometimes, I can't express the things I want. They make it hard...you can't even confront the person. (P07)*

This sentiment that participants could not speak up came only from participants who were immigrants to Canada.

**'Personal' Issues.** Participants asserted that when working with fellow healthcare aides, there were times where personal conflicts prevented one healthcare aide from helping another.

*Some people, it's personal...They have some issue with another coworker, and they don't come, and they don't wanna help that person. It's not supposed to be like that. It doesn't need to be this way cause it's for the residents. (P07)*

**Speaking a Foreign Language.** The use of foreign languages unfamiliar to the other healthcare team members and residents was a common finding in this study. Many participants described their dislike of this behaviour.

*I have nothing against them. They're fantastic people. The only thing that bothers me is when they know...they're not supposed to talk in their own language but they're still communicating to each other while we're working. I've had to say to some of them sometimes 'Can you please speak in English?' I don't like it. (P06)*

Speaking a foreign language by other members of the healthcare team also made some participants feel uncomfortable; generally because this behaviour was perceived as unprofessional and inappropriate for fostering a respectful workplace.

*"I've experienced where they're talking in ...their own language – but if they are three or four people and they're talking in their language it feels little bit uncomfortable for me."*  
(P03)

Additionally, members of the healthcare team sometimes spoke a foreign language in front of residents.

*It bothers me when someone is talking in another language at the bedside. Cause it's not good for the patient. (P07)*

One participant explained that while staff speaking a foreign language made her feel uncomfortable, she felt she did not want to speak up with her team members or manager about her feelings or the noncompliance of staff with this policy.

*They're not allowed to talk [in a foreign language]. We can complain about that. But no, I don't want to make a big deal about that. (P03)*

Again, the belief that they could not speak up emerged only from participants who had immigrated to Canada. A participant noted that while frequent use of their native language by staff was a coping strategy for involved staff, it was an isolating practice which diminished capacity for relationships with other members of their team.

*I appreciate minorities clinging together because that's how they're coping. It might not be the most functional coping mechanism but they're just trying to survive and get their job and feed their families and bring money home...it affects everybody, because then you get a lot of minorities in their groups and their circles, and they kind of don't reach out to anybody on the staff or on the team. They just kind of cling to each other. (P01)*

Additionally, speaking foreign languages contributed to poor communication and most importantly, had the potential to lead to inferior care delivery or outcomes for residents.

*It's not as though I'm targeting any special community but sometimes when you're standing there, you're lost. 'What? I didn't hear that.' But I always ask them to repeat, because I need to know about the [residents]. I'm going on the floor and working with them. It's a big issue. (P07)*

**Non-Regular Healthcare Aides.** Non-regular healthcare aides did not always do inadequate work. However, the overarching sentiment expressed by participants was that the behaviours and incompetence displayed by non-regular healthcare aides did not exist within the regular healthcare aide team.

*I can't say everyone from agency is bad; some are good, but some are bad. I've had really bad experiences with some [agency healthcare aides]. (P10)*

**Avoid Their Work.** Participants reported that float healthcare aides could have bad attitudes and avoided their work responsibilities.

*It's happened when we don't have a regular co-worker from my floor, we got someone from another floor. Some people...they come on the floor, and they show attitude.*

*Whatever they want to do, they will do it. They want to help you then they will do it. If they don't want to, then they won't. (P02)*

Agency healthcare aides 'stood around' and hid from plain sight to avoid their work duties.

Consequently, participants deemed these workers of no benefit.

*I don't always see the point of having people come from agencies because some of them they just stand around and they don't really do anything anyways...Sometimes I find them in the linen room on their phones when I told them to get back to work. (P10)*

Participants reported that when agency staff avoided their work duties, they had to compensate by assuming greater risk, potentially compromising their safety and that of the residents for whom they cared. A participant shared a specific situation to illustrate this point. After setting up a resident for a two-person lift transfer and calling the agency healthcare aide, she received no assistance. Engaging in unsafe practices made participants feel devalued because they felt forced to do additional work. Participants also described the personal risk they took on by engaging in unsafe practices; they felt badly.

*There's been times where I've had to do transfers by myself when I couldn't find help...It makes me feel very devalued because I have to do all this work by myself. It makes me feel like I'm doing all this extra work in these situations. It makes me feel bad because I put my body at risk when I'm in these kinds of situations <pause> because I take a risk. (P10)*

***Uncertified Healthcare Aides: 'They don't really know anything'***. Another challenge of working with agency healthcare aides was these healthcare aides often lacked the certification credentials that most long-term care facilities require for employment.

*All these people that [the agencies] hire to be healthcare aides, some of them are not even certified. (P10)*

Participants stated that in contrast with regular healthcare aides, uncertified healthcare aides did not understand their role; usually attributed to their lack of education. Thus, they were unable to function safely and competently independently.

*They're bringing in people that are uncertified healthcare aides and that's another thing that I think is just not good because they don't really know anything. They don't have the experience. They haven't taken the course. They haven't had the proper training. (P10)*

Participants shared that working with uncertified healthcare aides was sometimes harder, and at minimum, no easier than working alone.

*Uncertified healthcare aides, they cannot do certain things. Whoever is a certified healthcare aide, they have to stay with the uncertified healthcare aide [when] assisting the patient with walking or lifting [the patient] because [the uncertified healthcare aide] cannot do it by themselves. We have to stay with them so it's not easier. (P03)*

**Certified or not: 'They don't know your unit'.** Participants also stated that non-regular healthcare aides (i.e., float, casual, or agency) usually did not possess the knowledge about the unit and the individual residents assigned to their care that was needed for optimal team functioning. This led to a greater workload placed upon participants (i.e., regular healthcare aides).

*If it's a casual staff or agency comes, you have more work because they don't know the floor. (P11)*

*Sometimes you get the float worker. They don't know about your unit so that's more work for you too, cause you have to explain everything to them. (P07)*

The greater workload was explained as being 'double' the usual workload by participants.

*If [non-regular healthcare aides] don't know the residents, you can't leave [non-regular healthcare aides alone with the resident]. Even if it's a one person assist, you can't let [non-regular healthcare aides] do the care by themselves. You always have to work with them. It's similar to doing double your job. (P11)*

The lack of knowledge and expertise by non-regular healthcare aides, and the subsequent requirement that participant explained practices to them took more time and resulted in rushing. Participants thought that working short staffed was better than working with a non-regular healthcare aide.

*It's like you're reteaching; you're training somebody. Meanwhile, you're trying to do your job at the same time, and you're trying to run around. You're running around, running around. Sometimes we just feel it is better to work short. (P06)*

In addition, non-regular healthcare aides were more work for participants because they had to try to find work that was manageable for the non-regular healthcare aide so they could be useful.

*It is more work. I try to find something for them to do something where they can be useful. (P10)*

**'You are the one who will feel responsible'**. When working with non-regular healthcare aides, participants also reported that they bore the brunt of the responsibility, not the non-regular team member they worked with.

*If they're not able to finish [taking care of their residents], then you are the one who will feel responsible. Like "I have to." (P07)*

The sense of responsibility that participants felt for residents forced them to compensate for the lack of knowledge that non-regular healthcare aides possessed because quality of care concerns inevitably arose with these less knowledgeable staff. Participants stated that working directly alongside agency staff was the only way to ensure that appropriate care was given.

*For me, when I work with agency or float, I'd rather work together because...I think it's better, because I don't want you to do something wrong on the resident; getting the resident mad and also make more work for everybody. (P11)*

**Poor Communication.** Non-regular healthcare aides were more likely to possess a poor grasp of English which negatively influenced their ability to understand their tasks, deliver care, or communicate with others.

*Sometimes some of [the agency healthcare aides] don't speak proper English...Some of them don't know how to read. Some people from these agencies, they don't speak very good English, and sometimes residents can't even understand them." (P10)*

Agency staff were also reported to have difficulty speaking up. A participant who worked as an agency healthcare aide shared that she did not always feel comfortable speaking up and voicing her concerns even when quality of care concerns arose.

*It's kind of challenging, because some places in the morning – mostly, I work nights when I'm doing the traveling job – so in the morning there are some residents that will need to get dressed and get up. Usually in the morning when I want to give my care, I make sure I brush their teeth, clean their faces and their hands, their back. But some of these staffs they don't do that. So, when I want to do it, they will say, "No, we don't really have that time. We don't do this. Just do what we do." And I'm not really comfortable with it, but there's nothing I can do. I just go with what they do. (P08)*

**Better Compensation.** Despite all these challenges, participants shared that agency healthcare aides were, paradoxically, paid more than those employed by long-term care facilities, which contributed to some healthcare aides leaving their long-term care facility position or taking a job with an agency as a second job. This study had participants who did both.

*I've only [worked at one long-term care facility] for taking care of the elderly, but we have a lot [of healthcare aides who work as] agency [healthcare aides and work] in other facilities too. My coworker is working two jobs [like this]. (P11)*

***Feeling Devalued***

Participants shared that they felt devalued by all levels of structures in long-term care. Everything from the micro-level interactions with residents and nurses to meso-level interactions managers could make participants feel devalued. Further feelings of devaluation came from macro-level system structuring. Feeling devalued often led to feelings of frustration or dissatisfaction and encompassed concepts of feeling unappreciated, distrusted, insulted, and unsupported. Participants reported that healthcare aides were largely supportive of one another. However, support was less consistently received from managers. Few participants considered the role of the macro system but for those who did, system constructs were viewed largely as undervaluing them and their contributions.

**Micro Level: Residents and Nurses.** Participants felt by and large that they were appreciated by residents, but it was acknowledged by some participants that residents with cognitive or behaviour difficulties failed to recognize or appreciate the hard work of participants.

*We have some behavioral [residents]. They never notice your value. Whatever you do for them, it's not enough. (P07)*

Participants reported that nurse 'bias' against a healthcare aide was a challenge that was sometimes encountered.

*Some nurses are biased, too. They are like, "You're good for me if you butter me up." So [the nurse is] good to me, but not to another person who is not buttering [them] up? ...This is not my job, to give [the nurse] attention. My job is to give attention to the resident. (P04)*

Another challenge encountered by participants occurred when nurses refused to help or used their position within the healthcare hierarchy to diminish the decision-making opportunities of healthcare aides.

*Sometimes it depends on the nurses. Some are good as well, but some no. They say, "It's not part of my job, so I will not do that." (P04)*

*[Nurses] can just command you: 'These things need to be done,' and we are the ones following. (P07)*

Participants shared that some nurses were controlling, impacting not only their decision-making opportunities but also demonstrating distrust towards participants. A participant recounted an example of a time this happened, leaving her frustrated.

*I provide care to a certain lady and I'm pushing her on her walker to go and bring something to the garbage area and put away her dirty laundry before I bring her to supper, and then I have one of the nurses saying, "Where are you going? Where are you going? You're not bringing her for a bath. It's not her bath day." I'm like, "I'm just throwing away the garbage" cause I'm not going to leave her alone on her walker and I'm not gonna go and take her to the dining room with a bunch of dirty clothes and dirty briefs in my hand. There's one particular nurse...she likes to be in control. She does that with a lot of us healthcare aides at my job. It's kind of frustrating. (P06)*

The control and distrust directed towards participants by nurses left them feeling their knowledge and expertise went unappreciated; they felt insulted by this.

*I find it a little, I don't know, insulting at times that, and not appreciated because they want me to do it a different way...Trust us enough to know that we're doing the right thing for the residents, that we know what we're doing and give us that flexibility to make some of the decisions on our own without having to come to the nurses to ask permission to do something simple. Like changing a bath or whatever. Like one day, someone doesn't want a bath, so we have to switch it. I don't wanna have to come and ask a nurse. I know what I'm doing. I'm gonna kinda do it myself, and of course I'll let you know what I'm*

*doing. But just having that appreciation that we're making the right choices, and we know what we're doing. (P06)*

**Meso Level: Managers.** While some managers were supportive of participants, findings from the data were mixed. For example, some participants reported that they did not feel well supported or appreciated by their managers.

*There's certain incidences that...sometimes I just don't feel, we don't feel appreciated. (P06)*

Negative feedback outweighed positive feedback from managers and contributed to participants feeling undervalued and underappreciated.

*I guess I can't really speak for my other coworkers, but we've had talks about how [the managers] sometimes, we're not appreciated enough. Sometimes it's like, "Oh, you're doing this wrong, or this wrong". Not more of "Oh, you're doing such a good job. Keep up the good work." (P06)*

Failing to enforce policy or follow through participant concerns was perceived negatively and made participants feel further unsupported. For example, a participant shared how a manager posted a memo about enforcing the policy that staff must not speak foreign language on the job. By not ensuring that staff spoke English, this participant linked the lack of follow-through by this manager as contributing to an environment that fostered unprofessionalism and disrespect in the workplace.

*There is a memo and my manager, he was kind of strict. He's like, okay, I'm gonna give you one warning [to speak English], and next I will take you to the HR office. I don't know. People are not taking it serious, anyway. It's like, whatever...I guess there is not enough serious action that is taken. So that's why no [staff] cares about [listening]. That's what I find. [Follow-through and enforcement of the policy to speak English] needs to be*

*taken more seriously. Especially if you're at the bedside. If you're in a certain place, if you're in the med room, and you two are Filipino or Indian, you can talk in your own language. Who cares? No one else is listening to you. But especially when you're in the hallway or at the bedside, you need to be professional, and that's what's called a respectful workplace. (P07)*

Participants also reported that managers and other organizational leaders were 'too busy' to appreciate or support them. For example, a participant described how her manager only spoke to her about her performance during her annual performance appraisal. Her description of the types of things shared during that appraisal demonstrated the obvious omission of expressions of appreciation or support for staff by managers or other organizational leaders.

*The superior person, like the managers and other people, they are always busy, so I don't know [if they notice or value my contributions]. There is an annual... [progress report] ...They call us in their office, and there is a 15-minute chitchat. They will explain everything like if someone is complaining about us sometimes, or if someone appreciates us. Whatever we did good and bad in the past, they always outline it for us. But our charge nurse, they always appreciate us whatever we do throughout the shift. (P07)*

**Macro Level: The System.** System-level constructs were viewed as undermining the value and contributions of healthcare aides. These constructs included recognition, remuneration, immigrant workers, recruitment efforts, and the politicization of healthcare. One participant pointed out how the government failed to recognize the value of healthcare aides and their contributions compared to those of nurses. This participant also highlighted the inadequacy of healthcare aide remuneration and the link between remuneration and intent to stay in her job as a healthcare aide.

*The thing is that it's too bad that the government; we're not as recognized as nurses are...I think [healthcare aides] should at least all be making \$25 an hour. For everything we have to do...If I was making at least \$25 an hour, I would be okay staying. I mean I don't know even know if I want to stay in this forever. (P10)*

Wages were also viewed as linked to staffing levels.

*If the pay was better, the staffing would be better, ultimately. (P10)*

The fact that healthcare aides were paid more if they took employment with private agencies was viewed as contributing to staffing shortages as healthcare aides left their jobs in long-term care facilities for 'travel' jobs.

*I think that if we got paid better wages it would fix the staffing issues and it would eliminate people from going to travel [i.e., agency] healthcare aide. Like a lot of them were leaving their positions to go do the travel [i.e., agency] healthcare [aide]. A lot of them did, because it's good money. (P10)*

This participant also believed that the system benefitted from using immigrant workers to fill healthcare aide positions because these workers were more afraid of striking than their Canadian born counterparts.

*We had a chance to strike, probably a year or two ago, with our collective agreement but a lot of these people I work with, they're from different countries and they're afraid to strike. They're too afraid to strike and if we would have striked we would have gotten more money. (P10)*

Some of these challenges were viewed as injustices. This same participant perceived recruitment and not retention, as the priority for system level administrators. In place of paying healthcare aides more money to facilitate retention, recruitment efforts which paid for and

shortened the education of incoming healthcare aides were viewed as undermining the value and contributions of existing healthcare aides.

*I think that that's another injustice, because I think that it's not fair...that people could become healthcare aides now after taking some training for a month. It's basically free the course now. And some of us that have been doing this for years, we paid to take the course; and now the course is free. There's so many frustrating factors...A lot of us didn't like it...Instead of paying us more money, they're making the course free for people. (P10)*

Many of these factors – recognition, remuneration, workload, recruitment, and retention – were viewed as linked with the politicization of healthcare.

*There's so many political things going on here with the pay, the work, amount of work required. (P10)*

### ***Difficulty Dreaming***

Most participants recognized and articulated the need for things to improve in their long-term care organizations.

*Something's gotta change or else nobody is going to be able to be happy, to show up and do bedside [care]. (P01)*

Nonetheless, dreaming was sometimes difficult for some participants – particularly those who were racialized, one of whom also reported immigrating to Canada. These participants often failed to recognize that the responsibility for difficult working conditions and the delivery of quality care to residents extended beyond them, to their organizations. This was clearly demonstrated when participants said they needed to work on their time management when the unit was at its busiest and they had a limited ability to provide timely quality care to every resident. For example, a participant who worked in two different facilities tried to explain that

staffing levels were adequate, and she and other healthcare aides needed to focus on their time management.

*We can manage the time, so we don't need the extra staff in the morning especially at [long-term care facility #1]. But at [long-term care facility #2] ...we have enough staff but sometimes, if they are running, it's really hard work...Time management [is the biggest thing that makes it hard to do my job] ...Sometimes, especially in the morning, we don't have the time to get up everybody together, so we aren't gonna be finished until later, later. The care should be done by like 11:30AM or something before lunch. (P02)*

*I'm trying to [use] my time management properly. Sometimes it does not work for me and it's not like I'm gonna give up. I'm gonna keep working on it. You keep working on it.*

(P09)

### **Summary**

Ten long-term healthcare aides participated in this study and offered rich descriptions on their perspectives of structural empowerment in their workplaces. Details emerged from the interview data provided by participants on what matters most to healthcare aides and the challenges they faced. Participants valued the residents for whom they cared and provided high quality care to them. They also valued finding satisfaction in their work and being able to work in functional teams. Challenges faced by participants were diverse and ranged from workload and work role challenges to inadequate access to opportunities. Participants frequently reported concerns surrounding the staffing levels and amount of time they had to deliver care and shared that working with some healthcare aide coworkers made their work more difficult – particularly when working with non-regular healthcare aides such as agency or float staff. Feeling devalued was another challenge encountered by participants, as was dreaming of a better future.

## **Chapter 5: Discussion & Implications**

### **Discussion**

Long-term care facilities continue to face an onslaught of challenges in this post-pandemic era related to various issues including the struggle to find enough staff, funding challenges, and the continuously growing volume of residents who possess increasingly complex care needs. Healthcare aides are the workers responsible for providing the majority of care to long-term care residents. They, therefore, occupy a strategically essential, though often overlooked, role in optimizing quality of care to these vulnerable and often frail individuals. The identification of modifiable organizational structures which facilitate or diminish long-term care healthcare aides' structural empowerment is a necessary requisite towards achieving the goals of creating healthy work and care environments, a healthy workforce, and optimizing resident quality of care. This study contributes to our understanding of the ways that structures in long-term care facilities empower or disempower healthcare aides; the different ways that immigrants as compared to domestic Canadian healthcare aides and racialized as compared to non-racialized healthcare aides view and respond to challenges in the workplace; the notable differences between regular and non-regular healthcare aides; and the promising practices that participants dreamed about.

### **Empowering and Disempowering Organizational Structures**

This study explored the organizational structures associated with structural empowerment (i.e., systemic power – formal power; informal power; power structures – information, support, and resources; opportunity; and proportions) and healthcare aide perceptions of whether or not these were empowering for them. Findings from the study demonstrate that six organizational structures are of particular importance to healthcare aides. The first two organizational structures – formal power and informal power – were found, to be mostly empowering to participants. A

third organizational structure, support, yielded mixed findings; some participants believed they were supported by managers, while others, less so. Two other organizational structures – resources and opportunity – were disempowering. Proportions, a final organizational structure identified as noteworthy, intersected with larger constructs in society creating an over-representation of minorities.

### ***Formal Power***

According to Kanter (1993), individuals in visible work roles possess power. Unlike Hewko et al. (2015) who reported that healthcare aides are largely invisible, this study did not find that the participants viewed their work as unseen. On the contrary, similar to Karmacharya et al. (2023), this study found that healthcare aides' work was seen and appreciated, leading to greater empowerment for them. The COVID-19 pandemic made visible the role and value of healthcare workers and long-term care healthcare aides were no exception to this (Canadian Centre for Policy Alternatives - Manitoba, 2023; Geary, 2020; Petz, 2020). It is possible that this shift in public perception helped participants feel more visible and recognized than they did in the pre-pandemic era; Hewko et al.'s study occurred pre-pandemic.

Expressions of recognition, compliments, or gratitude enabled participants to feel like they were seen and recognized. This finding highlights the importance of fostering personal relationships with residents and their families since these relationships often formed the foundation from which residents and their family expressed recognition and gratitude to healthcare aides for their care work. It also demonstrates the key role that organizational leaders, managers, and other members of the frontline care team have in optimizing healthcare aide empowerment; by consistently and regularly taking the time to recognize and appreciate the work of healthcare aides, these workers are imbued with formal power, increasing their empowerment.

Kanter (1993) also posits that work roles which are linked to the central purpose of their organization possess formal power. This study uncovered the highly relational approach that most participants took to providing care, stepping beyond the confines of a task-centric view of their work role. Participants viewed their role as central to the purpose of their organization, which they defined repeatedly as “*providing good care to the residents*” (P02). Their organization’s purpose was congruent with the subtheme *Residents and their Quality of Care*. Considered together, this suggests that the priorities of healthcare aides in this study aligned with those of their organization, creating a sense of proximity to their organization’s purpose and contributing positively to their sense of empowerment. Further, the finding that a relational, person-centre care approach supports the empowerment needs of long-term healthcare aides – while supported by the existing literature (Caspar & O’Rourke, 2008; Hamann, 2014; Yeatts & Cready, 2007) – is novel and one not found in the recent literature.

Possessing decision-making power is another source of formal power (Kanter, 1993). This study found that participants had some decision-making power around timing and approach to care delivery. However, findings were mixed as to whether their views were heard and trusted. Similar to Andersen and Spiers’ (2016) study, some participants in this study reported being subject to a rigid medical hierarchy and had to adhere to the requests or demands of professional healthcare colleagues. They also possessed expansive work responsibilities and limited power to elicit meaningful change (Andersen & Spiers, 2016; Chaudhuri et al., 2013).

### ***Informal Power***

Kanter (1993) states that informal power is derived from relationships with colleagues. In the healthcare literature, this was viewed as the team functioning of individuals in a given work setting. The volume and depth of discussion devoted by participants in this study to the topic of teamwork revealed the high value of informal power for long-term care healthcare aides to

mobilize resources and achieve their aim of providing high quality care to residents. Rich data illustrated not only the importance of proper functioning teams to the participants in this study, but also depth to subthemes regarding specific competencies of functional teams. These themes coincide well with the existing literature on interprofessional teams. As seen in Table V, when considered in conjunction with the subtheme *Residents and their Quality of Care* within the theme of *What is Important to Healthcare Aides*, the findings of this study align well with the Canadian Interprofessional Health Collaborative (CIHC) Competency Framework for Advancing Collaboration (Canadian Interprofessional Health Collaborative, 2024).

**Table V**

*Fit of Data with the CIHC Competency Framework for Advancing Collaboration*

Domains from the CIHC Competency Framework for Advancing Collaboration (2024)	Matching Subthemes
Relationship-Focused Care/Services	Residents and their Quality of Care
Team Communication	Open Communication
Role Clarification and Negotiation	Complementary Roles and Functions
Team Functioning	Shared Values and Goals
Team Differences/Disagreements Processing	Support and Respect/Open Communication
Collaborative Leadership	Shared Decision-Making

Confirming Kanter's (1993) position that relationships with colleagues is a source of systemically derived power, this study revealed the ways that individual participants recognized that on their own they were both more inefficient and ineffective in their work roles than they were in a team. This study found that many healthcare aides speak languages other than English – likely as their first language (Chamberlain et al., 2019). Novel, however, were the findings on the use of foreign languages in the care environment and their perceived negative influence on team functioning and quality of care in this setting. Similar to other studies, this study also identified that functional team dynamics are essential to the empowerment of long-term care healthcare

aides (Cready et al, 2008; Yeatts & Cready, 2007). Likewise, participants who worked in functional teams were more likely to be trusted and respected for their knowledge and expertise, increasing their autonomy and impact (Yeatts & Cready, 2007). In contrast, when team dysfunction was present, this study demonstrated that care was more likely to be missed, safety compromised, and more burden placed on individuals – particularly when those were regulars on the unit.

### *Support*

Kanter (1993) theorizes that support is requisite to staff empowerment and that individuals with poor relationships with those in positions of formal power are more likely to experience powerlessness. The subtheme *Feeling Devalued* demonstrated that some participants in this study did not feel supported by the nurses or managers with whom they worked. This was a meaningful source of disempowerment for these workers. Nurses who controlled and distrusted participants made them feel devalued and disempowered. Meanwhile, lack of positive feedback and follow-through from managers were perceived as unsupportive and disempowering to participants. This study highlighted the obvious: an annual 15-minute performance conversation on its own was insufficient for participants to feel supported by their managers.

Nonetheless, this organizational structure was not perceived as disempowering to all participants and this study identified key behaviours and approaches used by managers which contributed to participants' feelings of being supported and empowered; these included listening and addressing concerns, helping out on the floor, and encouraging and accommodating the pursuit of nursing studies. The findings that managers' support conferred a desire to do more work was another novel finding of this study but is supported by Kanter's (1993) theory that positive feedback loops exist within power structures; in this case increased manager support contributed to employee commitment and performance which in turn contributed to a perceived

increase manager support. This study also found that the support of leaders has a positive influence on healthcare aide retention (Karmacharya et al., 2023).

### ***Resources***

This study confirmed other findings in the literature that healthcare aide roles contained expansive workload demands and spans of responsibility without the requisite resources needed to optimally perform their jobs (Andersen & Spiers, 2016; Kostiwa & Meeks, 2009; Kuo et al., 2008; Wang et al., 2023). Kanter (1993) asserts that resources are required for workers to do their job and defines powerlessness as being responsible for outcomes without adequate access to the resources needed to get the job done. The subthemes *Staffing* and *Time* illustrated that the inadequacy of these resources – a regular occurrence for participants – robbed them of their power, and, ultimately, of their ability to provide quality care to residents when these resources were lacking.

**Time.** This study found that participants regularly lacked sufficient time to perform all the tasks assigned to them. Lack of time led to rushing, missed care, and missed breaks. Such consequences are not without precedent in the literature where similar findings regarding rushing and missed care exist (Kuo et al., 2008; Song, Hoben, et al., 2020; Wang et al., 2024). This study found the occurrence of these more commonly coincided with short-staffing and the use of non-regular healthcare aides. This study also revealed that there are predictable times when the workload is heavier, and staff have to rush to accomplish all their tasks. Inadequate time contributed negatively to participant empowerment and positively to participant powerlessness.

**Staffing.** This study demonstrated that baseline staffing levels in long-term care may be inadequate and could be bolstered, particularly during predictable times of peak busyness. The high needs of residents contributed to and exacerbated existing staffing challenges in an already resource constrained environment. While organizations did well at accommodating increased

staffing ratios for specific resident needs (e.g., bariatric, high risk of falls) and emergent infection control concerns (e.g., communicable disease outbreak), they were less nimble with meeting the chronic heavy workload healthcare aides experienced as a result of insufficient staffing ratios. This, combined with the constant rushing and 'time management' in which healthcare aides engaged, affirmed that staffing ratios in Canadian long-term care organizations need to be investigated and increased (Patterson et al., 2023).

This study also demonstrated that in the post-pandemic period, short-staffing and the use of non-regular healthcare aides was a chronic problem for this healthcare sector and both negatively impacted the ability of participants to effectively perform their jobs (Patterson et al., 2023). The added workload of both short-staffing and the use of non-regular healthcare aides created added burden, discontent, disempowerment, and powerlessness for participants. The use of agency healthcare aides was particularly grievous to participants who viewed these workers as underperforming but overpaid. Similarly, Karmacharya et al. (2023) found the use of agency staff was perceived as threatening to worker morale. Finally, this study found that filling underfilled healthcare aide positions with non-regular staff failed to meet the resource needs of participants in these high demand work environments; related to the perceived lack of knowledge, experience, expertise, and accountability of non-regular healthcare aides, and often added, not reduced, burden on participants. Working with non-regular healthcare aides was perceived by participants (regular healthcare aides) to be no better, and sometimes worse, than working short-staffed owing to the added burden of work which it presented to them (Stevenson, 2021).

### ***Opportunity***

This study revealed that prospects for job mobility and professional growth were limited, contributing to disempowerment for healthcare aides (Kanter, 1993). Participants were, nonetheless, eager for opportunities with half of the participants in this study either enrolled or

contemplating the pursuit of continuing education – nearly exclusively in nursing (Vincent et al., 2016). This study also demonstrated that participants recognized the limitations of their knowledge; on the job education, therefore, is all the more imperative for these workers to increase their knowledge to facilitate the provision of optimal quality care to residents in ways that are evidence informed (Chamberlain et al., 2019).

It is worth highlighting that the pursuit of continuing education was viewed as a means to escape the disempowering and difficult working conditions of the healthcare aide position. Perhaps this is especially relevant in this area where a strong hierarchy is embedded within the work structure of so many long-term care facilities. Few participants wanted to remain at the bottom of this hierarchy, and fewer still were able to secure access to opportunities which would allow them to escape.

### *Proportions*

Race and gender impacted the work and context of work for participants beyond the scope of Kanter's (1993) theory. Similar to literature on the subject, individuals from gender and race minorities were over-represented in this study (Chamberlain et al., 2019; Estabrooks et al., 2015) and subjected to work that was difficult, stressful, and even dangerous (Syed, 2020). The danger of participants' work matched findings from elsewhere in the literature that violence is experienced by healthcare aides a daily basis and is normalized as part of their jobs (Banerjee et al., 2012; Kelly, 2017).

Findings from this study, therefore, confirm what is already known – that the long-term care sector functions within a context of historical colonialism, patriarchy, and neoliberalism; all of these intersect in ways that devalue individuals of gender and race minorities as well as the role of care work (Syed, 2020). Examples included findings from this study: functioning at the bottom of an established hierarchy; lack of control; low pay; lack of opportunity; high demand

and unsafe working conditions; non-existent occupational mobility; and minimal educational opportunities. Consider, for example, that data in this study revealed that some participants recognized that capitalist and political systems worked to perpetuate and benefit from the recruitment of racialized, often immigrant, workers to the role of healthcare aides facilitating their refusal to address staffing, pay, or working conditions sufficiently to safeguard retention of these workers. Such approaches communicate clearly the lack of value healthcare aides are perceived to have by the society in which they function.

### **Immigrant Healthcare Aide Compared to Domestic Canadian Healthcare Aide**

**Perspectives.** The analysis of immigration status was omitted in this study; in its place, race data were sought (Chamberlain et al., 2019; Chaudhuri et al., 2013; Syed, 2020). Nonetheless, just under half of participants (4/10) disclosed whether they immigrated to Canada or were Canadian born. Information on immigration status was not directly elicited but still emerged from the data, demonstrating its importance in this population. While differences did not emerge between immigrant as compared to domestic Canadian healthcare aide groups in the existing literature on long-term care healthcare aide empowerment (e.g., Andersen, 2016; Perreira, 2019) differences emerged from the data of this study and are included in the discussion in the subsequent section.

### **Racialized Healthcare Aide Compared to Non-Racialized Healthcare Aide**

**Perspectives.** As all ten participants disclosed their race, richer comparisons could be made in this study by examining the racial status of participant, rather than their immigration status. Nonetheless, where data on the immigration status of a participant are known, it has been included in the discussion on the perspectives of racialized participants in comparison to those of non-racialized participants.

Non-racialized participants were more likely to assign responsibility for improvement to their facility, government or other system structures. For example, one participant highlighted the

need for facilities to place a greater focus on the mental well-being of residents and staff. Another participant – who identified as Canadian born – articulated the numerous ways that the system benefitted from the use of immigrant workers and utilized recruitment strategies to disempower existing workers. Non-racialized participants were also more likely to challenge authority, the status quo, and questionable practices. For example, one participant shared that she refused to bathe a resident when she believed it was a time and safety concern. To further exert her autonomy and defiance of the workload and staffing ratios used on a specific unit, this participant refused to pick up shifts there, which facilitated her ability to safeguard her well-being. This decision-making autonomy enhanced empowerment for her. Experienced non-racialized participants were the only ones who reported that they were denied decision-making autonomy; nonetheless, it may be that all participants experienced this lack of autonomy. In addition to wanting more autonomy, these participants – one of whom identified as a domestic Canadian healthcare aide – wanted to be trusted and to have their expertise recognized. Furthermore, these findings existed in more experienced participants (11 and 13 years of experience as a healthcare aide) and highlight the need for long-term care facilities to create cultures that minimize hierarchy and instead foster adaptive leadership models (Wang et al., 2024). Non-racialized participants, like their racialized counterparts, believed there should be more educational opportunities offered by their long-term care facilities. However, their view of the pursuit of additional educational opportunities – in particular, the pursuit of nursing education – was viewed by one non-racialized participant as a way out of a disempowering and physically unsustainable work role.

Racialized participants in this study were more likely to assign responsibility for challenges faced in their work on themselves. For example, racialized participants – some of whom identified as immigrants – were more likely to blame themselves and their time

management for missed care. While the reasons for this are no doubt nuanced and complex, it is possible, that non-racialized healthcare aides possessed a better understanding of empowerment structures than their racialized counterparts did. When non-racialized participants were unable to access the power needed through those structures, they were more likely to feel disempowered (Wu et al., 2005). Racialized participants were also more likely to acquiescence to the formal powers and status quo in their long-term care facilities. For example, some embraced the role of doing the 'physical' work while the nurse was the 'leader' and did the 'mental' work, willingly submitting to established hierarchical norms; some of these participants were the same ones who shared that they were immigrants. Racialized participants were also less likely to speak up. Examples of this included not confronting coworkers when they spoke a foreign language, and not challenging co-workers even when they were skipping essential care for a resident. Finally, racialized participants did not ask for more decision-making autonomy but were particularly keen on seeking out education and job mobility opportunities; racialized participants – included immigrants – framed the pursuit of nursing education as desirable owing to their desire to learn more or grow.

### **Differences Between Regular and Non-Regular Healthcare Aides**

Primarily by the virtue of meeting the eligibility of this study, all the participants of this study qualified as regular healthcare aides (i.e., worked a minimum of, on average, 15 hours per week on a specific long-term care facility's unit); nearly half (4/10) also worked in other facilities. In addition to working as regular healthcare aides, participants also functioned as non-regular healthcare aides, working as float, casual, or agency healthcare aides in other long-term care units or facilities. Owing to the multiple roles assumed by participants, this study was able to capture the perspectives of participants as both regular and non-regular healthcare aides, adding richness to the data and allowing comparisons to be made between the two. Further, whether they

worked as non-regular healthcare aides elsewhere or not, all participants worked with non-regular healthcare aides in their role as regular healthcare aides and were able to elucidate the key differences that they noted in working with non-regular healthcare aides compared to working with other regular healthcare aides.

Indeed, while it was not an aim of this study, the data revealed some pressing differences between regular and non-regular healthcare aides according to participants. At the core of these differences was an underlying belief that the quality of care provided by regular healthcare aides surpassed that provided by their non-regular counterparts. This finding provides evidence for the premise that consistency of staff corresponds with improved quality of care (Carnahan & Unroe, 2022). Regular healthcare aides provided enhanced quality of care to residents through relational care approaches, a high degree of accountability, role and unit expertise, and reciprocity within the health team. In contrast, non-regular healthcare aides were limited in their ability to provide quality care to residents because they were more task-oriented, less accountable, less knowledgeable about the unit and/or their work role, and required help to perform their work.

### ***Relational Compared to Task-Oriented Care***

This study found that regular healthcare aides prioritized fostering genuine caring relationships with the residents for whom they cared and used those relationships as the launchpad from which to generate their other care activities. Germane to these relationships, regular healthcare aides came to know their residents, their needs, and preferences. From this knowledge, these workers adjusted their care practices in meaningful ways, resulting in a high degree of person-centred care – the gold standard of care approaches in long-term care (Yang et al., 2019). In comparison, non-regular healthcare aides did not have the requisite knowledge and relationships to provide relational care that met the individualized care needs and preferences of residents. At best, in the absence of such knowledge and relationships, it is apparent that even the

most well-intentioned of non-regular healthcare aide were undermined in their ability to provide high quality person-centred care to residents. At worst, non-regular healthcare aides were limited to the provision of task-based care only.

### ***High Compared to Low Accountability***

In this study participants reported that regular healthcare aides held themselves accountable for the quality of their work. Additionally, regular healthcare aides were held to high accountability standards by their leaders and organizations. While participants as regular healthcare aides felt the burden of that responsibility, they responded well to it by ensuring care was delivered appropriately and in a timely fashion, often covering for those less experienced, capable, or knowledgeable. In contrast, participants viewed non-regular healthcare aides – in particular those employed by outside agencies – as having significantly less accountability for the care that they delivered; this related to their lack of expertise, ability, and knowledge. Some workers were found to, intentionally or not, exploit this lack of accountability by avoiding responsibility, hiding, or failing to respond to call bells in a timely fashion. According to study participants, this compromised team functioning and quality of resident care.

### ***Expertise Compared to non-Expertise***

Participants also shared their perceptions about the expertise that regular healthcare aides possessed, not only in relation to the residents for whom they provided care, but also pertaining to the unit processes and role responsibilities of their position. This expertise facilitated their effectiveness and efficiency as contrasted to their non-regular counterparts. For example, regular healthcare aides were reported to be more knowledgeable about their unit, facility, and processes of care, unlike non-regular healthcare aides who had to be told or guess. This expertise allowed regular healthcare aides to have more time to connect with residents or do other non-essential tasks (e.g., play the piano for residents) which enhanced the quality of care and care environment

for residents. Additionally, regular healthcare aides were often able to help others because they completed their work in a timely fashion.

The landscape regarding healthcare aide education is disparate in Canada (Estabrooks et al., 2015; Hewko et al., 2015) and Manitoba is one of seven Canadian provinces and territories without a standard provincial curriculum for healthcare aides (Afzal et al., 2018). Despite this, the study found that the majority of regular healthcare aides were perceived by participants to have certification to work as a healthcare aide. The perception with regard to non-regular healthcare aides' education, meanwhile, was they were not always certified, which contributed to the lack of knowledge they possessed regarding their role and processes of care. Perceived lack of familiarity with the unit was a driver of non-regular healthcare aides' inadequate unit knowledge and for this it made little difference whether they were certified or not.

#### ***Teamwork: Reciprocity Compared to Needing Help***

The relationships, accountability, and expertise reported to exist in regular healthcare aides were foundational to the development of functional team dynamics; Figure II (p. 123) was developed on the basis of these findings. Regular healthcare aides were reported by participants to be givers and takers – asking for help when they needed it and reciprocating or even extending help without having to be asked. Non-regular healthcare aides, in contrast, were largely takers according to participants. These workers did not have the requisite knowledge or accountability to reciprocate help. As a consequence, non-regular healthcare aides inhibited team functioning, whereas regular healthcare aides fostered it. With their knowledge and expertise, regular healthcare aides were trusted members of the team and more likely to be engaged in all of the team competencies identified in this study (i.e., complementary roles and function; support and respect; shared values and goals; open communication; and shared decision-making). In addition to possessing a more limited knowledge of roles, functions, residents, and units, non-regular

healthcare aides were outsiders who were more likely to feel uncomfortable speaking up or challenging norms, and less likely to feel supported and respected within the team or to engage in shared decision-making. As outsiders, they were also more likely to experience incivility from regular healthcare aides, further diminishing team functioning when these two categories of workers had to work together. The differences between team functioning with regular healthcare aides in comparison to non-regular healthcare aides was, therefore, stark.

## Figure II

*Three Elements Foundational to the Development of Functional Teamwork (and Exhibited by Regular Healthcare Aides)*



## Dreaming: Promising Practices

While the findings demonstrated the challenges that some racialized participants experienced with dreaming within the subtheme *Difficulty Dreaming*, the evidence from the majority of the data showed that dreaming of small practice changes and policy shifts were how participants envisioned and articulated their idealized vision for the future of long-term care. The exception to this was the single participant who identified as Canadian born and non-racialized. She articulated broad changes to organization and system structures which included appropriate recognition, remuneration, workload, recruitment, and retention.

The remaining participants in this study identified promising practices as part of their idealized dream state for long-term care facilities. These included flexible staffing for peak periods of busyness; a later start time for breakfast as an strategy to reduce rushing and missed care; proper team functioning; working in pairs; and helping the next shift by preparing information and physical resources ahead of time. Embedding these promising practices changes into policy was another promising practice identified by participants; it also represented the idealized dream state for them. More specifically, embedding the practices of working in pairs and nurses helping healthcare aides with transfers into policy were seen as ideal. Other dream state ideals shared by participants correspond with five organizational structures within Kanter's (1993) theory already discussed (i.e., relational person-centred care; support from managers and organizations; sufficient time and staffing; and access to educational opportunities).

### **Methodological Reflections**

Owing to the small sample size, use of a convenience sample and data collection by a single novice investigator, the findings of this study are limited in their transferability. However, the gender, race, and age of participants were obtained and largely matched the existing literature on healthcare aides in long-term care, demonstrating the representativeness of the sample; collection of this demographic information supports the transferability of the study's findings to other organizations within the long-term care sector. A challenge was encountered carrying out this study exactly as designed; data analysis did not occur iteratively with data collection as intended but was mostly performed subsequent to it.

The qualitative methodology utilized in this study captured the views of participants relevant to the topic of structural empowerment. Rich understanding of participants' perspectives was elicited, capturing complexity and intersectionality of phenomena. The appreciative inquiry approach embedded within this study included the discover and dream processes defined therein.

With an egalitarian approach, this strategy facilitated participants' comfort in sharing an array of personal stories and anecdotes, was well-suited to the study's aim, and elicited their experiences, values, and wishes. Considered together, the qualitative methodology, appreciative inquiry approach, and sample population utilized in this study represented a synergistic convergence of strategies which enabled the voices of long-term care healthcare aides to be elicited; these are voices, paradoxical to their vital role in care delivery, which have been systemically silenced and overlooked both in the workplace and the literature. This study fills a notable gap in the literature.

### **Implications for Practice, Theory, and Research**

This study sought to add new insights into worker well-being and resident quality of care by focusing on empowerment structures from the perspectives of long-term care healthcare aides. This study adds to the existing literature on organizational context and reiterates its stance that the optimization of organizational structures has the potential to enhance both worker well-being and the quality of care delivered to residents. This study also has potential to inform current practice and future research in the area through its development of a rich description of the structural factors that support the empowerment of these essential and strategically located frontline healthcare workers.

### **Practice Implications**

Long term care facilities and their leaders should aim to address healthcare aide empowerment by attending to deficiencies within their organizational structures. Prioritizing the well-being of these workers has the potential to yield improvements to the care environment and quality of care delivered. Focusing these efforts on the support, resources (i.e., time and staffing), and opportunities available to healthcare aides is essential and, in addition to their modifiability, represent the areas of greatest challenge identified in this study. However, if long-term care facilities are aware of areas' insufficiency within the structures of their organization, addressing

these issues has the potential to yield enhanced empowerment for long-term care healthcare aides.

Long-term care healthcare aides represent an untapped source of innovation – the innovation needed to dream of solutions to everyday problems in every long-term care organization. These participants were able to identify promising practices and idealized dream states specific to the challenges facing individual organizations. As experts, healthcare aides are not only able to critically think and balance the needs of the individual resident with those of the many for whom they care, their priorities align with those of their long-term care organization. Participants in this study also longed to be appreciated, recognized, and supported for the work they do; this was done well by some organizations, but not others. By seeking to implement appreciative inquiry approaches to quality improvement, long-term care facilities can build on existing efforts to appreciate, recognize, and support healthcare aides, showing them that they and their expertise are valuable to their organization and its leaders. Moreover, by prioritizing this approach, long-term care organizations will facilitate the creation of a culture of functional team dynamics between care providers who work in this environment. Fostering the voices and leadership capacity of these individuals has the potential to upset the traditional hierarchy to which this sector remains beholden, helping to optimize team functioning through shared leadership and decision-making processes.

The benefits of functional teams extend beyond the creation of shared leadership and decision-making to improved resident quality care which makes such an endeavor worthwhile in and of itself. Nonetheless, focussing on the aim of functional teams and the end goal of optimized quality of resident care without sufficient focus on the modifiable and non-modifiable drivers of these will lead organization and system leaders nowhere. To achieve functional team dynamics, a culture of relational care, high accountability, and expertise must be fostered among frontline

healthcare aides. This study asserts that these can only be optimally achieved through the use of regular healthcare aides.

Creating a resilient healthcare system also requires the recruitment and retention of committed healthcare aides who become and remain 'regular'. The long-term care sector must be embedded with structures that appropriately recognize, appreciate, and support existing and incoming workers. There is no room for system-level recruitment tactics that undermine existing regular healthcare aides. More to the point, efforts to pay for healthcare aide education in place of increasing the pay of existing healthcare aides may yield recruitment benefits, but at what cost to the existing regular and committed long-term care healthcare aides? Such efforts undermine the contributions and sacrifices existing healthcare aides have made to pursue their education without financial assistance and the value they have and continue to bring to the long-term care sector. If the current paid and supported education efforts yielded significant recruitment gains, then complementing them with retention strategies could counter the negative impact that these efforts have had as a stand-alone approach for existing healthcare aides. Our system and its organizations should consider strategies that are useful to both recruit and retain staff. For example, a greater focus on the creation of educational opportunities as well as job mobility and growth opportunities have the potential to act as both recruitment and retention tools. In particular, healthcare systems would benefit from supporting frontline healthcare aides to pursue professional degrees within the health sciences. This effort would empower existing workers while helping to create a steady supply of professional workers for healthcare organizations in the long-term care sector and beyond.

In addition to the creation of a culture with functional team dynamics through the recruitment and retention efforts necessary to ensure a full complement of regular healthcare aides, the long-term care sector must pivot from its reliance on overburdening their most

vulnerable and disempowered frontline workers. Increased funding for more care hours is an important means towards achieving this goal and creating a more manageable workload for long-term care healthcare aides. However, organizations can act without system-level involvement to increase resources so there is increased staffing during time of peak busyness. This approach incorporates a promising practice identified by a study participant, while addressing organizational structures identified as the greatest area of challenge to study participants. Adding another healthcare aide for a few hours in the morning has the benefit of reducing or eliminating missed care while addressing the empowerment needs of this group of workers by providing them with the time and staffing required to provide quality care. However, organizations must take care not to add assignments in addition to this added staffing. For example, in this study when baseline healthcare aides to resident ratios improved, there was an increased expectation that participants would give two baths per week to residents instead of just one. This expectation counteracted any benefit that could be conferred as a result of increased staffing ratios (other than the benefits associated with giving residents more frequent baths).

Finally, this study uncovered some of the often simple approaches to facilitating long-term care healthcare aides' feelings of empowerment. This study revealed that feeling seen and valued was key to participants' job satisfaction and represented an extrinsic reward for their work. While intrinsic rewards were drawn from the connection and personal meaning that healthcare aides assign to their work, these rewards represented only one source of enjoyment for participants and is one that is less modifiable from an organizational perspective. Therefore, organizations and their leaders should focus on recognizing and appreciating the contributions of frontline healthcare aides. Creating a culture of mutual appreciation and recognition so healthcare aides feel seen and appreciated by their coworkers enhances their job satisfaction and empowerment.

### **Theory Implications**

This study confirms the fit of Kanter's (1993) theory of structural power in organizations to the long-term care healthcare aide population and was a useful theory to examine the perspectives of long-term care healthcare aides regarding organizational structures and their related empowerment. Few recent studies have examined the concept within this population; fewer still from a qualitative perspective. Despite its usefulness, Kanter's theory does not adequately integrate the concepts of race, immigration status, and gender in a manner that fully considers their influence and impact on healthcare aide empowerment. This study, therefore, from its inception, was unable to adequately address the relationship between these concepts and healthcare aide empowerment. Kanter posits that proportions are important for employee empowerment and discusses tokenism within her theoretical framework. However, the vulnerability of this class of workers is not adequately examined from this theoretical perspective. Therefore, consideration should be given to using Kanter's theory in conjunction with a theory that supports more in-depth examination of these factors.

The appreciative inquiry approach also yielded value for this study, aiding in eliciting both the values and the potential dream possibilities for organizational structures from the perspectives of long-term care healthcare aide participants. The value of the perspectives of these front-line workers in dreaming of solutions to the structural empowerment challenges embedded in their work was also demonstrated through the use of an appreciative inquiry approach; participants were able to identify important promising practices.

### **Future Research**

By offering a comprehensive understanding of the context in which long-term care healthcare aides work, this study provides valuable information, particularly for research that is interested in empowerment, team functioning, and differences within groups (e.g., racialized as

compared to non-racialized healthcare aides). Future research should explore how addressing organizational structures in this resource constrained environment impacts empowerment, team functioning, or quality of resident care. A deeper exploration on the role of charge nurses and managers in long-term care healthcare aide empowerment has the potential to identify leader empowering behaviours perceived to be of greatest influence and impact upon this group of workers in this sector (Greco et al., 2006). Examining the relationship between job satisfaction and empowerment or burnout and empowerment in this population in the post-pandemic era could be considered other areas of salient interest to this healthcare sector.

Future research should consider the use of other theoretical frameworks in conjunction with Kanter's theory to better understand the relationship between race, immigration status, gender, organizational structures, and empowerment for long-term care healthcare aides within the current neoliberal market and political system; feminist political economy may be one such useful theoretical framework. Moreover, future studies should collect data on immigration status of healthcare aides (as well as data on race and other demographic indicators) and explore differences within and between groups.

Identifying organizations that are using an appreciative inquiry approach with their staff and examining outcomes would be another area of potential interest for future investigation. Likewise, further examination of the differences between regular and non-regular healthcare aides is warranted – particularly in relation to quality of care, team functioning, cost, and efficacy.

### **Conclusion**

The findings from this study suggest that modifiable organizational structures have the potential to improve resident care by empowering healthcare aides and may be mediated by the functionality of teams and the use of regular, as compared to, non-regular healthcare aides.

Strategies to improve long-term care healthcare aide empowerment should focus on improving their access to opportunities for education, resources (i.e., staffing and time), and support from managers and organizations. Race and gender are important considerations in this population and intersect with neoliberal ideals and political structures to perpetuate difficult, stressful, and dangerous working conditions for these workers while failing to adequately prioritize system-level retention strategies. Long-term care facilities should address challenges identified within their own organization and by this study's participants through the use of an appreciative inquiry approach involving all members of the care team including healthcare aides; such an approach has the potential to upset established hierarchies that disempower these workers, as well as enable the identification of promising practices facilitating an improved work and care environment. Empowering healthcare aides is a means to improve the well-being and satisfaction of these essential workers and represents an approach to ensuring these workers have what they need to do what they care most about – providing holistic, quality, evidence-informed care to residents.

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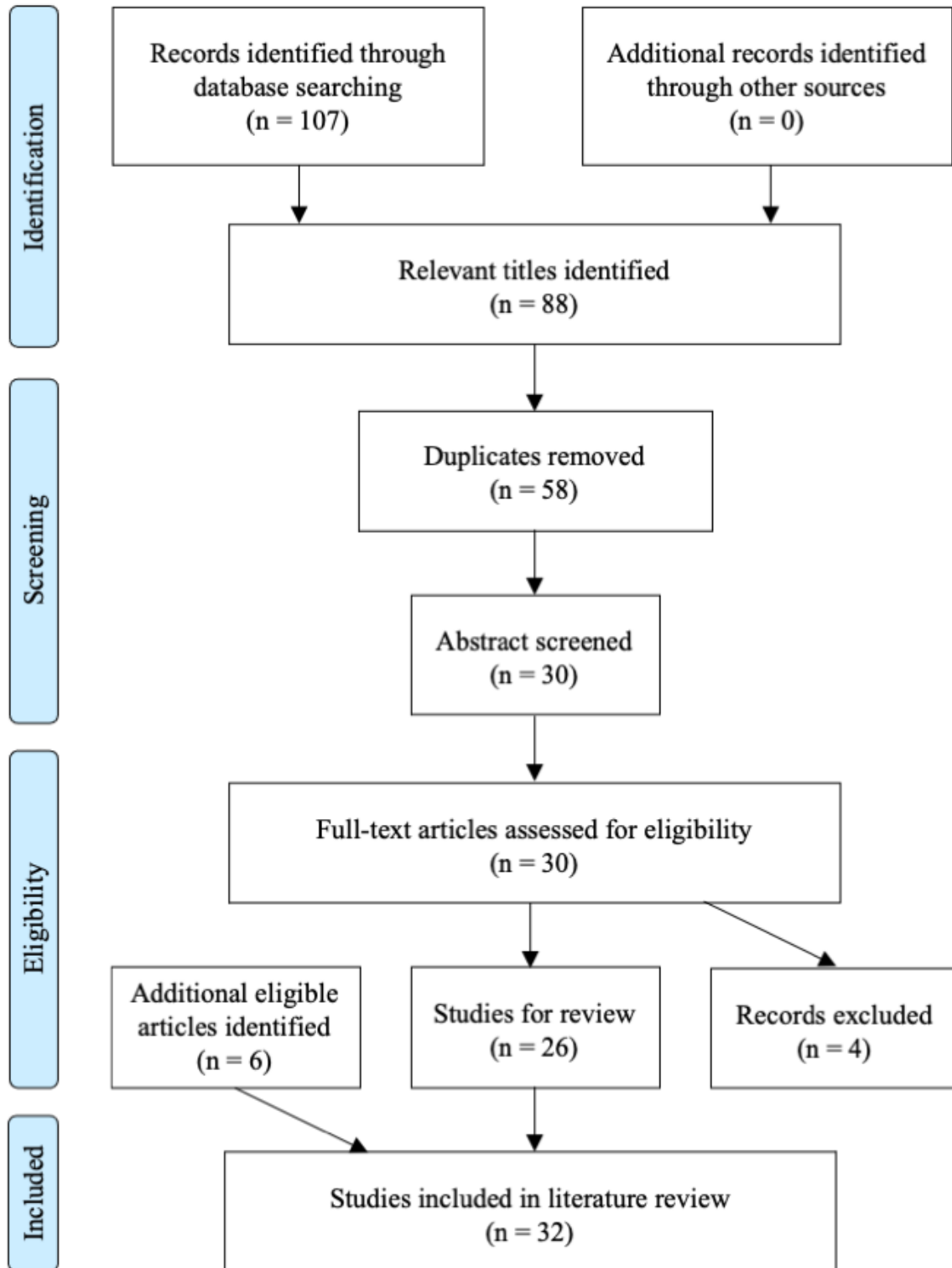
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**Appendix A: Literature Review Flow Diagram**

## **Appendix B: Script to Access Study Population**

Good morning/afternoon Directors of Care,

My name is Jocelyn Elias. I am a graduate nursing student at the University of Manitoba, College of Nursing. As a part of my Master of Nursing program, I will be conducting a research study entitled "Discovering and Dreaming: Understanding Long-term Care Healthcare Aide Perceptions of Structural Empowerment".

The purpose of this study is to develop an understanding of how organizational structures have helped long-term care healthcare aides to feel empowered and do their job. This study also aims to understand how these structures could be changed in the future to offer higher levels of empowerment for these individuals. Understanding what organizations have done well and how healthcare aides envision they could do even better will help organizations to develop organizational change strategies that prioritize the needs and perspectives of these important healthcare providers.

I am meeting with you today to ask for permission to recruit healthcare aides in your facility. Those who are willing will be provided with a package of recruitment posters and letters of invitation. You will be asked to assign an administrative staff person with the task of placing posters and letters of invitation in high traffic areas. Those who are willing will also be asked to allow me to recruit potential participants from your facility through an in-person presentation similar to this one. The in-person recruitment will be done on a first come, first served basis, until I have recruited enough participants to this study.

For this study, participants will be asked to fill out a brief demographic questionnaire, followed by a 60-75 minute video teleconference or telephone interview. Only I, the principal investigator, and my advisor, Dr. Judith Scanlan, will know participant identities. This study poses minimal risks and participation is voluntary. Participants' choice to take part in this study will not affect their employment and their employer will not know who participated. The results of this study will be shared through presentations, peer-reviewed journals, conferences, and the University of Manitoba's thesis website, MSpace. Study results will also be shared with participating facilities. As a token of appreciation, participants will be provided with a \$50 gift card.

The recruitment packages have my contact information on the outside envelope. Feel free to take an envelope and sign up on the sign-up sheet if you may be interested in allowing me to recruit from your facility's staff – even if you are not 100% sure. I would love to speak with you whether you are interested in granting permission to recruit at your site or not, as well as to answer any further questions you may have. Thank you for your consideration.

**Appendix C: Letter of Invitation**

**University of Manitoba** | Rady Faculty of Health Sciences

College of Nursing  
University of Manitoba  
89 Curry Place  
Winnipeg, Manitoba  
Canada R3T 2N2  
T: 204 474 7452  
F: 204 474 7682  
[nursing@umanitoba.ca](mailto:nursing@umanitoba.ca)

Dear Healthcare Aide,

My name is Jocelyn Elias. I am a graduate nursing student at the University of Manitoba, College of Nursing. As a part of my Master of Nursing program, I will be conducting a research study entitled “Discovering and Dreaming: Understanding Long-term Care Healthcare Aide Perceptions of Structural Empowerment”.

The purpose of this study is to develop an understanding of how organizational structures have helped long-term care healthcare aides to feel empowered and do their job. This study also aims to understand how these structures could be changed in the future to offer higher levels of empowerment for these individuals. Understanding what organizations have done well and how healthcare aides envision they could do even better will help organizations to develop organizational change strategies that prioritize the needs and perspectives of yourself and other healthcare aides.

I am writing to you today to invite you to participate in this study. Participants will be asked to participate in brief demographic questionnaire, followed by a 60-75 minute UM Zoom or telephone interview. As a token of appreciation, participants will be provided with a \$50 gift card (e.g., Sobeys, Tim Hortons). A few participants who agree to additional participation may also be selected to partake in a less than 60 minute summary meeting with the principal investigator later on in the research process. Individuals who participate in this summary meeting will be provided with another \$50 gift card (e.g., Sobeys, Tim Hortons) in appreciation of their time.

Participants who choose to take part in this study will not affect their employment and their employer will not know who participated. Only I, the principal investigator, and my advisor, Dr. Judith Scanlan, will know participant identities. This study poses minimal risks and participation is voluntary. The results of this study will be shared through presentations, peer-reviewed journals, conferences, and the University of Manitoba’s thesis website, MSpace. Study results will also be shared with participating facilities.

If you or your staff are interested in participating or have any further questions, please do not hesitate to contact me (at [REDACTED] or Dr. Judith Scanlan (at [REDACTED])). Thank-you for your consideration. I look forward to hearing back from you.

Sincerely,

[REDACTED]

Jocelyn Elias RN BN ENC(C)

Appendix D: Recruitment Poster

# Are you a healthcare aide in this long-term care facility?

**You are invited to participate in a research study.**

**Study Title:** **Discovering and Dreaming: Long-term Care Healthcare Aide Perceptions of Structural Empowerment**

**What is involved?**  
If you choose to participate you will be asked:  
1.) to answer some brief demographic questions about yourself  
2.) to participate in a virtual 60-75 minute one-on-one meeting about your ideas and experiences around workplace empowerment.  
In appreciation, participants will receive a \$50 gift card.

**Who can participate?**  
Healthcare aides who work a minimum of 15 hours/week and have worked in this long-term care facility for six months or longer are invited to participate.



**What do we want to learn?**  
We want to understand how organizational structures can help long-term care healthcare aides to feel empowered and do their job well. We want to understand what healthcare aides think organizations have done well and what they envision could be changed to build even better organizational structures in the future.

**Questions?**

For more information or to participate, please contact Jocelyn Elias at [redacted], or Dr. Judith Scanlan at [redacted]



**Appendix E: Eligibility Screening Form**

Participants must answer yes to all the following questions to meet study eligibility criteria.

Participant #: \_\_\_\_\_

Date: \_\_\_\_\_

1. Speaks English fluently?

Yes

No

2. Has worked as a long-term care healthcare aide for at least 6 months in a term or permanent position?

Yes

No

3. Has worked at least an average of 15 hours per week?

Yes

No

4. Consents to being audio-recorded?

Yes

No

5. Has access to computer/handheld device with microphone/speaker and internet (video camera optional) OR telephone?

Yes

No

**Appendix F: Informed Consent Form**

**University of Manitoba** | Rady Faculty of Health Sciences

College of Nursing  
University of Manitoba  
89 Curry Place  
Winnipeg, Manitoba  
Canada R3T 2N2  
T: 204 474 7452  
F: 204 474 7682  
[nursing@umanitoba.ca](mailto:nursing@umanitoba.ca)

**CONSENT FORM**

**Study Title:** Discovering and Dreaming: Long-term Care Healthcare Aide Perceptions of Structural Empowerment

**Principal Investigator:** Jocelyn Elias, RN BN ENC(C), Graduate Nursing Student, University of Manitoba; [REDACTED]

**Research Supervisor:** Dr. Judith Scanlan, RN PhD, Associate Professor, College of Nursing; [REDACTED]

-----  
**This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you an idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.**  
-----

**Purpose**

The purpose of this study is to develop an understanding of how organizational structures have helped long-term care healthcare aides to feel empowered and do their job. This study also aims to understand how organizational structures could be changed in the future to offer higher levels of empowerment for these individuals.

As a healthcare aide in long-term care, you have a unique understanding of how things could be improved. Understanding what organizations have done well and how you and other healthcare aides envision that long-term care organizations could do even better will help long-term care organizations to develop organizational change strategies that prioritize the needs and perspectives of healthcare aides.

**Procedures**

As a participant in this study, you will be asked to complete (1) a brief demographic questionnaire (10 minutes or less), and (2) a 60-75 minute interview with the researcher via video teleconference (i.e., UM Zoom) or telephone. You may also be selected to partake in a summary meeting (60 minutes or less) with the Principal Investigator to confirm research findings. This meeting is voluntary, and you may decline to participate in this meeting while still participating in the other portions of the study.

### **Recording**

The interview will be audio-recorded for the purpose of transcription and further analysis. Recording will be done on UM Zoom and stored using a UM approved storage platform (i.e., SharePoint). Audio recording helps ensure nothing is missed when seeking to understand your perspectives. These recordings will be transcribed using an external transcription services company.

### **Risk and Benefits**

Participation in this study poses minimal risk to you. Your involvement in this study will provide risks that are no greater than those encountered in your everyday life.

The non-judgemental interview approach being used in this study aims to benefit you and other study participants by prioritizing and valuing your important perspectives. This study will provide important knowledge that will also benefit the working conditions of long-term care healthcare aides in general.

### **Confidentiality**

All the information you provide as part of this study will be kept strictly confidential and stored on a University of Manitoba approved platform. The identification key and contact information of those involved in the study will be kept in a separate password-protected file from the research data. Only the Principal Investigator and her advisor will have access to the information that will be collected. The audio recording from your interview will be destroyed no more than three months after your interview is completed. The research data will be destroyed by December 2030. Your choice to take part in this study will not affect your employment and your employer will not know who participated.

Neither your name nor your contact information will appear in any publications stemming from this research. Some data and information from this study may be sent outside of the University of Manitoba to other researchers, organizations, or made publicly available. This is for further analysis, testing, as part of the research study, or a requirement by a granting agency or journal. Any information sent out of the University of Manitoba will not show your name or address, or any other identifiable personal information about you. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. The researcher cannot guarantee complete privacy of data collected through UM Zoom. Your personal information may be disclosed if required by law.

### **Compensation**

If you agree to participate in this study, you will receive an honorarium of a \$50 gift card (e.g., Sobeys, Tim Hortons) as a sign of appreciation. If you are selected and agree to partake in a summary meeting after your interview, you will be provided another \$50 gift card in appreciation for your time. Up to three participants will be selected to participate in the summary meeting. The gift card will be a digital card and will be emailed to you. Even if you change your mind and later withdraw your consent, the gift card(s) is yours to keep.

### **Withdrawal from Study**

You may withdraw from the study at any time, without penalty or repercussion. You may also decline to answer specific questions in the interview or demographic questionnaire if you so desire. If you withdraw your consent during the interview or soon after, your audio recording will be destroyed within a week or less of receiving your request. Your interview will not be

transcribed. Because this study uses a qualitative approach, data analysis is iterative and will begin as soon as the interview has been transcribed. Therefore, if you wish to withdraw your consent after you have participated in the interview, you must do so within two weeks from the date you are interviewed. To withdraw your consent, please reach out to the Principal Investigator, Jocelyn Elias, via email [REDACTED] or via telephone [REDACTED].

### **Dissemination**

The findings of this study will be shared publicly to help inform people on the study's findings related to organizational structures and long-term care healthcare aide empowerment. Public sharing of study findings will include a poster presentation in the University of Manitoba's College of Nursing Graduate Poster Competition and a summary document sent out to study participants and sites. It may include publication in a peer-reviewed journal and presentations at in-person conferences/online webinars or to key decision-makers in the Manitoba long-term care healthcare sector. The study will also be published on the University of Manitoba's thesis publication website, MSpace.

### **Summary of Results**

A brief summary of study results will be made available to all study participants by approximately February 2024. If you are interested in receiving a summary report, please indicate so on the last page of this consent form. If interested, please specify if you would prefer to receive these results by mail or email and provide the preferred address/email address.

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**Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.**

**The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.**

**This research has been approved by the Research Ethics Board at the University of Manitoba Fort Garry campus. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or [HumanEthics@umanitoba.ca](mailto:HumanEthics@umanitoba.ca). A copy of this consent form has been given to you to keep for your records and reference.**

Please mark the box below to confirm or refuse consent for the use of audio-recording of your interview:

- Yes, I consent to the use of audio-recording during my interview.  
 No, I do not consent to the use of audio-recording during my interview.

Participant's Printed Name: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree to be contacted to participate in a summary meeting after my interview.

- Yes, I am willing to be contacted about participating in a summary meeting.  
 No, do not contact me about participating in a summary meeting.

*\*NB: If you agree and are selected to participate, you will receive another \$50 gift card to thank you for your time and contributions.*

I would like to receive a summary of the research results.

- Yes, I would like to receive a summary of the research findings.  
 No, I do not wish to receive a summary of the research findings.

If yes:

I would prefer to receive the summary form via:

Mail: \_\_\_\_\_  
*(Mailing Address)*

Email: \_\_\_\_\_  
*(Email Address)*

To consent to this study, you may do any one of the following:

**1.) Sign, and mail\*\* this form to:**

Jocelyn Elias c/o College of Nursing  
 University of Manitoba  
 89 Curry Place  
 Winnipeg, Manitoba,  
 R3T 2N2

*\*\*NB: If you require a physical copy of this form, and/or a return envelope and postage, please contact Jocelyn Elias [REDACTED]*

**2.) Print, sign, scan, and email this form to:**

Jocelyn Elias [REDACTED]

**3.) Email Jocelyn Elias [REDACTED], stating:**

- i.) That you have read the consent form in its entirety,  
 ii.) That you agree to the terms of the consent form and wish to enrol in the study,  
 iii.) That you agree to be audio-recorded.

### Appendix G: Demographic Form

-----  
 For research personnel:

Participant #:

-----  
 Date: \_\_\_\_\_

**1. Age:** \_\_\_\_\_

**2. Please indicate your gender:**

- |  |   |
|--|---|
| <input type="checkbox"/> Male                            | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Female                          | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Non-binary/Trans/Gender Diverse |   |

**3. Please indicate your race:**

- |   |   |
|---|---|
| <input type="checkbox"/> Asian                | <input type="checkbox"/> Middle Eastern       |
| <input type="checkbox"/> Black                | <input type="checkbox"/> South Asian          |
| <input type="checkbox"/> Latino/Latinx        | <input type="checkbox"/> White                |
| <input type="checkbox"/> First Nations        | <input type="checkbox"/> Mixed Race           |
| <input type="checkbox"/> Inuit                | <input type="checkbox"/> Don't know           |
| <input type="checkbox"/> Métis                | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> East/Southeast Asian | <input type="checkbox"/> Other: _____         |

**4. Highest level of education completed:**

- |  |  |
|--|--|
| <input type="checkbox"/> High School diploma | <input type="checkbox"/> Master's degree               |
| <input type="checkbox"/> College diploma     | <input type="checkbox"/> Post-graduate degree          |
| <input type="checkbox"/> University degree   | <input type="checkbox"/> Other (please specify): _____ |

**5. How many years have you worked as a healthcare aide?** \_\_\_\_\_

**6. How many years have you worked at the long-term care facility where you are currently employed?** \_\_\_\_\_

**7. What is your work status (select all that apply)?**

- |                                    |                                    |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Full-time | <input type="checkbox"/> Term      |
| <input type="checkbox"/> Part-time | <input type="checkbox"/> Permanent |

**8. Do you have a second job?**

- |  |   |
|--|---|
| <input type="checkbox"/> No.                               | <input type="checkbox"/> Yes, as a healthcare aide at another long-term care facility |
| <input type="checkbox"/> Yes, but not as a healthcare aide |   |

## Appendix H: Interview Guide

(With Questions, Prompts and Rationale)

*The questions in this interview guide have been designed to elicit perspectives of care aides on the relationships, relative importance, and promising practices with regard to LTC power, opportunity, and proportion structures in ways that optimize healthcare aide empowerment. Initially questions designed to discover the current state of structures and their influence on care aide empowerment are posed (number questions in bold). Within the prompts section are prompts followed by a final bolded question asking participants to dream about an ideal future state. The final question and prompts ask participants to prioritize organizational structures relating to their perceived influence upon their structural empowerment.*

### Introduction:

Hi. My name is Jocelyn Elias, and I am a registered nurse [REDACTED]. I am doing my Master of Nursing degree, and this study is for the thesis portion of my degree. I want to thank you for agreeing to be part of this study on healthcare aides and the long-term care organizations they work in. I believe this is an important topic because healthcare aides aren't always valued the way they could be for their insights and hard work. My mom was a long-term care healthcare aide for most of her life, and I worked as a long-term care healthcare aide before I became a nurse. Taking good care of older people has always been important to me. These things have influenced my desire to focus my attention on the issues that healthcare aides face in the workplace so we can better understand them and find ways to improve their work conditions. I believe that healthcare aides are vital for delivering good care to residents in long-term care. In our discussions today, I am interested in discovering your perspectives about your work and your dreams of how to make your work better. When you're answering my questions today, if you think of any stories that you want to share that help to explain something that we are talking about, I would love to hear those. Do you have any questions at this point?

Before we begin, I want to remind you that:

1. You can withdraw your consent and stop this interview at any time. We can also pause, or you can ask me questions if you have questions about the research process.
2. There are no right or wrong answers. It is helpful for me to hear whatever you are thinking and know about today's topic.
3. What is said today stays between us and my advisor, Dr. Judith Scanlan, and is confidential. I want you to feel comfortable sharing your opinions/experiences and know that after this interview, you will be identified only by an anonymous number or pseudonym that I assign to your interview and the other forms we filled out (i.e. consent, demographic).
4. I may take some notes to help me document the conversation and remember something for later in our interview. I am also recording this conversation as we discussed previously. I will not identify anyone by name in my notes or report.
5. Do you have any other questions?

Let's get started...

### Questions:

1. **Tell me about your work as a healthcare aide.**
2. **a. Thinking about your work as an aide, could you tell me about a time when you were able to do a good job with your resident?**

*Prompts:* For example, the flexibility to provide personalized care to a resident? Perhaps you had more time or had the chance to do something a little extra that you knew was special for that person... What did that look like for you? What types of things made it possible for you to do this? **What do you think would help you do a really good job caring for a resident more often?**

- b. Tell me about a time when something prevented you from doing a good job.**

*\*Rationale:* Kanter's theory describes power as the ability to mobilize resources and accomplish tasks.

3. **a. In your work as a healthcare aide, how do you decide when and how to do your job? (Do you get to decide how and when?)**
- b. How visible are you to others in your work?**

*Prompts:* For example, do others notice the importance of the work you do? Do they notice if you do a good job or not? Do co-workers, organizational leaders, the resident, or family/friends, etc. notice and value your contributions? Tell me more about that.

- c. Tell me about your perceptions of your organization's purpose.**

*Prompts:* Do you think your role relates to your organization's purpose in any way?

*\*Rationale:* Discretion in decision-making is associated with formal power. Roles that are visible and appreciated, as well as roles which are linked to the central purpose of an organization are also theorized to be other aspects of formal power.

4. **Tell me about the people with whom you work and how they help you to do your work.**

*Prompts:* How do the relationships you have with others you work with help you to do your job well. For example, does a staff member do a task for you or supervisor support or encourage your team? What are your relationships like with other healthcare aides, nurses, your manager, or other support staff? Can you think of a time where a co-worker or boss helped you so you could do your job the way you wanted to do it or do your work in a better way – perhaps by being more effective or efficient? **What do you think your relationships with others in your workplace would need to be like in order to help you do your best work?**

*\*Rationale:* According to Kanter's theory informal power is found in relationship with superiors, peers and subordinates and can be generated from both within and outside of the organization, enhancing a worker's sense of empowerment.

5. **Can you describe to me the information you have to do your work? Can you think of a time where having information helped you to do your job well?**

*Prompts:* For example, this could be information at the resident, unit, or organization level. (E.g., knowing a resident's individual needs or preferences

or knowing unit practices or organizational policies) What information helped you to do your job? How did this information influence the work you do?

**What type of information do you need to do the very best that you can at your job?**

*\*Rationale: Access to information is theorized to be an organizational structure which contributes to employee empowerment.*

**6. Can you describe to me, the support you have to do your work?**

Prompts: For example, do your coworkers or leaders support you in your work? How does that look? **What type of support do you need to do your best work?**

*\*Rationale: Support is one of the organizational structures that is theorized to contribute to employee empowerment.*

**7. Can you describe to me the resources that you have to do your work?**

Prompts: For example, can you access everything you need to provide good care to your resident (e.g., brief, cloths)? Are there certain resources that you do not have access to and need to ask for if you need them? What does that look like? How does it impact your ability to do your job well?

Prompts: Do you have enough time to do your job well? Tell me more about that. **What resources do you need to do your best work?**

*\*Rationale: Resources is one of the organizational structures that is theorized to contribute to employee empowerment.*

**8. Can you tell me what opportunities there are for you?**

Prompts: This could be personal or professional growth or movement. For example, it could be changing jobs or learning something new. What did that look like? What do you enjoy or appreciate about these types of opportunities? What worked best for you about this? How did this impact the work you do as a healthcare aide? **What types of growth or opportunities do you need to do your job well?**

*\*Rationale: Opportunity structures including access to opportunities to develop knowledge and skills are theoretically linked to mobility and growth according to Kanter and provide another structural facilitator of employee empowerment.*

**9. I'd like you to think now about minorities in your workplace. A minority is someone who belongs to a group which is or has been underrepresented in society and/or which is or has been underprivileged in society due. An example of this is people of certain races and genders. Could you tell me about your experiences of minority workers in your job?**

Prompts: Tell me about the proportion of races and genders in your organization. What do they look like? How does the proportion of minorities influence how well you are able to do your job? Does it influence the ways that you do your work? **What type of proportions of minorities do you think would help you do the best that you can at your work?**

*\*Rationale: Kanter states that as a greater number of minority employees shift proportions within an organization, the social experiences and behaviours of employees will be impacted,*

*influencing organizational outcomes. Understanding the perspectives of healthcare aides of the role and gender and race in their organization is important in addressing sexist and racist organizational structures and empowering the healthcare aide workforce.*

10. Together we have identified the following (*recap main points*). I would like you to think about these things together and tell me **what are the top 2 or 3 things that are most helpful for you to do your job? What are the top 2 or 3 things that would be the most important for creating a better future for long-term care healthcare aides?**

*\*Rationale: Asking healthcare aides to prioritize the empowerment structures of most importance to them will help identify those structures perceived to be of greatest importance to healthcare aides.*