"The conditions of work are the conditions of care": A Focused Ethnography of Teamwork in a Senior Care Facility in New Brunswick

by

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ABSTRACT

Researchers have drawn attention to the vulnerable state of senior care facilities across Canada, and the complexity and quality of this work environment. Much work has also been conducted on the development of evidence-based best practice guidelines in elder care. However, research on the implementation of evidence-based work environment best practice guidelines in long-term care, especially for dementia care, is in its infancy. This study explores the process used to implement a Registered Nurses' Association of Ontario (RNAO) Healthy Work Environment (HWE) Best Practice Guideline (BPG) on teamwork in long-term care and the impact on staff, the work environment, residents, and family members.

The following questions guided the study: What process was used to implement the RNAO HWE BPG on teamwork? How did the RNAO HWE BPG influence staff teamwork? What was the impact of the implementation of guideline recommendations on the work environment? How did the implementation of guideline recommendations impact staff, residents, and family members? What social and other contextual factors influenced the implementation process?

The study on enhancing teamwork took place in a dementia care unit in a senior care facility in the province of New Brunswick. The methodology was focused ethnography, and methods included in-depth interviews with 12 participants, observation, document review, and research journaling.

The main research findings were: Leadership team members (senior managers) initially followed a hierarchical approach to implementation of the RNAO HWE BPG recommendations, which became more collaborative as the process evolved; leadership

team members and unit managers (front-line managers) utilized a contextual approach to implementation of BPG recommendations, customizing the process to fit the specific needs of the senior care facility; multiple ways of knowing contributed to the enhancement of teamwork processes; leadership team members and staff both expected the leadership team to play a major role in sustaining teamwork. The RNAO HWE BPG implementation also impacted team members in positive ways: staff reported satisfaction in working together for the benefit of residents and also reported that residents could sense the atmosphere on the unit and react to it.

The conclusions indicate that embracing a RNAO HWE BPG teamwork approach can maximize the efforts of staff in a senior care facility and positively impact resident care. Recommendations include: enhancing policies and procedures related to teamwork; fostering self-confidence and agency among team members; supporting flexible leadership for leadership team members and unit managers; developing an education program on multiple ways of knowing; as well as ongoing research and innovation. Implementation science strategies such as facilitation could be used to revisit the evidence-based RNAO HWE BPG and implement subsequent recommendations of the tool.

DEDICATION

I dedicate this work to my husband Michael Dobbelsteyn and our sons Ryan and Keegan Dobbelsteyn. Your love and support made all the difference to me and I thank you so very much. As well, I would like to dedicate this work to the women in my family who have been a positive force in my life from the very beginning: my mother Deanna McAllister, and my Grandmother, the late Elsie Fletcher. Thank you for believing in me and loving me in my life!

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CHAPTER ONE

Research Problem, Purpose, Questions, and Concepts

Statistics Canada, (2010) projects that the number of seniors will more than double from 4.7 million in 2009 to approximately 10 million by 2036. The implications of this shift in population are not yet clear but what is clear is that with age, the prevalence of dementia increases. Currently, in Canada, seven percent of people who are 65 years of age and older require long term residential care in a senior care facility setting (Canadian Institute of Health Information, 2012). Many of these seniors have dementia and require specialized care from staff (Alzheimer's Society of Canada, 2009). The Canadian Healthcare Association (CHA) looked at new directions for facility-based long-term care stating that residents' needs are complex and more attention must be given, "to processes that will help transform long term care homes into desirable places to live and work" (CHA, 2009, p. 11). In their report, entitled *The Rising Tide: The Impact of Dementia on Canadian Society*, The Alzheimer's Society of Canada (2009) calls for a national dementia strategy. One of their five recommendations was that the dementia workforce (staff who care for people with dementia) in Canada be strengthened. This is at the core of this research study.

In response to these concerns, the Registered Nurses' Association of Ontario (RNAO) developed 12 Healthy Work Environment Best Practice Guidelines (HWE BPGs). Topics include: effective staffing and workload practices, sustaining nursing leadership, embracing cultural diversity, professionalism, workplace health and safety,

preventing violence at work, managing conflict, adopting e-health solutions, inter-professional healthcare, practice education, preventing nurse fatigue, and collaborative practice of nursing teams. The staff and managers who care for people with dementia in a senior care facility, and residents' family members in the province of New Brunswick, Canada, their work environment, and the implementation of recommendations from a RNAO HWE BPG on teamwork entitled *Collaborative Practice of Nursing Teams* (RNAO, 2006) are the topic of this research study.

In this chapter, I present the research problem and describe the study setting. I also explain the purpose of this study, identify my research questions, and reveal my own interest in this topic. In addition, I explain the three key concepts that frame the study: HWE, Teamwork, and Evidence-Based Practice and articulate the relevance of the study. I conclude with an explanation of how the dissertation is organized, and provide a chapter summary.

The Research Problem

The mission, vision, and value statements for senior care facilities in New Brunswick typically state the intention of the Boards of Directors and management is to provide both a satisfactory living environment for residents and a satisfactory working environment for staff. The research literature on working environments for staff in healthcare settings frequently refers to, "creating healthy work environments" (Baumann, et al., 2001; Griffin et al., 2006; RNAO, 2006). RNAO (2006) defines a healthy work environment as, "a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, organizational performance, and societal outcomes" (p. 13). Despite an awareness of the importance of healthy working environments, concerns

exist about the actual quality of working and living environments for staff and residents in senior care facilities in Canada.

In the last decade, researchers in elder care in the US and Canada have drawn attention to shifting demands on senior care facilities and the impact on staff and the work environment. In the US, Castle and Engberg (2007) pointed to increasing costs and demand for services for the elderly the increasing frailty of residents and difficulties with recruitment and retention of qualified staff. In Canada, Petch, Tierney, and Cummings (2013) raised an alert about senior care facility staffing levels in the province of Alberta. Ireland (2013) reported that staff in Thunder Bay, Ontario, cannot, "get to the needs of people", resulting in, "abuse by lack of care" (p. 97). In a 2013 report of the Canadian Institute of Health Information, the average senior care facility resident was 85 years old and residents had complex care needs, many being completely dependent on senior care facility staff, of whom there are too few to provide safe care. And, recently in New Brunswick, an article in *The Daily Gleaner* (2017) newspaper entitled, "NB Nursing Homes Face Staff Crunch", discussed the impact of insufficient staff in senior care facilities. The article examined some of the underlying reasons for this problem, and stated that a province-wide survey is planned to assess the problems with staff recruitment and retention.

In the past decade there has been a marked increase in important research in long-term care, including research on work environments, however, a significant gap continues to exist in the knowledge we have about this setting. Estabrooks, Squires, Carleton, Cummings, and Norton (2015) raised concerns about how little is known about the largely unregulated workforce providing care in nursing homes. Although research has

been conducted on the use of clinical BPGs in hospitals, home care, and nursing homes, it was difficult to find any studies on the implementation of HWE BPGs in senior care facilities. Estabrooks, Squires, Hayduk et al. (2015), for example, stated, "We found no studies that considered the effects of individual and organizational factors on care aides' use of best practices in nursing home settings." (p. 537e2). However, using hierarchical linear modeling, they found that individual characteristics played a prominent role in predicting care aides' use of evidence-based practices. Examples of these individual characteristics included: education level, English as first language, health status, and attitude toward research. Contextual factors including culture, social capital, formal and informal interactions and adequate orientation were also found to be important.

Although some recent work is being done on work environments in long-term care, a significant gap continues to exist in the knowledge we have about this setting. Moreover, although RNAO HWE BPGs have been under development for the past decade no research studies have explored the specific role of RNAO HWE BPGs on teamwork in a senior care facility setting and the resulting impact on staff, the work environment, residents, and family members. The senior care facility in this study had introduced a RNAO HWE BPG to address an identified problem with teamwork on a specific dementia care unit. The issue under exploration is the process used to implement recommendations from the RNAO HWE BPG and explore the resulting impact on staff, the work environment, and residents. My intent is to understand the complexity of implementing the RNAO HWE BPG recommendations on teamwork in a work environment that is in a vulnerable state.

Long-term Care in New Brunswick

This study took place in a dementia care unit in a senior care facility in the province of New Brunswick, Canada. The province's Nursing Home Act defines senior care facilities as:

> Residential facilities operated, whether for profit or not, for the purpose of supervisory, personal, or nursing care for seven or more persons who are not related by blood or marriage to the operator of the home, and who by reason of age, infirmity, or mental or physical disability are not fully able to care for themselves, however, this definition does not include an institution operated under the Mental Health Act, the Hospital Services Act, or the Family Service Act. (New Brunswick Nursing Home Act, 1994, Section 1)

In New Brunswick, senior care facilities or "nursing homes" are distinguished from other types of long-term care facilities such as Special Care Homes, by the level of care that residents require. The senior care facilities admit people who require the highest level of care as determined by an entry assessment conducted by health professionals. In recent years, gerontological nursing, a specialty within nursing related to caring for the elderly, has emerged.

Gerontological nursing is the nursing specialty practiced in senior care facilities. The Canadian Gerontological Nursing Association's (CGNA, 2010) stated goals are to "promote the health and wellness of older adults" (p. 3), and to set standards for gerontological nursing care. CGNA describes this type of nursing care as follows:

> Gerontological nursing adds a specialized and expanding body of knowledge of gerontology and geriatrics to general nursing practice. In gerontological nursing practice, nurses collaborate with clients to promote well-being, optimize functional abilities, and at advocates for clients. Research findings are

> incorporated through the application of theory and evidence-based nursing therapeutics to meet clients' goals and expected outcomes. (p. 8)

A CIHI (2013) report on aging in Canada stated that the average senior care facility resident is 85 years old and is experiencing several health challenges. Residents in senior care facilities are dependent on staff for assistance with their activities of daily living such as eating, bathing, and toileting. This increasing dependency of residents on staff for care, funding challenges, and the shortage of staff create challenges for administrators that can influence the day-to-day operations of senior care facilities.

In terms of regulation, each province regulates senior care facilities through an inspection process to insure they follow provincial legislation. In addition, senior care facilities in Canada can apply for accreditation status from Accreditation Canada. This voluntary process involves the senior care facility staff and managers completing a self-assessment, followed by a site visit from a surveyor to confirm the self-assessment. Achieving accreditation demonstrates that the senior care facility meets national standards for long-term care provision. The senior care facility that is the study setting is fully accredited by Accreditation Canada. *Leading Practice,* an Accreditation Canada (2013) publication, is an example of how knowledge is shared to improve health services in accredited organizations. This document identifies teamwork as one vital component needed to develop healthier working environments in healthcare settings.

The Purpose of the Study

The purpose of this study was to understand the implementation of recommendations from a RNAO HWE BPG on teamwork and how this impacted staff teamwork on a dementia care unit in a senior care facility in New Brunswick. Using a

focused ethnography methodology (Morse & Richards, 2002) my specific goals were to: a) listen to the experiences of staff, unit managers and leadership team members who implemented the RNAO HWE BPG recommendations aimed at improving teamwork on the unit; b) gain insight into the social and or other contextual issues that impacted implementation and gain an understanding of how these issues were managed; and c) become knowledgeable about the contextual factors relevant to teamwork in the senior care facility, specifically in relation to teamwork in the dementia care unit. A focus on strategies to enhance teamwork in senior care facilities serves to potentially mitigate current and future staffing problems and ultimately create healthier work and living environments for staff and residents.

The Research Questions

This study documents the actions taken by one senior care facility in New Brunswick to implement recommendations from a RNAO HWE BPG to enhance teamwork on a dementia care unit, and to explore the issues that surrounded the implementation. The following research questions shaped this study:

1. What process was used to implement recommendations from a RNAO HWE BPG on teamwork?
2. How did the RNAO HWE BPG influence staff teamwork?
3. What was the impact of the RNAO HWE BPG implementation on the work environment?
4. How did the implementation of recommendations from the RNAO HWE BPG on teamwork impact staff, residents and family members?

5. What social and other contextual factors influenced the RNAO HWE BPG implementation?

Key Concepts

Three concepts provide a foundation for this study: Healthy Work Environments, Teamwork, and Evidence-Based Practice. I discuss each of these in turn.

Healthy work environments.

To provide a foundational understanding of the components of a healthy work environment, I use the *Conceptual Model for Healthy Work Environments for Nurses-Components, Factors, and Outcomes (*RNAO, 2006) (see figure 1 depicted below).

This conceptual model identifies the components, factors, and outcomes of a healthy work environment for nurses. It also depicts the interdependence among individual, organizational, and external levels related to the organization. In addition, the model organizes elements of the work environment into three components: (a) a physical/structural/policy component (i.e., workload, changing schedules, heavy lifting, exposure to hazardous substances, and threats to personal safety); (b) a cognitive/psychosocial/cultural component (i.e., clinical knowledge, coping skills, communication skills, role clarity, team relationships, labour management relations, and changing demographics); and (c) a professional/occupational component (i.e., commitment to clients, ethics, values, scope of practice, and control over practice).

In addition to the above three components, the model identifies how various factors within each component operate at the level of the individual, the organization, and the external environment. For example, the physical/ structural/ policy component,

factors include: individual work demand factors, organizational physical factors, and external policy factors. The final part of the model is at the core and identifies outcomes relating to individual staff/client, organization, and society. RNAO (2006) makes an important point in relation to the structure of the model: "The lines within the model are dotted to indicate the synergistic interaction among all levels and components of the model" (p. 15).

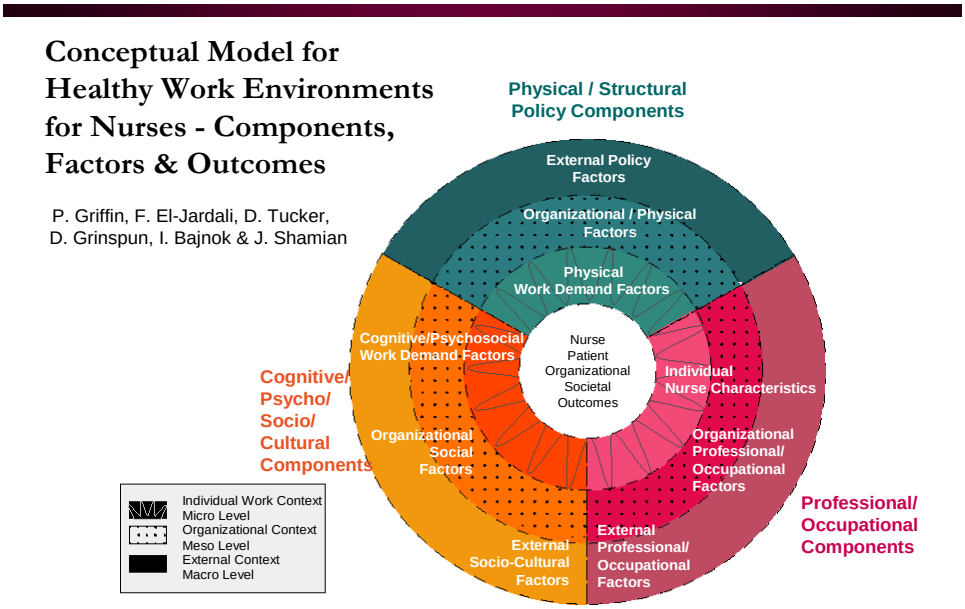

Figure 1. Conceptual Model for Healthy Work Environments

Teamwork.

Teamwork fits within each of the three components of the healthy work environment model. For example, working as a team to carry out physical care would be part of the physical/structural/policy component at the individual factor level. Teamwork

is also a part of the cognitive/psycho-social/cultural component at the individual level relating to roles and relationships. Within the professional/occupational component, teamwork is referred to at the organizational level (intra-disciplinary relationships).

The RNAO HWE BPG on teamwork, *Collaborative Practice of Nursing Teams* (RNAO, 2006) uses a definition of collaboration from Henneman, Lee and Cohen (1995): "A joint venture or cooperative endeavor that ensures a willingness to participate. This relationship involves shared planning and decision making, based on knowledge and expertise rather than on role and title" (p. 61). RNAO (2006) also indicated that input should be sought at the outset, prior to full implementation, from all people who may be affected by BPG implementation.

Katzenbach and Smith (2003) defined teamwork as a process of building trust and interdependence, enough to enable movement from individual accountability to mutual accountability. These authors referred to teamwork as team performance and have introduced the "team performance curve". This curve depicts the development of a beginning pseudo team to an extraordinary team. According to Saltz (1992), the rationale for depending on teamwork is that it enhances the staff's ability to meet the needs of clients in the most effective way possible, which is more likely to contribute to better quality care. Similarly, Heinemann (2002) found that the use of teams in health care delivery continues to grow in the face of health system changes such as restructuring, reorganization, cost containment, and increasing complexity of health care knowledge.

Although teamwork has become popular in a wide range of fields, in many instances the concept or term 'team' may be inadequately defined, and even groups of people who merely work together have been labeled a 'team' (Katzenbach & Smith,

2003). These authors also commented on teams lacking a clear purpose and not holding common goals. This observation is important because if these basic elements of teamwork are not in place, it may be difficult to achieve the desired outcome. The basic elements of teamwork that Katzenbach and Smith identified were: having a small sized team, insuring an adequate mix of complementary skills on the team, agreeing on a meaningful purpose, setting specific goals, articulating a clear working approach, and having both individual and mutual accountability. They noted that, in the business world, high performance teams are rare. In my study, the team was not considered to be small (as reported by participants) and included people on the day, evening and night shifts; there was a complementary mix of expertise and skills on the team (including dietary workers, activation staff, unit managers, RNs, LPNs, RAs, and housekeepers); resident-focused care was the identified common goal; a teamwork approach was articulated and was being enhanced; and staff and unit managers both reported varying levels of accountability.

Evidence-based practice.

RNAO HWE BPGS are a form of evidence-based practice. Evidence-based practice (EBP) is described as, "the conscientious, explicit, and judicious use of the current best research in making decisions" (Sacket, Rosenburg, Gray, Hayes, & Richardson, 1996, p. 17). EBP originated from the medical profession and was adopted in the mid 1990's by other professions such as nursing (Purkis & Bjornsdottir, 2006), and social work education (Walker, 2003). Since that time, various forms of EBP have developed to facilitate implementation of this approach in practice. Knowledge

utilization (KU) flows from EBP (Estabrooks, 1999) and is discussed in Chapter 2. My study is informed by previous literature on both EBP and KU.

The Canadian Nurses Association (CNA) is a proponent of EBP in nursing. The CNA position statement on EBP states:

> Evidence-based decision-making is an important element of quality care in all domains of nursing practice. Evidence-based decision-making is essential to optimize outcomes for patients, improve clinical practice, achieve cost-effective nursing care, and insure accountability and transparency in decision-making. (CNA, 2002)

This position statement proposes that evidence-based nursing is a shared responsibility of the individual nurse, professional associations, researchers, educators, employers, and governments. The International Council of Nurses (ICN) has not developed a position statement on evidence-based practice, but they do allude to it in their position statements on competency and scope of practice by stating that nursing is constantly evolving and is impacted by new knowledge development (ICN, 2006).

Cileska (2008) wrote about EBP in nursing and asked questions such as, "How far have we come?" and "What is next?" She emphasized that EBP is more than research utilization, rather, "it is the incorporation of the best research evidence along with patient preferences, the clinical setting and circumstances, and healthcare resources into decisions about patient care" (p. 38). Cileska explained how EBP in nursing has evolved in recent years and indicators of its popularity include: website development and recent textbooks published on this topic. An abstract journal titled *Evidence Based Nursing* began publishing in 1998, and the journal, *Worldviews on Evidence-Based Nursing* began publishing in 2004.

Alternatively, some researchers are interested in practice-based evidence. In an article about practitioners as theorists, Reed (2008) argued that knowledge and theories

developed in practice are responsive to the situation and that, "action is a reality of practice" (p. 320). Reed placed emphasis on the value of thinking while doing by healthcare practitioners. Similarly, Mantkoukas (2006) examined the relations between EBP and reflective practice. He reviewed the literature on this topic and concluded that knowledge created from reflection on one's practice may be as beneficial as EBP and that each could benefit from the other. During the in-depth interviews with participants, examples of practice-based evidence surfaced and I noted these ways of knowing existed in parallel to the EBP, noting that both were useful for enhancing teamwork.

The concepts HWE, Teamwork, and EBP are reflected in the RNAO HWE BPG on teamwork, which is the focus of this study. In the next section I explore the evolution of BPGs, the scholarly critique of BPGs, and the importance of contextualization of BPGs specific to a particular setting.

Best Practice Guidelines

Over the past twenty years in healthcare, there has been an evolution of the development of evidence-based BPGs with the stated goal of improving patient care and staff work environments. BPGs in health care are sets of recommendations, based on research findings, which are intended to bring about a desired change in work processes, staff outcomes, client outcomes, organizational performance, and system performance. BPGs are implemented in organizations with diverse visions, missions, values, cultures, contexts, clients and staff needs.

However, critics tend to view BPGs as normative and question their value. Nursing researchers Holmes, Murray, Perron, and McCabe (2008) argued that in the process of using a BPG, critical thinking is reduced and the BPG, "rewards action

without thought" (p. 7). A second criticism comes from nursing researchers Nolan and Bradley (2008). They argued little attention is given to the role of context in the development and use of BPGs, and therefore recommendations tend to be implemented in a linear fashion starting at the beginning and following each part through to the end. Further, Perry, Grange, Heyman, and Noble (2008) described nurses who were dedicated to ensuring BPGs were implemented as championing the process and wondered whether BPGs are yet another top down initiative (following the nursing process, nursing models, and primary nursing). Although the scholars cited above have written theoretical conceptual papers on BPGs, they have not yet conducted empirical research to address their concerns. Bardach (2011), from the discipline of education, has also criticized the term best practice. In his book, *A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving,* he said there never really are "best practices" but perhaps "good or smart practices" (p. 48). Based on an updated search in October, 2017, the points these critics raise have yet to be studied, justifying the need for more research on this topic. I link BPGs to normative theory next.

BPGs and normative theory.

Norms are defined as, "the standard that is regarded as normal" (Collins, 2002, p. 518). Somekh and Lewin (2011) define normative as, "a term that denotes conformity to an authoritative standard. It is used to describe values and ideals but can also have connotations of oppression" (p. 326). Normative theory used in relation to businesses or healthcare organizations, therefore, would refer to the way organizations are organized by norms, ideals, or standards that serve the interests of the dominant group. For example, Weiner (1982) pointed to behavioural outcomes such as "commitment" in organizations

where commitment is viewed as a normative motivational process. The author concluded that for organizations to achieve their stated outcomes they "must define their own value system, get members to accept it, and attract members with compatible value systems" (p. 426). Normative theory, therefore is linked to RNAO HWE BPG use (implementation practices) because critics are theorizing that BPGs are merely normative. Standards, norms, values and ideals can and are shaped by the organizational context. Estabrooks et al. (2016) highlight the importance of context when considering factors that promote best practice use.

Contextualizing best practices.

Critical scholars have stated that attention to context is extremely important when implementing BPGs. Ambler (2005), from the field of computer science, stated, "The myth of 'best practices' is firmly entrenched and what if best practice is not right for your project" (p. 2). Ambler argued that one size does not fit all; he said that it is important to customize practices to fit the problem, leading to better results. Instead, Ambler prefers the term "contextual practice" as it focuses on what works best in a specific context. He argued, "The contexts in which practices are effective are worlds apart" (p. 2).

Kaner, Bach, and Pettichord (2002) also favour "contextual practices" (p. 1) over best practices and provide insight into the basic principles of the context-driven school in relation to best practices. Some of these principles are as follows:

- The value of any practice depends on its context.
- There are good practices in context, but there are no best practices.
- People, working together, are the most important part of any project's context.
- Projects unfold over time in ways that are unpredictable.

- The product is the solution. If the problem isn't solved, the product doesn't work. (p. 1)

Scholars have also discussed the impact of context on organizational behavior. For example, Johns (2006) described context as, "situational opportunities and constraints that affect the occurrence and meaning of organizational behavior as well as functional relationships between variables" (p. 386). John's main points were that context can have both subtle and more powerful effects on implementation and researchers need to properly account for contextual effects; facets or aspects of context tend to be interrelated; context can be situational or event based; context can be meaningful in relation to a bundle of stimuli; and context can also be a constant and although it may not necessarily be measured, it needs to be considered in the analysis of findings. John's also expressed concern that researchers rarely consider context and its impact. John's work supports that of Rousseau (2001) who stated that contextualization in organizational behavior research is more important now than in the past, for two reasons: "organizational research is becoming more global and there is more diversity in the nature of work and work settings" (p. 384). Rousseau (2001) described contextualization as a way of approaching research where knowledge of the settings to be studied is brought into design and implementation decisions.

RNAO and best practice guidelines.

RNAO is focused on EBP and KU through their development of both clinical and HWE BPGs. Although, as stated previously, BPGs are sometimes conceptualized as normative. RNAO (2006) states implementation of the RNAO HWE BPGs may be context dependent or context-sensitive. I interpret this to mean that RNAO intends their

BPGs to be operationalized or used as is appropriate for a specific context. RNAO (2006) states, "The guideline contains much valuable information but is not intended to be read and applied at one time. We recommend that you review and reflect on the document and implement the guideline as appropriate for your organization at a particular time" (p. 23). RNAO then provides seven steps for guidance in using the document that include: study the HWE organizing framework model, identify areas to focus on, read recommendations and research summaries, focus on recommendations needed by your organization, develop a plan, share the plan with your team, and revise the plan as needed (p. 24).

Besides developing HWE BPGs, RNAO has initiated a range of activities to support the implementation of their guidelines including: holding an annual summer institute on RNAO HWE BPGs, identification of "champions", naming Best Practice Spotlight Organizations, providing facilitators for organizations implementing the guidelines, offering e-learning modules, organizing conferences to share successes and knowledge translation of guidelines into six languages, and promoting RNAO HWE BPGs in other Canadian provinces and territories as well as in other countries. In Ontario, the provincial government promotes EBP and provides funding through an RFP process for nurse-led quality initiatives such as implementation of a clinical or HWE BPG (Discussion with Dr. Valerie Grdisa, 2018). In addition, RNAO BPGs are reviewed and updated every three to five years (RNAO, 2006).

The RNAO HWE BPG on teamwork, *Collaborative Practice Among Nursing Teams* (RNAO, 2006) is presented in a booklet format. This BPG was reviewed and updated and split into two BPGs: Inter-professional teams, 2013 and Inter-professional

teams, 2016. The BPG used in this study includes a model of healthy work environments, outlines the purpose and scope of the guideline, and provides instructions on its use, with specific recommendations for three levels: (a) individual staff and team recommendations, (b) organizational recommendations, and (c) external/system recommendations. Based on a recent review of the RNAO website, they have now developed 12 HWE BPGs, which demonstrates the complexity of the concept of a HWE. Other topics of the RNAO HWE BPGs include: effective staffing and workload practices, sustaining nursing leadership, embracing cultural diversity, professionalism, workplace health and safety, preventing violence at work, managing conflict, adopting e-health solutions, inter-professional health care, practice education, and preventing nurse fatigue.

In summary, scholarly work on evidence-based best practices, normative theory, and contextual practices alerted me to explore situational elements that could affect the implementation of the RNAO HWE BPG on teamwork in the senior care facility. The five basic principles of the context-driven school of thought identified by Kaner, Bach, and Pettichord (2002) were especially useful to me as I interviewed participants. It was important to determine if the team on this dementia unit of the senior care facility implemented the RNAO HWE BPG on teamwork as presented, i.e., as normative or contextualized the BPG, i.e., as non-normative to fit their own situation. In short, it was important to determine whether the senior care facility staff involved in implementing the guideline used it as a "guide" (i.e., contextualized the guideline), or followed it as a predetermined set of rules (i.e., normative interpretation of the guideline).

My Positioning

My interest in elder care, evidence-based practice in long-term care, generally, and RNAO HWE BPGs, specifically, stems from my previous education as a Registered Nurse and my work experience in the senior care facility system in New Brunswick. Ten years of my nursing career included senior management positions (Director of Nursing and Chief Executive Officer) and one of my objectives was to add to the understanding of what makes the senior care facility work environment healthier for staff and, subsequently, better for residents.

In 2007, I was invited to attend the RNAO Summer Institute on Healthy Work Environment Best Practice Guidelines. I attended this one-week institute to learn more about the topic of RNAO HWE BPGs. I was curious about the possible use of these guidelines in senior care facilities. When I returned to New Brunswick I had the opportunity to approach a senior care facility CEO to inquire about her knowledge and interest in evidence-based practice and specifically, RNAO HWE BPGs. After which the CEO sent two of her leadership team members to the next *Summer Institute* to learn about BPGs. On their return, the team members reported to the leadership team at the senior care facility, who decided to proceed with implementing the RNAO HWE BPG recommendations on teamwork on a unit that had previously identified a problem with teamwork. Subsequently, I met with the CEO to discuss the possibility of conducting a research study to explore the process and outcomes of the implementation of the RNAO HWE BPG on teamwork in her senior care facility. Having gained permission from the CEO, who could be seen as what Berg (2009) defined as the gatekeeper, i.e., the

individual who has the power to deny or grant access to the setting, my research study changed from a possibility to a reality.

Based upon my experience in the long-term care system, my interest in teamwork in senior care facilities, my knowledge of the (minimal) published literature on this topic, and my previous involvement in conducting qualitative research, I was well positioned to conduct this study. I had studied elements of teamwork for the past seven years and in 2008 presented a paper at an international conference on the topic in China. Also, over a ten-year period of working in the senior care facility system, I observed the following workplace concerns: an increasing level of dependency of residents; insufficient hours-of-care per resident per day; an increasing number of elderly requiring long-term care, including an increasing number of persons with dementia. Those issues were emerging a decade ago and have become an even greater concern in senior care facilities today.

Organization of the Dissertation

This dissertation is organized in seven chapters. In Chapter one I have explained the research problem, purpose and questions, and the key concepts that provide the foundation for my study. In Chapters two and three I review previous relevant literature and outline the methodology and methods of my study, respectively. Chapter four establishes the context for the study: a dementia care unit in a long-term care facility in the New Brunswick. In Chapter five I report the findings of the study, and in Chapter six I analyze the findings in relation to previous research literature. In the final chapter I formulate conclusions and make recommendations based on the findings.

Chapter Summary

In this chapter, I have introduced the research problem, the research setting, my research topic, and research questions. I have also explained the key concepts of Healthy Work Environments, Teamwork, and Evidence-based Practice, which form the foundation of my study. I identified the research problem as a vulnerable work environment in long-term care currently and a lack of research on the potential of RNAO HWE BPGs to change the working and living environment in senior care facilities. The purpose of this study was identified as understanding the complexity of implementing a RNAO HWE BPG on teamwork in a senior care facility setting and the impact on staff, family members and resident care. I have positioned myself in the study as someone with experience in health care, specifically long-term care. In addition, I have explained how this dissertation is organized. By exploring how one senior care facility implemented a RNAO HWE BPG to support teamwork and its impact on staff, family members, and ultimately resident care, my intent is to add new knowledge to the literature on elder care research, evidence-based practice, and implementation science. In the next chapter I look at previous relevant research and show where my work fits in relation to other scholarly work in these areas.

CHAPTER TWO

A Literature Review

This literature review situates my work in the research literature on elder care, evidence-base practice/knowledge utilization, and implementation science generally, and HWEs, BPGs, and teamwork, specifically. My topic fits within a field of study that has grown substantially in the past decade. The literature review: provided a foundation to my study; revealed where my research fit with previous research in the field; illuminated gaps in knowledge related to teamwork in senior care facilities; and alerted me to areas to probe during interviews and for further research. This field of study is pursued by researchers who are interested in achieving quality health care for seniors by understanding the context or working environment for staff and aim to enhance it through research.

Although no known studies could be found on the specific topic of using an RNAO HWE BPGs to enhance teamwork in senior care facilities, I retrieved many studies on various elements related to working environments in senior care facilities such as: leadership, staffing, research utilization, occupational health and safety, staff retention, climate and communication, other forms of evidence-based practice, and organizational performance. The literature search was designed to capture relevant information published in nursing and other disciplines on research related to the research topic. Literature for this review was retrieved from several electronic databases, including Cumulative Index of Nursing and Allied Health Literature (CINAHL), Business Source Premier, Sociological Abstracts, Medline, Health Star, Abstracts in Social Gerontology,

and Philosopher's Index. Key search terms included: long-term care, nursing homes, best practice guidelines, evidence-based practice, healthy work environments, best practices, teamwork, normative theory, and contextualization of best practices, knowledge utilization, elder care, and implementation science. Studies relating to clinical best practice guideline implementation in senior care facilities were excluded from this review because of their patient or condition focus (i.e., preventing falls or reducing restraints) rather than having a healthy work environment focus. In addition, I conducted secondary searches by reviewing reference lists of retrieved articles to determine if additional references existed that were not identified by my initial electronic searches. The search began in 2011 and continued until 2018, in accordance with the emergent nature of qualitative research. I begin by presenting research on overarching areas relevant to this study such as: elder care research, evidence-based practice/knowledge utilization, and implementation science, and follow with research related to the key concepts of this study: healthy work environments, teamwork, and best practice guidelines. I conclude the chapter with a summary of how findings from this review have informed my research study.

Elder Care Research

There has been a growing interest in elder care research in Canada. Based on the demographic shift towards an aging population and the increasing prevalence of dementia, among other chronic conditions, elder care research has become important in terms of generating new knowledge to care for the elderly. Within the past 10 years, elder care research has focused on various topics. Research in the field of elder care that relates specifically to my study explores organizational contexts or working environments in

long-term care, dementia care, and implementation of evidence-based practice tools such as BPGs. I present the first two of these here and the third in the next sections on evidence-based practice/knowledge utilization and implementation science.

Organizational contexts or working environments in long-term care.

Research relating to the organizational context or working environment in long-term care facilities covers a wide range of topics including: job satisfaction, symptom burden on staff and modifiable elements in the work environment, staff burnout, rushed and missed resident care, health care aides' use of time, and defining the care unit in a senior care facility.

The first study I discuss examines job satisfaction of health care aides in long-term care. In a systematic review of contributing factors to job satisfaction (e.g. both individual and organizational) in residential long-term care facilities, researchers sought to understand factors associated with job satisfaction for care aides, nursing assistants, and nurse aides in long term care facilities (Squires et al., 2015). The important individual factors were staff autonomy and empowerment, and the important organizational factors were workload and facility resources. The evidence reviewed in this study points to the importance of personal and organizational support for improving care aides' job satisfaction, which links to my study in relation to staff work environment and, ultimately, sustaining teamwork in a long-term care setting.

The next study I reviewed was related to health care aides use of time in a long-term care unit. Mallidou, Cummings, Schalm, & Estabrooks, (2013) studied seven health care aides'use of time in a 52-bed senior care facility in Canada. This was an

observational study, using data recording observational sheet and semi-structured interviews, and field notes to document unit culture. Findings indicated that healthcare aides spent most of their time in personal care activities, their work is frequently interrupted by other activities resulting in fragmented care; also social interactions and activities with residents were limited due to lack of time. This research on time use is valuable to my study in that it alerted me to the conditions of work for health care aides and allowed me to probe this topic in the in-depth interview process.

As part of the TREC study, the issue of what constitutes a resident care unit in a senior care facility arose. The next study was conducted to explore this topic. Estabrooks et al. (2011) studied what constitutes a resident care unit in 36 senior care facilities in Alberta, Saskatchewan, and Manitoba. The results supported the definition of a care unit developed by researchers and support the resident unit as the area to target for interventions to improve resident care. In the senior care facility in my study, each unit is named and distinct from others, particularly the dementia care unit as it is a secured unit, however, this may not be the case for all resident care units in senior care facilities.

The next topic in current relevant elder care research that I reviewed concerned staff burnout in senior care facilities. Researchers in Western Canada were interested in the influence of the organizational context or working environment on care aides working in long-term care facilities (Chamberlain et al., 2017). The sample for this study was 1194 care aides from 30 senior care facilities who were surveyed about organizational context, demographic characteristics, and frequency of dementia-related behaviours associated with burnout. Findings indicated that both individual care aide factors and organization factors contributed to care aide burnout, however, the organization context

factors could be managed or modified. This study is valuable to my work as the findings suggest that improving the work environment (through teamwork or improving unit culture) can mitigate burnout and limit turnover.

One final study I reviewed in relation to work context in 36 senior care facilities in Alberta, Manitoba, and Saskatchewan, Canada, focused on the symptom burden (described as the accumulation of symptoms from diseases) and the link between symptom burden and modifying factors of the work environment (Estabrooks, et al., 2015). This was a retrospective analysis of longitudinal survey data including 3660 residents and 1381 staff. The authors concluded that the symptom burden is greater near the end of life; however, symptom burden differs between high and low context facilities. Modifiable features of organizational context included: leadership styles, communication patterns, data feedback, and additional resources. This study has made me aware of the impact of the organizational context or the work environment and how changing it or enhancing it can positively affect resident care.

In summary, the research findings from the above studies reveal the link between organizational contexts or working environments in senior care facilities and modifying factors in the working environment to enhance resident care. Two of the key concepts in my study, teams and teamwork, are also modifiable organizational context factors. Based on this literature, to avoid staff burnout and increase job satisfaction, factors that can be managed or modified need to be such as maintaining autonomy of staff and insuring a safe manageable workload (Squires et al., 2015) and staff burnout can be mitigated by improving teamwork (Chamberlain et al., 2017).

Dementia care.

Dementia care is not the main topic of my study, however, the study setting I use is a dementia care unit, therefore I will review some current studies on dementia care. Key relevant studies on dementia care relate to: staff attitudes towards dementia care (strain and satisfaction); behavourial interventions to decrease challenging behaviours in senior care facilities; using dementia care mapping to improve person-centered care; and workplace aggression experienced by staff in dementia care. Modifiable workplace factors are also discussed, which are related to the working environment in dementia care.

For example, Brodaty, Draper, and Low (2003) used a cross-sectional design and surveyed 253 nursing home staff in 12 senior care facilities in Australia. Staff attitudes, strain, and satisfaction were measured and findings indicated that staff perceived residents as difficult to deal with and perceived their behaviours to be deliberate. Researchers recommended the provision of more education, training, and support for staff. This study does not state whether or not these staff worked in specialized dementia care units, and if they did not, this might explain the lack of understanding of dementia and associated behaviours. My study was conducted with staff who work on a specialized dementia care unit

Research studies have also explored behavourial interventions aimed at decreasing problematic dementia behaviours in senior care facilities. A literature review by Allen-Burge, Stevens, & Burgio, (1999) provided helpful discussion augmented by examples from the authors' previous intervention research on this topic, including a

program they developed for teaching behavior management skills to nurse's aides. Topics of this educational program included: diversion and distraction, positive reinforcement, specialized communication skills, identifying difficult behaviours, and identifying triggers to resident problematic behaviours.

The next study looked at aggression in dementia care. Bostrom et al. (2012) aimed to describe aggression in dementia care in two different environments: Residential Alzheimer Care Centers and Secured Dementia Units. Physical assault was reported as the most frequent type of aggression, followed by emotional abuse. The aggressive acts were occurring in the secure units rather than the residential care center. The authors recommended further research looking at modifiable factors and strategies to deal with aggressive behavior. These two studies relate closely to me study in that the use of teamwork (and enhancing it through the use of an evidence-based BPG) is one modifiable factor in the work environment how work is organized.

A large-scale dementia care mapping study is being planned in the Netherlands. Van de ven et al. (2012) have published a design plan for a randomized control trial that will examine person-centered care through dementia-care mapping. The design plan indicates that this will be a large randomized control study of residents in 34 specialized dementia-care units in the Netherlands and their care givers. One group will receive the dementia care mapping intervention while the control group will receive usual care. The process for dementia care mapping is presented as a three part process: 1) minimum four hour observation of resident behavior, 2) complete feedback picture of the resident, and 3) develop and implement informed action plan for improvement in care management.

The results of this study could be helpful to me in that dementia care mapping could be something done by team members in my study if it proves effective.

In summary, researchers conducting studies on dementia care have found that there is strain on staff who work in dementia care and that more staff support and training is needed. As well, an important study on behavioral interventions in dementia care provided ideas on distraction, diversion and specialized communication skills that would be helpful for staff. Aggression in dementia clientele was found to be higher in secured dementia care units and care mapping is being studied as a way to prevent and or respond to aggression in people with dementia. The need for additional education for staff working in dementia care was identified in three of these studies (Brodaty, Draper, and Low, 2003; Allen-Burge, Stevens, and Burgio, 1999; and Bostrom, et al., 2012). In my work regarding teamwork in a dementia care unit, I can ask questions about these topics and ascertain if they have used some of these techniques in caring for residents with dementia. A gap in this research was the lack of studies exploring teamwork as a way of organizing care in a dementia unit.

Knowledge Utilization

In this study, I explore the use of an evidence-based RNAO HWE BPG to enhance teamwork and the working environment in a senior care facility. The RNAO HWE BPG is an example of a knowledge utilization tool. Knowledge utilization can be defined as, "the use of knowledge generated through research for policy and practice decisions" (Rich, 1991, p. 319). Estabrooks, et al. (2008) studied the evolution of the concept of knowledge utilization from 1945-2004. They concluded that Rogers (1962) was the primary researcher in this field with his diffusion of innovations model. This

model explains why and at what rate new ideas spread. Rogers proposes that this model is based on four elements: communication channels, the innovation itself, time, and a social system. They also stated that evidence-based medicine emerged next. Since that time, several theories of knowledge utilization have been developed including: the Promoting Action on Research Implementation in Health Services (PARIHS), (Kitson et al., 1998); Normalization Process Theory (May & Finch, 2009); Theoretical Domains Framework (Canes, O'Connor, &, Michie, 2012) and the Consolidated Framework for Implementation Research (Damschroder, et al.(2009). These theories of knowledge utilization are relevant to my work because they have laid the groundwork for development of RNAO HWE BPGs, which are a form of knowledge utilization.

In Canada, Estabrooks et al. (2009) developed and implemented the Translating Research in Elder Care program (TREC) to accomplish three goals: 1) to build knowledge use/translation theory about the role of the work environment in long-term care; 2) to pilot knowledge transfer interventions; and 3) to enhance knowledge use in long-term care. This research study was conducted in 36 Western Canadian senior care facilities, and spanned 5 years. The study included three projects: an observational study, a series of case studies, and the feedback projects. Data extracted from the minimum data set were collected and analyzed for a one-year period. Results indicated that resident profiles differed across the three provinces due to the system design in each province (e.g., some focusing earlier on enhancing community care for seniors). Three study protocols were published for TREC (Estabrooks et al. 2009) and several studies have resulted from this work. The two study that inform my work are: *The hidden complexity of long-term care: How context mediates knowledge translation and use of*

best practices (Cammer et al., 2014), and *The influence of organizational context on best practice use by care aides in residential long-term care setting* (Estabrooks et al., 2015).

Cammer et al. (2014) studied the features of context as they relate to knowledge utilization in long-term care. Twenty one interviews were conducted in one of the TREC sites in Saskatchewan to answer the question, "How does organizational context mediate the use of knowledge in practice in long-term care facilities?" The authors used grounded theory to analyze the data and developed *The Hidden Complexity of Long-Term Care Model*. Work environment factors in the model that influence knowledge utilization included: physical environment, resources, ambiguity, relationships, and philosophies. This study does not talk about specific best practices but infer clinical care best practices generally. This study is relevant to my work because it identified specific work environment factors and I can use these in my own study (e.g., in data collection and analysis).

Estabrooks et al. (2015) studied both individual factors and work environment factors that influence knowledge utilization (clinical best practices). Researchers used data from the TREC program and used hierarchical linear modeling to look at both individual factors and work environment factors impacting both instrumental and conceptual research use (identified only as best practices). Results indicated that individual characteristics played the main role in knowledge utilization, however work environment factors (social capital, staffing, and time) also played a significant role..

Both of these studies verify that the long-term care work environment is a complex one and that work environment factors are important in relation to knowledge utilization (using best practices) to improve resident care. My own study explores the

implementation and impact of an evidence-based RNAO HWE BPG to enhance teamwork and the working environment, which in turn affects residents in terms of quality care. The above two studies explore topics very close to my own research and inform my work by alerting me to both individual factors and work environment factors as important in knowledge utilization in my study. A gap in these previous studies is knowledge utilization relating to HWE BPGs in a dementia care unit.

Implementation Science

Implementing evidence-based practices in healthcare settings does not happen spontaneously but requires specialized knowledge and effort. The specialized knowledge to do so lies in the field of Implementation Science. In this section, I present three articles on this topic to reveal what is known in this field and to situate my work within that knowledge.

In the field of health care, implementation science is, "the scientific study of methods to promote the systematic uptake of research findings and other EBPs into routine practice, and hence, to improve the quality and effectiveness of health care services" (Bauer et al., 2015, p. 1). In an essay on this topic, Bauer et al. stated that implementation science usually starts with an EBP that may address a gap in quality care in a healthcare organization. They outline several principles and methods of implementation science. The first thing to do is, "to distinguish the implementation processes from the EBP you seek to implement" (p. 4). Further, these authors stated that implementation science differs from clinical research (which tends to focus on health effects) in that it focuses on, "rates and quality of use of EBPs rather than their effects" (p. 4). A key component of implementation studies is the focus on evaluating the

implementation process which can be done in various ways such as process evaluation, formative evaluation, and summative evaluation. Types of data can be either quantitative or qualitative and can come from different sources (e.g. patients, providers, or systems). These authors support the use of theory and frameworks in implementation research design decisions.

In 2005, Fixsen et al. published a synthesis of the literature on implementation science in an effort to determine what is known about the key components of implementation. These authors identified a five part conceptual framework of implementation which includes: a source (best practice); a destination (staff and organization); a communication link (working group who are implementing the best practice); a feedback mechanism (flow of performance information to and from stakeholders); and a sphere of influence (social, political, and other contextual factors that impact organizations). Next, these authors set out stages of the implementation process, which for them included: exploration and adoption, program installation, initial implementation, full operation, innovation, and sustainability. Based on their joint experiences with implementation science, the authors state, "Each attempted implementation of evidence-based practices and programs presents an opportunity to learn more about the program itself and the conditions under which it can be used with fidelity and good effect" (p. 17). Finally, these authors make four recommendations for research on implementation specifically: identify the components of the EBP; determine the effectiveness of the implementation process; measure implementation outcomes independent of a specific program; and describe facilitating organizational and socio-political factors to implementation.

In 2009, Damschroder et al. described the methodology they used to develop a Consolidated Framework for Implementation Research (CFIR) which involved using a snowballing approach to identify theories in previous research; combining constructs; deciding on the key components based on the authors' previous research and their review of the literature. The authors identified five components that they used to map this process: the EBP characteristics; the external (e.g. client needs, resources) and internal settings (e.g. culture, leadership engagement); characteristics of the staff involved; and the process of implementation. Damschroder presented these five components as essential to an implementation evaluation.

In summary, implementation science is a relatively new field of knowledge that has developed based on the need to implement evidence-based practices in a systematic way. Each of the above three articles has informed my study in unique ways. Bauer et al. 2015 provided a clear definition of implementation science and explained the evaluative nature of this work. Although I conceptualized my work as an exploratory study rather than an evaluation, it did consider participants perceptions on the impact of implementing the RNAO HWE BPG. In contrast, Damschroder et al. (2009) were more focused on the process of implementation, which included the development of a framework that was used to guide implementation programs. In my study, I used the RNAO Conceptual Framework for Healthy Work Environments to identify the many concepts and factors in the complex and multidimensional concept of a healthy work environment in a health care setting, which was helpful identifying internal, external and staff characteristics at the beginning of my research and throughout the implementation process. From Fixsen et al. 2005 I learned about the stages of the implementation process

as proposed by these authors. My research fit the stages of the implementation process at step three which was initial implementation. The point they made about measuring outcomes outside of a specific program pressed me to look beyond the RNAO HWE BPG to broader literature and in response to my research questions.

Healthy Work Environments

My literature search on HWE involved examining research on several components, factors, and outcomes identified in the HWE conceptual model that related to teamwork. I begin with a discussion of research literature on HWE generally, and then move on to HWE in the context of senior care facilities specifically. I conclude with a discussion of reports (grey literature) that are also relevant to this study.

The first three studies I review next relate to HWE and business outcomes such as organizational performance and how this is closely connected to staff well-being. In two theoretical papers, Kelloway and Day (2005a) discussed healthy work environments from the perspectives of management and psychology, respectively. These authors conceptualized a healthy work environment as one that incorporates health promotion activities, provides employee assistance programs, offers flexible benefits, and ensures quality working conditions. It also treats employees fairly, and provides programs for employee development, health and safety, and stress management. In addition, the authors identified four "costs" related to unhealthy work environments: psychological strain (problems with mood, concentration, and making decisions); physical strain (sleep disturbances, upper respiratory infections, digestive problems); behavioral strain (development of nervous habits like nail biting, increased smoking, development of eating disorders); and organizational strain (absenteeism, poor performance, increase

accident rate). Based on this, if calculated, the 'costs' of unhealthy workplaces would be substantial. In their second article, Kelloway and Day (2005b) focused on building healthy workplaces. They suggested a national strategy that included the development of an educational skills building program and a monitoring system that tracks working conditions. In this study the researchers focused on health promotion for staff and the costs of an unhealthy work environment. My study focused on the strategy of using teamwork to enhance the working environment. Kelloway and Day's study informs my work in that long-term care facilities are also businesses, but are sometimes not considered as such.

Harter, Schmidt, and Keyes (2002) also focused on the attributes of healthy workplaces. In a meta-analysis of well-being in the workplace and its relationship to business outcomes, the authors concluded that the well-being of staff and organizational performance are not independent, rather they "are complimentary and dependent components of a financially and psychologically healthy workplace" (p. 16). This research on workplace wellness is relevant to my study and similar in that it is supportive of management focusing on healthy work environments in pursuit of improved organizational outcomes. Senior care facilities, whether for-profit or not-for-profit, are businesses that provide a service to people, therefore this previous research informs my study.

The costs of unhealthy work environments are also noted in research on long-term care facilities. Chappell and Novak (1992), for example, measured burden, burnout, and perceived job pressure on nursing assistants, and the impact of providing support to alleviate their levels of stress. Findings indicated that the negative costs could not be

mitigated completely by providing social support at work, even though it was somewhat helpful. Major changes in staff workload and providing more rewards at work were considered to be crucial. The issues of costs of unhealthy work environments provides a strong rational for efforts to enhance the working environment and this links this study to my work.

In addition, I retrieved seven studies that documented elements of healthy work environments in healthcare settings. These studies identified absenteeism and job satisfaction, respectively, as topics of study relating to HWEs. In Montreal, Canada, Lavoie-Tremblay (2004) interviewed 60 workers in a participatory study on the effects of implementing an intervention to create a healthier work environment on a hospital unit with high absenteeism. Findings included the following: it was very difficult to establish trust among the team due to the fast pace of change within the health care system; it was important for all engaged parties to show leadership and recognize the need to act synergistically; and establishing and maintaining partnerships required investment of time, energy, and compromise. Absenteeism can also be an issue in senior care facilities, making this study relevant to my work.

In the United States, H. Smith, Hood, Waldman, and V. Smith (2005) were also interested in improving the work environment in health care settings. Smith et al. used a quantitative case study to analyze the practice environment's potential to positively influence nurses' job satisfaction in a large medical center in New Mexico. A survey involving 61 nurses revealed attitudes towards the practice environment, practice environment characteristics, and job outcomes. The findings confirmed the importance

of carefully creating a practice environment that enables nurses to fulfill their expectations.

Research on HWEs in the context of long-term care is particularly relevant to my study. In the next four studies, I present previous research on burnout of nursing assistants, turnover and absenteeism of front-line staff, job satisfaction, organizational context (work environment) characteristics that promote best practice use. In the United States, Long and Long (1998) conducted ethnographic research on turnover and absenteeism of front-line staff, which included nurses' aides, nurses, and nursing managers working in long term care. The researchers found that staff's behaviours were influenced by a recurring "cycle of powerlessness" (p. 17). This was compounded by the staff's level on the organizational hierarchy, i.e., at the bottom of the chart. As well, these researchers found that senior care facilities were places where the residents, not the staff, are valued, a perception that also affected the level of staff absenteeism. My study is closely related to this study; however these researchers examine why staff leave, and I look at an approach (i.e. teamwork) that may make them want to stay.

In Ontario, Canada, a two-part qualitative study conducted by Bookley-Basset et al. (2008) and O'Brien-Pallas, Doran, Laporte, and Hiroz (2009) conducted a two-part qualitative study on job satisfaction for nurses working outside of hospital settings in long-term care. These researchers noted that even though different healthy work environment initiatives had been put in place, no evaluation had been done to determine the effectiveness of these initiatives such as the implementation of BPGs to improve the work environment.

There is also a growing international interest in the relationship between the quality of the work environment for staff and the quality of care for residents in long-term care. The next two studies relate to this topic. Sikorska-Simmons (2006) examined this relationship in 43 assisted living facilities in the United States using self-administered questionnaires to 335 residents and 298 staff members. The research findings indicated greater resident satisfaction was associated with higher staff job satisfaction and more positive staff views of organizational culture (e.g., greater teamwork and participation in decision-making). Similarly, Backhaus et al. (2016) explored the relationship between the quality of staff and the quality of care in Dutch long-term care facilities. In a cross-sectional observational study, data were collected from 55 units to assess aspects of staffing as well as quality of care. The authors concluded that the quality of the team impacts the quality of care. This study alerted me to the impact of the work environment and teamwork on staff and residents in my study; I gleaned from participants that a reflection-in-the mirror effect occurs when residents pick up on the atmosphere among staff around them and display this, whether it be happiness or tension.

Working conditions were also linked to empowerment of staff in a Swedish study on working conditions of eldercare nursing staff. They conducted an evaluation of an intervention program based on empowerment (Petterson, Donnersvard, Lagerstrom & Toomingas, 2006). In this study, researchers conducted an evaluation of an intervention program based on empowerment using a pre-post survey methodology to assess changes in specific measures related to workload, staff resources, health and well-being, health resources, and quality of care before and after an eighteen-month intervention. The

unexpected result was that the intervention positively impacted working conditions and the perceived quality of care provided, rather than staff health and well-being as hypothesized. This finding was helpful to my study as it alerted me to the importance of exploring the topic of staff agency and self-confidence in participant interviews.

Systematic reviews also provided insight into HWEs in health care settings and long-term care conducted in Canada and Australia, respectively. In Canada, Schalk, Bijl, Halfens, Hollands, and Cummings (2010) systematically reviewed the literature on interventions to improve the nursing work environment and their effectiveness. Nine interventions were reviewed for effectiveness in terms of improving the work environment. I was especially interested in the following findings concerning the study components: none of the interventions included a BPG, all but one of the interventions related in part to teamwork, and only three of the studies were conducted in senior care facility settings. However, the authors identified four of the nine interventions as the most effective of those reviewed at improving the working environment in long-term care. These interventions included: (a) primary nursing care, (b) an educational toolbox, (c) individualized patient care, and (d) violence prevention tools. This work is helpful to my study in that it speaks to the importance of interventions to improve the working environment. For example, violence prevention tools could help staff know how to anticipate violence, prevent it if possible, or deal with it safely. This issue is becoming prevalent in long-term care and enhancing staff's knowledge on the topic would be beneficial.

In Australia, another systematic review identified best available evidence related to a healthy work environment and team characteristics in the context of collaborative

practice within nursing teams (Pearson et al., 2006). The implications for teamwork identified by these authors were: the empowerment of staff to develop unit policies; the development of a coordinated multidisciplinary team approach; and the development of measures to monitor specific outcomes of teamwork. The characteristics of teamwork found to promote positive outcomes were: accountability, commitment, enthusiasm, motivation, social support, and effective communication. In their discussion of the implications for future research, and especially relevant to this study, the authors included a recommendation to examine the impact of teamwork on outcomes other than staff satisfaction.

There is also a growing literature in various healthcare settings related to HWEs and leadership styles. The next 12 studies are on leadership styles in relation to HWE. In a European study of nurses' expert opinions in hospitals, Doran, Clarke, Hayes, and Nincic (2014) explored what they called "workplace interventions" (p. 40), which are work environment interventions designed to impact HWE, job satisfaction, and nurse retention. These authors found that both teamwork and leadership interventions promoted a HWE, as well as safety, staff scheduling, and professional development. A study of 540 units of magnet hospitals in the US, Kramer, Maguire, and Brewer (2011) also found that visionary leadership and teamwork/collaboration impact the development and maintenance of HWE. An important finding from their study was nurses' perceptions that the quality of patient care directly correlated with the quality of work environment for staff. Visionary leadership was crucial in creating a quality work environment for staff.

In a meta-analysis that examined leadership practices in hospitals and HWE, Kramer, Schmalenbeg, and Maguire (2011) identified nine essential elements of a HWE. These elements included both intra-disciplinary teamwork and collaboration, and quality leadership at the various levels within hospitals. Other elements included: ongoing education; staff empowerment; patient-centered culture; and appropriate staffing structures. Pearson et al. (2007) conducted a systematic review that identified both teamwork/collaboration and positive leadership attributes that foster and sustain HWEs. These authors identified six other elements that also contribute to creating a HWE and stressed that it is not the implementation of one element but a combination of elements that is conducive to a HWE.

Leadership and HWEs in health care settings have also been areas of increasing interest to researchers in Canada. Cummings et al. (2009) conducted a multidisciplinary systematic review of 53 studies on leadership styles and HWEs in Canada, the US, Europe and Australia. Using content analysis, these researchers categorized 64 outcomes into five categories to understand leadership styles and outcome patterns for the nursing workforce and the work environment. They concluded that relationship-focused leadership practices (rather than task-focused or a dissonant leadership style) contributed to improved workforce outcomes and more effective and productive work environments in health care settings.

Also, and particularly relevant to my study, Cummings et al. (2014) conducted a pilot intervention study with 21 managers who work in long-term care facilities. A two-day "Coaching for Impressive Care" workshop was implemented with the managers with four stated objectives: to identify managers' perceptions of themselves as coaches of

employees; to understand the managers' intentions to coach; to understand the barriers and facilitators to the workshop skills in practice; and to follow up by asking about both the effect on managers and employees after the workshop had been completed. The workshop included topics such as: connect, appreciate, respond, and empower, which highlight the overlapping nature of elements of a HWE such as leadership skills or style and the importance of teams and teamwork in long-term care, again showing how these concepts are interconnected. The conclusion reached from this study was that, "Coaching managers is a practical way to improve staff effectiveness and performance and overall excellence" (p. 206). Also, planning for performance change was a coaching skill that employees used more frequently following the workshop.

Indeed, leadership has also been linked to organizational performance in other studies of long-term care facilities. In a study of 32 senior care facilities in the United States, Scott-Cawiezell et al. (2005) found leadership to be a point of divergence between high and low performing facilities. They stated,

> Leadership must emphasize the value of staff, leadership must design and facilitate effective communication processes and structures, leadership must facilitate the coming together of diverse staff members to form high performing teams, and leadership must be diligent to maintain an internal focus on providing a high standard of care for the residents. (p. 379)

These findings stress the importance of leadership in long-term care facilities, which became an important aspect of my study. The findings also bring into question the educational preparation of nursing leaders who work in elder care and whether or not

they are adequately prepared in terms of current evidence to lead a high performing senior care facility.

The interplay among leadership, communication, and teamwork was also considered in a comparative case study by Vogelsmeier (2008) who examined secondary data from a study in five senior care facilities in the United States. Vogelsmeier found that nursing leadership ranked positively in the high performing facilities and negatively in the low performing facilities, and influenced the environment in which open communication and relationship building occurred. In addition, the presence of teamwork among team members influenced organizational performance, which, in turn, influenced team effectiveness.

Gifford, Davies, Tourangeau, and Lefebre (2011) described a leadership intervention to promote the use of a clinical BPG in home health care. Through the use of interviews and chart audits, the intervention was planned and involved a workshop and teleconferences at two sites involving 15 leaders. They concluded that creating a team leadership plan can promote the use of evidence-based best practices. Similarly, Ploeg, Davies, Edwards, Gifford, and Miller (2007) reported the identified factors that influenced implementation of BPGs (clinical). In a qualitative study involving 22 organizations, these researchers identified facilitators and barriers to BPG implementation. Key facilitators were: education through group interaction, positive attitudes, leadership support, teamwork, external support from professional association, and collaboration between the organizations. Barriers included: negative attitudes, limited adoption of guideline recommendations into policies and practice and time/resource

restraints. The conclusion was to strategically address the barriers to staff, leaders, and senior managers.

Lastly, researchers have also studied the link between a HWE and personal characteristics of leaders in the nursing profession. For example, Shirey (2006) studied authentic leaders in relation to creating healthier work environments for nursing practice in hospitals. She defined authentic leaders as having attributes such as genuineness, trustworthiness, reliability, compassion, and believability. Shirey also articulated a practical guide on how to become an authentic leader in healthcare as well as a research agenda to advance authentic leadership through the disciplines of business administration and nursing. And, Spence Laschinger, Finegan and Wilk (2011) examined the link between the well-being of nurses and the empowered unit leader. In a survey of 3156 Canadian nurses, these researchers found that the perceptions of leader-member exchange positively influenced empowerment of staff, which, in turn, resulted in higher levels of staff nurses' sense of job satisfaction. This research finding is relevant to my study in that the senior care facility has a unit manager and staff reported that their relationship with the unit manager was crucial to their job satisfaction.

The above studies highlight the complexity of the concept of HWEs and the leadership related elements of a HWE identified by previous research. These studies helped me to broaden my view of my research topic and consider the overlapping nature of various components of the long-term care work environment and the importance of considering these together as a part of the whole of a HWE.

In addition to research literature, I also uncovered national reports on HWEs that addressed the following topics: creating professional practice environments, cataloguing

best practices for HWE, creating supportive cultures, and developing recruitment and retention strategies. In 2001, the newly formed Canadian Nursing Advisory Committee established six research projects to look at current strategies for healthy workplaces, the costs of absenteeism and overtime, strategies for addressing workload issues, factors pertaining to nurses' satisfaction, nurses' definitions of respect and autonomy in the workplace, and the structures within which nurses interact with doctors and patients. The outcome of meetings, research projects, and consultations was 51 recommendations grouped into three categories, one of which was to "create professional practice environments that will attract and retain a healthy, committed workforce for the 21st century" (Health Canada, 2002, p. 2).

A second national report identified the need for healthy workplaces in the Canadian healthcare system. The Canadian Healthcare Association (2006) prepared a policy brief that recommended: (a) the establishment of a clearinghouse of information and best practices related to healthy workplaces; (b) the creation of a pan-Canadian strategy to design and implement healthy workplace policies; (c) the establishment of indicators to measure and compare workplace health; and (d) the inclusion of elements of assessing healthy workplaces in the accreditation process (p. 5). Three other national reports were published between 2004 and 2006 looking at creating healthy workplace strategies in healthcare (Canadian Council on Health Services Accreditation, 2006; Government of Canada, 2006; Lowe, 2004).

Based on similar conclusions, these reports offered similar recommendations: create supportive cultures, establish strong leadership, develop a plan that is connected to

a strategic plan, use EBP, and monitor and measure progress; however, there is little evidence that progress has been made in addressing these issues.

International reports have also focused on HWEs. In 2010, the World Health Organization presented a policy brief titled, "How to Create an Attractive and Supportive Working Environment for Health Professionals" (Wiskow, Albreht, & de Pietro, 2010). The authors' position in this document is that poor work environments compromise health-workforce supply and quality of patient care; and healthy work environments provide an incentive for the recruitment and retention of health workers. The authors linked HWEs with quality of care:

> Supportive work environments provide conditions that enable health workers to perform effectively, making best use of their knowledge, skills, and competencies and the available resources in order to provide high-quality health services. This is the interface of the work environment and quality of care. (p. 5)

These authors divide the quality of the work environment into two dimensions: employment quality and work quality. Under work quality, they identify the following elements: work autonomy; work organization; organizational culture; trust; safety and health; pace of work; and social work environment (p. 6). Based on these identified dimensions, the authors make recommendations to improve health sector work environments.

A second publication by WHO proposed a framework and model to create healthier work environment across various settings on the healthcare continuum and throughout the world (Burton, 2010). The model was based on four avenues of influence: the physical work environment, personal health resources, psychosocial work environment, and community involvement. In addition to these avenues of influence, process steps were identified such as assessment, planning, and improving the work

environment. The core principles of the model included worker involvement in the process steps and leadership engagement.

In summary, the previous literature on HWEs is varied and relates to topics such as: costs related to unhealthy work environments; strategies to create healthier work environments, for example, use of a teamwork approach; approaches to improving organizational outcomes; the link between the practice environment and job satisfaction and retention of staff in long-term care. The studies reviewed linked leadership styles and work environment, which added knowledge to my topic, broadened my mindset, highlighted the interdependent multidimensional nature of HWE. The link established in previous literature between quality of work environments for staff and the quality of care for residents speaks to the relevance of my study and the importance of efforts to improve the conditions of work and ultimately, the conditions of care. I could not find any studies relating to HWE research in senior care facilities.

Research on Teamwork

My study involves the implementation of a RNAO BPG on teamwork in a long-term care facility in New Brunswick, Canada. I confined my search for articles on teamwork mainly to the disciplines of business administration, sociology, and nursing as literature from these fields of study is most applicable to my interdisciplinary research topic. I begin with a brief overview of relevant literature on teamwork in business administration and sociology, and follow with a more detailed account of research on teamwork and nursing generally, and long-term care specifically.

Business Administration brings an important disciplinary perspective to understanding teamwork and the next two studies reflect this disciplinary perspective. In

a study involving more than 50 teams in 30 companies in the US, Katzenbach and Smith (2003) provided systematic guidance for team development, starting with what makes a team perform as compared to what hinders team performance. In summary, they said to think of a team as encompassing "discrete units of performance rather than just positive sets of values" (p. 11). They elaborated by saying that good intentions alone do not make a team. In their view, the essence of a team is a "common commitment" (p. 12), agreement on a common purpose translated into performance goals, and a focus on results. They advised that it is important to have the right size team with the right mix of skills.

Also working in Business Administration, Caldwell, Truong, Linh, and Tuan (2011) focused more on the link between leadership style and teamwork, especially the importance of transformational leadership as a source of strategic competitive advantage. They said, "Unlocking employee potential makes a key difference" (p. 178), and emphasized the importance of empowering teams to maximize productivity. I noted how the language in the discipline of business is different from that of nursing. For instance, Caldwell et al., focused on three main themes advantageous to teamwork: help the organization create increased wealth, achieve desired organizational outcomes, and establish work environments that are more satisfying to employees. The first two of these themes would 'fit' better with privatized long-term care facilities; the second and third could fit within provincially run long-term care facilities by viewing them as a way to help the organization achieve its goals including resident satisfaction.

The above two studies inform my work in important ways. The work by Katzenbach and Smith (2003) is cited widely in the literature on this topic and identified

the basic elements of teams and teamwork based on their experience in studying teamwork in organizations and working with organizations to improve teamwork. Their definition of teams informed my interview questions on teamwork. Caldwell et al. (2011) emphasized the value employees can have when managers listen to them and "unlock their potential". I looked for this in my own study setting.

Sociology also provides a lens through which we can view teamwork in senior care facilities. In a key study from a sociological perspective, Gubrium (1997) looked at the social organization of care in one US senior care facility. Amongst other findings, he characterized the various 'worlds' of people in a senior care facility (residents, staff, managers, etc.), and the 'places' in which these worlds exist (offices, rooms, lounges, and nursing stations) as isolating factors in the operations of the senior care facility. In relations to 'worlds', he stated, "each world provides its participants with a way of looking at and understanding daily life at the manor" (p. 37). For Gubrium, the challenge for senior care facilities lies in integrating the various worlds to work as a team and to better serve residents. This would mean breaking down, overlapping, blending, or interweaving 'worlds' and 'places' to enhance teamwork and improve the work environment. I was attentive to both "worlds" and "places" when I entered the study setting.

In the next section, I present literature on various types of teams in healthcare settings such as self-organizing teams, daily practice teams/unit-based teams, free-flowing teams, and self-managed teams.

From the discipline of Nursing and related to types of teams and teamwork, Anderson et al. (2005) examined relationship patterns necessary for what they termed

"self-organization" in senior care facilities in the US. These authors state, "Self-organization occurs when people are free to interact, exchange information, and adjust behavior to meet the immediate demands of the environment" (p. 104). They identified three critical components of self-organization in senior care facilities: appropriate information flow, good connections among team members, and sufficient cognitive diversity among the team members. The authors also pointed out that if relationships among the people working together as a team are based on self-organization, rules for staff are not always necessary. Anderson et al., (2005) argue that an over-reliance on rules has been problematic in senior care facilities and they propose a list of evidence-based management practices to improve the situation. These include: less rule enforcement, more open communication, empowerment of staff, relationship-focused management behaviours, and better collaboration between staff and management.

Alternatively, Tempkin-Greener, Cai, Katz, Zhao, and Mukamel, (2009) focused on the prevalence of daily practice teams which are unit teams and the characteristics of facilities that foster such teams. The study involved 149 senior care facilities in the United States; data were collected from 292 administrators and 6867 direct care staff. Of particular interest to my study, the senior care facility administrators reported a high prevalence of teams (more than 70%), whereas based on employee surveys, just 5% of direct care staff perceived that they worked in daily practice teams. Most importantly, these researchers found that higher team penetration was associated with three factors: management perceptions of team importance in providing quality care, staff participation in other functional teams (care planning), and higher staffing ratios.

Cohen, Ptaskiewicz, and Mipos (2010) define unit-based teams as "natural working groups who work collaboratively to solve problems, improve performance, and enhance quality for measurable results" (p. 1). In describing how unit-based teams work, these authors stated that unit-based teams align the work of the unit with goals, mission, vision and strategies of the organization. In their study, Cohen et al. found that understanding the roles of all team members was vital to the success of unit-based teams, and education sessions on problem solving and brainstorming were valuable. Similarly, Grimm and August (2011) reported that using unit-based teams increased employee engagement and performance in a healthcare setting. These authors stated that the unit-based team included all members of the natural work group and the focus was to transform working relationships and in doing so improve performance. Other scholars have focused on learning across teams and have discussed the sharing of unit-based teams' knowledge through a "double-knit" approach (McDermott, 1998). McDermott believes in shared learning across teams within organizations using communities of practice that facilitates sharing of knowledge and standardizing practices, hence the "double-knit" approach meaning to combine knowledge and share among all organization teams.

Although I was unable to find any applicable research article concerning teamwork and dementia care in senior care facilities, I did find a concept paper on this topic (Slone, Prather, Robinson, & Olin, 1996) that was helpful for my study. Using specific cases, these authors argued that a special "free-flowing" teamwork is required for dementia care. In each case, staff members gleaned insight into how to work best with specific dementia residents, including how to use certain techniques to distract residents;

however, they determined that staff members did not necessarily share their 'secret solutions' with their co-workers. Beyond this, they concluded that effective teamwork with dementia care residents required recognition of the importance of maintaining staff morale.

More recently, a relatively new concept of self-managed or self-organized teams is being studied and reported in the research literature. Hoda, Noble, and Marshall (2010) describe self-organized teams as being composed of individuals that "manage their own workload and shift work among themselves based on need and best fit, and participate in team decision making" (p. 2). In a study of how self-managed teams in 14 different software development organizations in New Zealand managed themselves, Hoda et al. identified six roles adopted by self-managed teams: mentor, coordinator, translator, champion, promoter, and terminator.

Yeatts and Seward (2000) described the potential effects of self-managed teams (SMWT) on health care delivery and staff turnover in a senior care facility, in Wisconsin, USA. These researchers found that changing workplace culture from authoritarian to a teamwork environment, i.e., implementing SMWT was difficult. They found that education and facilitation were important. Their findings pointed to the positive effects of SMWT such as improving resident care and increased participation in decision-making, which, in turn, related to increased job satisfaction. However, the researchers were cautionary in stating, "Additional rigorous testing is needed to substantiate or refute these initial conclusions" (p. 22). In a follow-up study, Yeatts and Cready (2007) found that teamwork had modest effects such as increased empowerment, better performance, and improved coordination and collaboration.

In contrast, Langfred (2007) in a longitudinal study of 35 self-managing teams in the field of business in the US, explored the downside of self-management. He contended that self-managing teams could become dysfunctional when they face conflict, and team members are not always good at managing themselves. He also found the flexibility and adaptability of self-managing teams to be limiting factors.

The above studies all look at various types of teams. The studies were informative in relation to my study as they prompted a comparison between types of teams being discussed in the literature and in my study. Some described teams similar to the one in my study, a unit-based team. Others described teams that have characteristics that are valuable to consider such as self-management approaches that could be applied to unit-based teams. Next I present literature on measures of team effectiveness and the characteristics of effective and ineffective teams.

Tempkin-Greener, Gross, Kunitz and Mukamel (2004) evaluated the validity of a survey instrument that assessed interdisciplinary team performance in long-term care facilities in the United States. The measures of team effectiveness included: leadership, coordination, communication, conflict management, and team cohesion. The results indicated a good to high reliability for all measures of team effectiveness. Also, in an exploratory study of the experiences and perceptions of 12 registered nurses regarding teamwork in five senior care facilities in England, Wicke, Coppin and Payne (2004) found communication to be a measure of team effectiveness. Many participants reported that achieving good teamwork was difficult due to inadequate communication between shifts and between full-time and part-time staff. Management was perceived as remote.

Although this group of nurses aspired to a goal of teamwork, the authors concluded that barriers related to organizational culture had to be overcome first.

A more recent study conducted by Norwegian researchers, looked at forty senior care facility units and analyzed how teams operated and their effect on the quality of care provided (Havig, Skogstad, Veenstra, & Romeran, 2013). They found that functional teams are related to higher levels of quality care in senior care facilities. The two contributing factors to effective teams in their view were membership stability and main tasks being completed at the unit level but not at the larger ward level.

In the Netherlands, Buljac, Van Woerkom, and Van Wijngaarden (2013) studied whether or not "real teams" in the long-term care sector are healthy teams. They defined "real teams" as teams with team boundaries and stability of membership. Based on results from a longitudinal survey, they found that teamwork leads to better outcomes in long-term care settings if teamwork involves more stability of membership and clarified team boundaries. Task interdependence was found to be detrimental and therefore is not included in the authors' definition of "real teams".

Shortell et al. (2004) studied team effectiveness in hospital care in the United States. In their study, patient satisfaction, the presence of a team champion, and involvement of a physician on the team were associated with greater team effectiveness. They also concluded that team size makes a difference: larger teams make it more difficult to develop effective teams and have issues of cost, coordination, and conflict. However, the authors also noted smaller teams can lack diversity, experience, and sufficient source of ideas and skills to get the job done. The key message from this study

is that team size needs to be managed carefully, a factor that I was attentive to in my study.

In another study of team effectiveness in hospital settings in the United States, Kramer, Maguire, and Brewer (2011) studied magnet hospitals in the US. They were interested in effective teamwork and the extent to which the working environment in magnet hospitals was healthy. They concluded that promoting teamwork and collaboration positively affect the development of HWEs.

The literature on team effectiveness also considered deficiencies in teamwork. In Sweden, Ericson-Lidman and Strandberg (2015) used a participatory research design to explore the "troubled conscience" of staff working in long-term care. The researchers found that challenging situations for staff in the provision of care in senior residential facilities can come from the burden of carrying stress on one's conscience. They concluded that a participatory approach to problem solving allowed staff members to deal constructively with issues and concerns relating to teamwork. In essence, the authors are saying that having a "troubled conscience" can be a driving force for team effectiveness and the enhancement of care.

The above studies on elements of team effectiveness provide relevant evidence-based knowledge for my study. In a review of documentation and throughout the interview process, I was attentive to measures of team effectiveness, especially looking for signs of stress on staff and how they dealt with that. The studies informed my thinking and my research methodology.

I conclude this section on teamwork literature with two studies, the first raises concerns about staff empowerment and the second links teamwork to organizational

culture. Cott (1997) studied the relationship patterns that developed among staff as they worked in a senior care facility in Ontario, Canada. A self-administered survey was used with 93 health care workers on three teams. Using a social network analysis approach, Cott concluded that while teamwork may be enhancing the decision-making by health professionals, its effects are minimal and are limited to a group of higher status professionals (RNs and managers) and not the lower level sub-disciplines (aides and assistants). She stated that the phrase, "I decide, you carry it out" has merely changed to," We decide, you carry it out" (p. 1419). Both Cott and Anderson et al. (2005) suggest that senior care facility staff are not empowered to carry out their work in a way that makes sense to them, therefore, management practices need to change.

Tyler and Parker (2011) studied the link between organizational culture and teamwork in twenty long-term care facilities in the United States. They presented their findings of teamwork elements in a table, according to their observations of "high teamwork" and "low teamwork" in senior care facilities. For high performing facilities, the elements included members: working interdependently, coordinating their actions, exchanging information, interacting dynamically, and working towards a common goal. Conversely, for low teamwork facilities the results showed a lack of those elements. Results showed that a high amount of teamwork was associated with positive attitudes among employees regarding their co-workers. In contrast, in low teamwork facilities, both managers and direct care staff spoke negatively about their co-workers. The authors concluded that teamwork was associated with organizational culture and the modeling of positive cultural values and attitudes by managers was important.

The structure and meaning of interdisciplinary teams in senior care facilities is another area of research study. Cott (1998) interviewed 26 staff working on five multidisciplinary teams in one long-term care facility in Ontario, Canada. She found that staff in different parts of the organizational structure had differing understandings about the meaning of teamwork. Direct nursing care staff had set roles, little involvement in team decision-making, and a ritualistic way of going about their work. In contrast, other professionals had complex roles and greater involvement in teamwork. Supervisory nurses had one foot in each of these structural positions and therefore shared aspects of both orientations. Cott concluded that this disconnect negatively affected the organization and resulted in alienation of front-line staff.

In summary, the literature surrounding teamwork in senior care facilities is limited. The literature that does exist provided valuable insights into attributes of effective teams and various teamwork models applicable to senior care facilities. Attributes of an effective team relevant to this study included: embracing a common commitment, unlocking employee potential, the relaxation of rules and regulations, sharing decision making, establishing smaller teams, promoting positive attitudes, and recognizing the importance of flexible leadership. My search also revealed different models of teamwork, including a unit-based team, which is neither a self-managed team nor one formed by someone else. This type of team most closely reflects the team in the setting for this research study.

Research on HWE BPGs

Very little is known about the implementation of RNAO HWE BPGs on teamwork in senior care facilities. In this section, I describe the only published study I

have been able to find that specifically explores RNAO HWE BPGs. I then look at three studies relating to promising practices in long-term care and the relationships between promising practices, context and organizational characteristics. Finally, I present a recent Canadian study that examines work environment factors and BPG implementation by care aides. Because of the scarcity of studies on the implementation of RNAO HWE BPGs, some literature on evidence-based practice and best practices has been included.

One study was retrieved on implementing RNAO HWE BPG (O'Brien-Pallas & White, 2010). This study, based in Ontario, Canada, assessed the uptake of six foundational RNAO HWE BPGs including *Collaborative Practice Among Nursing Teams* (2006) in hospitals, community care agencies, and mental health agencies. In relation to teams and teamwork, the researchers reported that implementation of the RNAO HWE BPGs on teamwork had a positive impact on nursing teams and helped teams with team relations, workplace norms, staffing, communication styles, and team culture. The authors stated, "Nurses reported that implementing the HWE BPGs improved the quality of their nursing practice, the quality of their nursing work environments, and patient outcomes in their nursing work setting" (p .3). This was the only study I could find on the implementation of RNAO HWE BPGs and I was unable to find any studies of RNAO HWE BPGs in relation to senior care facilities.

However, other relevant and important studies have looked at BPGs in healthcare. This work includes studies on context (work environment) and best practice use and paths to spread best practices in Canada.

Cummings, Estabrooks, Midodzi, Wallin, and Hayduk (2007) were interested in context and the influence of organizational characteristics on research utilization,

evidence-based practice or best practices in acute care settings in Canada. The objective of the study was to test a model of research utilization and to assess the influence of context by using the framework, *Promoting Action Research in Health Services* (PARIHS). The hospital characteristics that positively influenced the use of research were staff development, nurse-to-nurse collaboration, and staffing/support services. The recommendations most relevant for my work stated, "future research is needed to (a) establish a consistent set of contextual measures to compare across a variety of healthcare settings, (b) measure research utilization related to implementation practices, and (c) examine context as a covariate to determine modifiable contextual factors" (p. s38). These findings are consistent with my observations of the specific unique characteristics of senior care facilities and the case for contextual practices.

A more recent study of work environments in senior care facilities in Canada, Estabrooks, Knopp-Sihota, Cummings, and Norton (2016) found that more favourable contexts or work environments in long-term care facilities reported higher use of best practices. Prior to this, a study of the use of best practices by care aides in long-term care settings (Estabrooks et al., 2015) involved 25 nursing homes in 3 Western Canadian provinces, and included 1262 care aide participants. The authors found that the specific work environment or context played a significant role in whether or not care aides implemented best practices in long-term care settings. Individual factors were found to be the prominent predictors of best practice use including: "age, sex, highest education, English as first language, time worked on unit, shift worked, exhaustion, cynicism, efficacy, job satisfaction, physical health status, mental health status, attitude towards research, belief suspension, intent to use research, information sources, and adequate

knowledge" (p. 537e4). At the unit level, the author identified social capital as a factor influencing best practice use.

Another recent study of best practices in senior care looked at, "Pathways for best practice diffusion: The structure of informal relationships in Canada's long-term care sector" (Dearing et al., 2017). This study involved a survey of senior leaders in 958 long-term care facilities regarding informal relationships among similar facilities across the country. The authors concluded that an informal advice-seeking network exists in the long-term care sector in Canada, and this network may provide a route to effectively implement evidence-based practice with the goal of improving resident care nationwide.

As well as studies related to best practices, I found a study that addressed "promising practices" in health care. Specifically related to long-term care, Sociologist Patricia Armstrong (2010) along with a team of interdisciplinary international researchers was awarded funding through the Social Science and Humanities Research Council of Canada (SSHRC) for a major collaborative study entitled, *Re-Imagining Long Term Residential Care: An International Study of Promising Practices*. This study examines new international practices for organizing long-term residential care. The goal of the research is to identify promising practices that ensure that residents and staff are treated with respect and dignity. Notably, Armstrong makes a distinction between the terms "best practices" and "promising practices" when she states:

> We prefer 'promising practices' to the more common 'best practices' because we begin with the assumptions that the issues are complex, that care involves relationships, and that the context and social locations as well as the individual needs and preferences matter, making it neither possible nor desirable to find a single, right way. (p. 11)

Armstrong's work supports the premise that "promising practices" are related to the context within which they occur. Equally interesting is that whereas most studies of best practices tend to document problems with residents or staff, Armstrong's project focuses on both the residents and staff and improving the care environment for both. Armstrong's stated premise, "the conditions of work are the conditions of care" (p. 12) resonates with my work and is reflected in the title of my dissertation. This research is ongoing and has not yet been published.

In summary, through previous research presented in this section, I discovered that researchers share my own interest in healthy work environment best practices or promising practices in long-term care. However, there is limited previous literature on the implementation of RNAO HWE BPGs generally and teamwork specifically, which indicates a need to enhance knowledge in this growing and important field. The knowledge that has been generated by other researchers, especially work in Canada relating to work environment factors and best practice use in long term care (e.g. Estabrooks et al., 2015) has been invaluable to my understanding of workplace culture in elder care. As well, knowing that an international study led by a Canadian researcher is focusing on promising practices in long-term care and re-imagining long-term care for the future (Armstrong, 2010) speaks to the timeliness and relevance of my study. The area of HWE BPGs is an area that is under-researched and therefore a gap exists currently.

Relevance of the Present Study

The present research study is important and timely. The critical impact of work environments in addressing the urgent need for recruitment and retention of staff working in health care is well documented (Dunleavy, Shamian, & Thompson, 2003; Grinspun, 2006; Shindul- Rothschild, 1994). There is already competition for staff among acute care, community care, and senior care facilities in New Brunswick (Daily Gleaner, 2017). Consequently, to recruit and retain staff, senior care facilities need to differentiate themselves as a preferred work environment. Understanding the role that the work environment plays in recruitment and retention of staff is crucial to organizational performance (Castle & Engberg, 2007). The potential staff shortage and the link between recruitment and the conditions of work environments in long-term care speak to the timeliness of this study.

There are other compelling reasons why this study is timely and relevant. In most regions of Canada, senior care facilities are the housing and care delivery model for increasing numbers of frail elderly citizens. Grinspun (2006) stated that building healthy work environments is central to insuring quality patient care. Estabrooks, Midodzi, Cummings, Ricker, and Giovannetti (2005) supported Grinspun's comments in a study linking healthy work environments for staff to better outcomes for recipients of care. The researchers found that nursing characteristics such as higher nurse education level, richer nurse skill mix, and better relationships between nurses and physicians reduced the mortality of patients. Equally important is the direct relationship between staff satisfaction and quality resident outcomes (Dugan et al., 1996). Also, in a recent study of unregulated workers in long-term care facilities, Estabrooks, Squires, Carleton,

Cummings, and Norton (2015) found work environment characteristics that affect care aides can result in burnout which has an effect on quality of resident care, staff health, and staff retention.

The work of developing and implementing RNAO HWE BPGs has spanned more than a decade. There has been a significant ongoing investment of human and financial resources to develop and implement RNAO HWE BPGs especially in Ontario and Saskatchewan. RNAO's HWE BPGs have been introduced in China, Japan, and Italy, and have been translated into French, Japanese, Spanish, Italian, and Chinese (RNAO, 2011). Yet little is known about the impact of RNAO's HWE BPGs, especially on management, staff, family members, and residents in senior care facilities.

Although RNAO BPGs have been developed to support teamwork and enhance the work environment in senior care, little is known about the impact these guidelines have on long-term care facilities. Holmes et al. (2008) stated, "To date there have been very few studies, if any, that fairly evaluate the implementation of BPGs" (p. 400). My study begins to fill an identified gap in the literature about the use of a RNAO HWE BPGs on teamwork in a senior care facility setting.

Chapter Summary

In this chapter, I have situated my work in the fields of elder care research, knowledge utilization, and implementation science. I have also located my research in previous research on teamwork, healthy work environments, and RNAO HWE BPGs in senior care facilities. Research on elder care revealed topics on dementia care that pertain to my study such as dealing with aggression, care mapping, and behavioural

interventions. In relation to the previous literature on knowledge utilization, I learned about a large national study that linked work environment factors to best practice use which is helpful to me in my research as specific work environment factors that are modifiable are identified. Other knowledge utilization work indicated that senior care environments are complex and work environment factors can be changed to improve resident care. I reviewed studies related to implementation science and learned that frameworks and processes exist for implementing EBP, something that was new to me. Helpful to me was the idea that outcomes need to be measured outside of the specific program used to implement them.

In relation to previous research literature on HWE, it is comprised of studies about the costs related to unhealthy work environments such as absenteeism, safety concerns and injuries, and increased psychological strain. Other issues related to relationships and power were identified in the literature such as lack of trust, insufficient empowerment, and perceived powerlessness, all things to be mindful of in exploring my own topic.

Strategies to create healthier work environments, including use of a teamwork approach, approaches to improving organizational outcomes, the link between the practice environment, job satisfaction, and impact on residents, as well as the retention of staff in long-term care were studied in previous literature. As I have shown, the literature surrounding teamwork in senior care facilities is limited. The literature that does exist provided valuable insights into attributes of effective teams and various teamwork models applicable to senior care facilities.

My search also revealed different models of teamwork, including a unit-based team, which is neither a self-managed team nor one formed by someone else. This type of team most closely reflects the team in the setting for this research study. Insights on teamwork from the business administration, sociology, and nursing literature pointed to psychological, physical, behavioural, and organizational strains in work environments. This literature base has been valuable to my study and cues were added to the interview guide to explore each of these areas of the long-term care work environment. Previous research on team building, making the work environment more satisfying for employees, and leveraging employees as the source of improved productivity was helpful to my study. Specifically, it helped me to recognize what the team on this senior care facility unit had accomplished throughout the BPG implementation.

The section on HWE BPGs is short, indicating a scarcity of previous literature on this topic. I highlighted the one known study conducted on RNAO HWE BPGS that provides information on the uptake of BPG recommendations in practice. I reviewed studies about promising practices in long-term care and the work environment context and organizational characteristics. Finally, I presented the most recent work on this topic, a large Canadian study that looked at work environment factors and best practice use in long-term care. The scarcity of previous research on HWE BPG implementation in senior care facilities speaks to the relevance of the present study.

Relevant insights from the literature alerted me to look for important links between the concepts of HWE, teamwork, and EBP, and the creation of caring and quality work environments, as well as positive practice caring, quality, positive practice, empowerment, recruitment, and retention. In contrast, previous research also alerted me

to concerns about teamwork such as a lack of information for managers on work environments, lack of staff empowerment, increasing complexity of care, increased workload for staff, shortages of staff, and authoritarian management approaches. These issues were all potentially relevant to my study and were probed during the interviews.

In this chapter, I have also illuminated gaps in research on HWE and critiques of BPGs. Three significant gaps in knowledge are apparent in the literature related to HWE BPGs: (a) no known studies have reported outcomes related to implementing a RNAO HWE BPG in a senior care facility setting; (b) no known studies have determined that BPGs are normative or non-normative in senior care facilities; and (c) no known studies have examined the contextualization of RNAO HWE BPGs in senior care facilities. These gaps in the literature alerted me to issues that would inform this present study.

In Chapter 3, I explain my epistemology and theoretical perspective, and focus specifically on the methodology and methods that I followed to gather qualitative information for this study.

CHAPTER THREE

Methodology and Methods

The purpose of this study was to gain an understanding of the impact of introducing an evidence-based BPG on staff teamwork, the work environment, and the care provided to residents in a dementia care unit of a senior care facility in New Brunswick, Canada.

In this chapter, I begin by making connections between epistemology, theoretical perspective, methodology, and methods applicable to my study. I then define and describe the selected methodology, focused ethnography, and the methods used for data collection and analysis. I conclude with a discussion of the ethical considerations of my study.

Linking Epistemology, Theoretical Perspective, Methodology, and Methods

Crotty (1998) identified a relationship between epistemologies, theoretical perspectives, methodologies, and methods, which I have used as guide for this study. Crotty stated:

> Methods are the techniques or procedures used to gather and analyze data related to some research question or hypothesis. Methodology is the strategy, plan of action, process or design lying behind the choice and use of methods and linking the choice and use of methods to the desired outcome. Theoretical perspective is the philosophical stance informing the methodology and thus providing a context for the process and grounding of its logic and criteria. Epistemology is the theory of knowledge embedded in the theoretical perspective and thereby in the methodology. (p. 3)

My epistemology aligns with subjectivism, which is defined as a philosophical tradition opposing objectivism, i.e., "supplying an alternative account in which human experience and understanding instead of objective truth occupies central stage" (Johnson & Lakoff, 1980, p. 9). This view aligns with my perception of the nature of knowledge and how it is created. It is also consistent with an interpretivist theoretical perspective, which looks for, "culturally derived and historically situated" (Crotty, 1998, p. 67) experiences of self and others. This view of knowledge necessitates a qualitative methodology.

My study fits with the eight characteristics of qualitative research identified by Creswell (2009). First, qualitative research occurs in natural settings; this study occurred in a place of work, i.e., a natural setting for the staff who work there. Second, the researcher is the key instrument in the study: I asked questions, observed the setting, and took careful notes. Third, there are multiple possible sources of data: I used in-depth interviews and reviewed pertinent documentation and journal notes. Fourth, qualitative research is inductive; I started with raw data and moved to abstraction and conceptualization using thematic analysis. Fifth, the search is for participants' meanings; I constructed meanings through data analysis. Sixth, the design is emergent; I was aware of this and made changes as required as the study was underway. Seventh, qualitative research is interpretivist; I sought understandings, meanings, and experiences attached to evidence-based practice, teamwork, and resident care. Eighth, I am presenting a holistic picture of the issue under study in this dissertation and in future publications, reports, and presentations of the findings.

Focused Ethnography

Focused ethnography is the specific methodology I selected for this study. It is derived from ethnography, which is a qualitative methodology that has evolved from cultural anthropology (Boyle, 1994). The word ethnography is derived from *ethno* (folk) and *graphy* (description), meaning a description of the people (Boyle, 1994). In the early years, ethnography was used mainly to study cultural groups, "by physical association with the people in their setting for an extensive period of fieldwork" (Germain, 1986, p. 147). Morse (1991) suggested that focused ethnography is an appropriate methodology to explore, "topic-oriented, small group ethnographies found in nursing" (p. 172).

Focused ethnography has been defined as an inquiry that is related to a social unit or processes within a small group that help us understand "the cultural rules, norms and values and how they are related to health and illness behaviors" (Morse, 1994, p. 172). In this study, the participants are linked by a common site or environment, i.e., the unit within the senior care facility. Morse and Field (1995) stated five important aspects of focused ethnography that resonated with my study:

1. The research topic is selected before data collection begins, unlike traditional ethnography where the specific topic emerges from data collection and analysis.
2. The participants are linked by a common site, which may be a workplace.
3. Common data collection techniques include interviews, field notes, documentation review, observation, and documenting everyday events.
4. Description of the context in which the behavior occurs is a critical dimension of an ethnographic study.
5. Data collection and analysis occur concurrently.(p. 155)

Further, Morse and Richards (2002) stated that focused ethnography, "is used primarily to elicit information on a special topic or shared experience" (p. 53). In my study, the

shared experience was the implementation of a HWE BPG to improve teamwork and the working environment on the unit. Morse and Richards also maintained that researchers do not need to utilize all the strategies when collecting data. For instance, they could use interviewing as their main strategy, which I did, without conducting a fieldwork component.

Specifically, focused ethnography allowed me to understand the interrelationship between people and their environments. Cruz and Higginbottom (2013) enabled me to understand beliefs, values, behaviours, and historically grounded social practices (implicit and explicit) embedded in participants' everyday work lives and facilitated my understanding of the topic from an insider or emic perspective (Morse & Richards, 2002).

Methods

I used three methods of qualitative data collection: (a) I reviewed pertinent documentation, including records of unit team meetings, the BPG booklet, and documented process improvements; (b) I kept a written journal (perceptions, thoughts, feelings, insights after each visit, after interviews, and whenever I thought of something in relation to my study that could be important) and referred to my journal notes during the coding process and while I was analyzing my findings; and (c) I conducted qualitative, in-depth, open-ended interviews with participants. The process for conducting the interviews followed several steps. I:

1. Developed an interview guide (Appendix A).
2. Identified potential participants.
3. Provided a letter of information about the study (Appendix B).

4. Obtained participant consent (Appendices C & D).
5. Scheduled the interviews in a suitable location and allowed enough time to complete.

Prior to conducting each interview, I expressed appreciation to each participant for participating, reminded participants of my name, and restated the purpose of the interview. I also assured participants of confidentiality, informed consent, and explained how they could withdraw at any time without penalty. In addition, I explained the duration of the interview, how it would be conducted, and sought the participants' permission to tape and transcribe the interviews. After the interviews, I also thanked the participants and advised them that the findings of the research would be made available to them at the conclusion of the study.

Selection of research participants.

In selecting participants for my study, I used purposive sampling (Higginbottom, Pillay, & Boadu, 2013), which involves inviting participants who have specific knowledge relevant to the study. For this, I relied on the recommendations of the Director of Operations for the study site. This involved developing a necessary trust between myself, as the researcher, and the Director of Operations. I explained to the Director of Operations the type of knowledge and experience people should have to participate in the interview process. I asked the Director to provide my letter of invitation to potential participants (Appendix B); the letter asked them to contact me directly if they were willing to participate.

The potential sample included managers, staff, and family members from the dementia care unit who were involved in implementing the BPG in their work environment. In terms of inclusion criteria, all participants who had either direct or indirect knowledge of the BPG implementation process and its outcomes within the unit could potentially be involved in the study. However, only English-speaking participants who signed an informed consent form and who were affiliated with the specific senior care facility were invited to participate. No residents were asked to take part in the study. I did not request a specific number of participants rather I specified a sample that would be representative of the unit team that was involved in and knowledgeable about the implementation of the BPG. As this is a qualitative study, having more people or higher numbers of each category of staff was not my goal. Rather having the right people who held knowledge about my topic was my priority.

I recruited 12 participants for the study. All participants had been involved in implementing the BPG on the dementia care unit. Based on the breadth, depth, and richness of data received, the group recruited was a satisfactory sample of the population, i.e., staff, managers, and family members associated with the dementia care unit.

In-depth interviewing.

I developed an interview guide (Appendix A) and used this to conduct in-depth open-ended interviews with the research participants. The format for the interview was adapted from Van den Hoonaard (2012). The content of the interview questions was derived from previous literature on the topics under exploration and was designed to ask questions that would assist in answering the research questions. The interview guide was not piloted but was presented to Graduate Advisory Committee Members for review at

Oral Presentation of my research proposal. The interviews were held in a quiet office during daytime working hours, separate from the unit under study. Some interviews were slightly longer than one hour and some were slightly less, however, most lasted one hour. I followed the interview guide as planned, and I taped and transcribed the interviews verbatim.

In her book *Qualitative Research in Action: A Canadian Primer,* van den Hoonaard (2012) compares the qualitative in-depth interview with the standardized survey type interview stating that the latter is limited and, "can only provide a rough sketch of the respondents' true situation and they cannot uncover any unexpected data" (p. 76). According to van den Hoonaard (2012), the purpose of in-depth interviewing is, "to allow people to explain their experiences, attitudes, feelings, and definitions of the situation in their own terms and ways that are meaningful to them" (p. 78). van den Hoonaard expanded on this by distinguishing in-depth interviews from normal conversation in three ways: the interviewer must keep the discussion focused on the topic; the talking should be done mainly by the participant and the listening by the researcher; and the researcher must listen carefully in preparation for probes that may be needed. Besides listening to what was said, I was observant of how things were said and watched for non-verbal cues during the interviews.

Data analysis.

In qualitative research, the process of data analysis means making sense out of text or images, rather than numbers as is the case in quantitative research. I followed Creswell's (2009) six step process of thematic data analysis in qualitative research:

1. Organize and prepare raw data for analysis (transcribe interviews, list documents, etc.);

2. Read all data to get a general sense of the content and meaning;
3. Organize data by coding it or labeling it often with terms spoken by participants;
4. Use coding to generate a description of the setting, people, and themes for analysis;
5. Use narrative to interrelate themes and convey findings; and
6. Make an interpretation of the data. (p. 151-152)

I was also guided by Saldana's (2016) text, *The Coding Manual for Qualitative Researchers*. Saldana's explanation of how codes translate data and assign meaning to them, allowing researchers to further organize data at a conceptual level, was helpful to me. Thinking about the data continually and working with it enabled me to see the patterns that were occurring within the data. In addition, I followed van den Hoonaard's (2012) advice and opted to use a word processing program to manage the data rather than a specific data management program. For van den Hoonaard, using a word processing program to manage data ensures the researcher does the conceptual work required; she suggested that this is a good thing for new researchers to do.

My data analysis proceeded as follows: I transcribed the audio-taped interviews over a period of seven weeks. This was an intense and time-consuming process, however, it enabled me to become closer to the data by reading and hearing it repeatedly. While reading the transcripts, I jotted a single code word beside a paragraph; this was the first level of data coding. Instead of coding everything, I followed Saldana's (2016) advice "to code what rises to the surface" (p. 18). In other words, I looked for what was relevant text in the data and coded it. Then I read all the data again and again, adding more single word codes as I was reading. I then organized the codes into categories and worked towards finding prominent themes. Saldana identified a theme as, "an extended phrase or sentence that identifies what a unit of data

is about and/or what it means" (p. 199). This step took the longest and resulted in my recoding and reorganizing categories.

Besides coding transcribed interviews, I also coded my journal entries, and I reviewed and took notes on the documents the facility provided to me for review. Again, guided by Creswell (2009) and Saldana (2016), I followed a similar approach to coding the documents as I had done with the interview transcripts, and this qualitative information contributed to my thematic analysis.

Eventually, using the participants' own words, I constructed four themes: (1) Teamwork in a senior care facility setting: "If you work on the unit, you are part of the team"; (2) Teamwork contextualized: "Making it work for us"; (3) Impact of teamwork on team members: "We are here for the residents"; and (4) The work of sustaining teamwork: "We are working together like a team now".

Rigor

Attention to rigor ensures quality and trustworthiness of research findings (Higginbottom et al., 2013). Lincoln and Guba (1985) proposed four criteria for assessing rigor in qualitative research: credibility, transferability, confirmability, and dependability. The following table provided by Houghton, Shaw, and Murphy (2013, p. 15) shows how various strategies align with the four identified approaches to rigor:

Approaches to rigor	**Strategies**
Credibility	Prolonged engagement Triangulation Peer debriefing **Member checking**
Dependability	Audit trail Reflexivity
Confirmability	Audit trail **Reflexivity**
Transferability	**Thick descriptions**

Table 1. Approaches to Rigor

In my study, to insure credibility, I visited the setting on 12 days over the course of this study. The first four of these days were spent building rapport with the staff and managers. I met with managers, and toured the unit that was the study setting. I sat in the lounge to hear afternoon entertainment, went to the coffee shop each day, met, and talked to staff in the hallways or at the front entrance, and spoke with several volunteers and staff who became familiar with me being in the home. This promoted familiarity and the development of a trusting relationship between staff and managers and myself as the researcher, and helped move me beyond the role of observer to engagement within the setting (Lundry, 2013).

Participants involved in qualitative research studies need to be able to recognize their voices and experiences in the findings. Credibility also can be insured through member checking. This involves continually checking data, interpretations, and conclusions with participants (Lincoln & Guba, 1985). Unfortunately, I did not have the opportunity to do this during the study, even though I had planned to do so. Too much time has passed since the data were collected and some of the participants were no longer with the unit.

To insure dependability and confirmability, I established and maintained an audit trail from the outset, outlining all processes used to reach the end results and noting my rationale for all methodological decisions. In my audit trail notebook, I documented my own philosophical and epistemological positioning. I made notes about my belief in the democratization of knowledge and my decision to engage in research based on a post-positivist epistemology. Then I noted my experience and interests, and why I made a decision to choose a topic related to long-term care.

Reflexivity is another strategy I used to insure dependability and confirmability. As a researcher, I am an outsider to the organization, but I also have previous experience as a senior care facility administrator. This required me to be sensitive to my own preconceptions, specifically about BPGs and teamwork, while being open to the experiences of research participants who were closest to and knowledgeable about the processes they went through and their experiences along the way to BPG implementation. I was on a path to discovery and because of this I tried not only to listen but also to hear and understand people's thoughts through their words. In interviews, I tried to look beneath the surface of what participants said and sought

deeper meaning with comments such as, “Tell me more about what you mean”, and “I want to really understand what you are saying and could you expand on that”.

Transferability refers to the applicability of this research in other settings (Morse & Richards, (2002). To enhance transferability, I recorded detailed observations, interview data, and journal notes and kept a record of my theoretical insights from this information. I aimed to describe in detail all aspects of teamwork in the dementia care unit and elicited information on the shared experience of implementing a HWE BBG. I believe that I have provided sufficient thick description of the findings to stimulate interest by other senior care facilities in the potential of using an RNAO BPG, along with other ways of knowing, to enhance teamwork in a senior care facility.

Ethical Considerations

Prior to commencing this study, I obtained research and ethical approval from the University of New Brunswick (Appendix E) and the senior care facility (Appendix F). I followed the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institute Health Research, Natural Science and Engineering Council of Canada, & Social Science and Humanities Research Council of Canada, 2010) to guide this investigation.

The principle of respect for human dignity is foundational to the ethics framework. The three core principles that relate to respect include: “concern for welfare, respect for autonomy, and respect for the equal moral status for all humans” (p. 2). Throughout the study, I was cognizant of the possible impact of their being involved in the research may have on participants. Although I did not hear of any concerns, two ethical issues arose for me during the research study.

The first involved an interview with a woman whose father had been a resident in the senior care facility. When she told me, her father had recently passed away, I paused for a few seconds, expressed my sympathies to her, and then asked her to tell me about her father. I listened for quite some time, with interest. When I urged her to continue, she told me a story about her father, one I may not have heard had I not stopped to listen. I share it with you in her words:

> Dad started wandering and would go off on his own. It got scary, but seemed to be manageable. He would walk every day and it didn't matter if it was 20 below, he would be walking. He kept a little journal he would write everything down in, so after he died, my brother was going through them, and sometimes he would just write down the temperature and stuff and he would write things like, "Went for a walk, -20 degrees, cold day today, saw a rabbit. Was a perfect day." And we found that he was writing all these things, and at the end of it, he was just writing "perfect day". This was part of his funeral when they did the eulogy. It has brought us closer together as a family and helped us appreciate some of the things. So, this has become a sort of slogan in our family to say, "Perfect day".

This experience touched me and I felt privileged that this resident's daughter had decided to take part in my research study. This would not have been an easy decision for her as she was still grieving the loss of her father and she may have had feelings of guilt and had to cope with difficult family dynamics in moving him to a new living environment. Also, the interview would require her to relive that period of time when her father's dementia was worsening. Despite all that she had been through and the feelings that go along with that, she decided it was important to take part in my research study. She also continues to come to the senior care facility to volunteer and help others. I wrote about this in my journal and commented on how amazed I was by her strength and her kindness towards others. Ironically, knowing the population in a senior care facility, I had not considered

that this situation would arise. This experience taught me something I will never forget: the participant comes first; the research comes second.

The second ethical dilemma concerned privacy, specifically regarding the handling of written invitations to potential participants. The Tri-Council guidelines state, "Privacy is respected if an individual has an opportunity to exercise control over personal information by consenting to, or withholding consent for, collection, use and/or disclosure of information" (p. 43). Although my letter of invitation stipulated that each person was to call or email me to set up an interview appointment if they wished to participate in the study and I had discussed this with the managers in the senior care facility at the outset, I received a message from the Director of Operations saying that a secretary would contact each potential participant to set up an interview schedule, (I learned that they had done this with previous studies conducted at the senior care facility). I immediately called the CEO to discuss my concern about confidentiality and we agreed to proceed with this arrangement if the secretary and myself were the only two people knowing who had been scheduled for interviews. I clarified the arrangement with the Director of Operations who agreed that no questions would be asked about who participated. I also had a conversation about privacy with the secretary to ensure she understood the rationale for this and the importance of her keeping details of the participants confidential. She agreed. I checked back with her three separate times after the interviews concluded; she told me no one had asked who had been scheduled or took part in the study. Nor did anyone ask me about who was scheduled or about participants in the study. In the end, I am confident the privacy and confidentiality of staff and other participants were maintained, and no concerns were brought forward. This taught me that

even though things are written down, given to people, and discussed, misunderstandings still occur. In this case, prompt action was taken to mitigate the situation and maintain the ethical integrity of the process.

A fourth principle is that of distributive justice. Chapter 4 of the Tri-Council guidelines states researchers should not intentionally exclude members of society from participating in a study. However, I did exclude the residents with dementia as the residents on this unit were cognitively impaired and were deemed unable to answer questions. Family members of residents did take part in the study.

Chapter Summary

In this chapter I have linked the purpose of this research to epistemology, theoretical perspective, methodology, and methods of data gathering. I explained focused ethnography and why I used it as a methodology for my study. I described the setting and how I selected participants using purposive sampling. I outlined Creswell's (2009) six step process and Saldana's (2016) suggestions for coding and thematic analysis, which guided my work. I have also identified the ethical considerations I was cognizant of throughout the research process. In the following chapter, I provide a context for the study.

CHAPTER FOUR

Contextualizing the Study

Senior care facilities across Canada vary tremendously, as do systems of long-term care and developmental histories. In this chapter, I focus on the context of long-term care in the province of New Brunswick, and specifically the senior care facility site and the dementia care unit that were the sites of this study. I begin with a brief overview of the historical context for the study, and then provide background on the senior care facility: it's physical setting, mission, vision and values, strategic plan, and model of care.

Historical Context

When New Brunswick became a province in 1784, social services were administered under the New Brunswick Poor Law, and continued until 1867 when the British North America Act gave provinces the right to manage long-term care (Government of New Brunswick, 2007). In the 1950s and 1960s the long-term care system evolved and began licensing, regulating, and funding senior care facilities. Some senior care facilities had started at lodges or cottages, such as the Drew Nursing Home in Sackville, New Brunswick, and others began as "Poor Houses", as in the case of York Care Center in Fredericton, New Brunswick.

In the 1970s and 1980s, special care homes were established in the province providing a lighter level of community-based care than senior care facilities. As well, in an effort to keep seniors in their communities for as long as possible, the province expended community-based services to seniors (Province of New Brunswick, 2007). By

the 1990s, the long-term care system had matured with the expansion of the Single-Entry Point System which provided a single point of entry into the long-term care system in the province. This meant that the public could contact the Department of Social Development and request to be assessed for their eligibility for any service needs along a continuum, from community care to senior care facility care or services in-between such as special care homes. For the first time, eligibility for services was based on a person's functional ability (Province of New Brunswick, 2007). Late in the 1990s, the system for long-term care was further refined to include: in-home services, special care homes, community residences, and senior care facilities.

Over the years, issues concerning senior care facilities in the province have included: a moratorium on the addition of new beds to senior care facilities; changes to the financial contribution policy, including the exemption of principal residence from financial contribution; the building of new long-term care facilities to meet the demands for beds in the province; and concern about a shortage of qualified staff to care for residents in senior care facilities (Province of New Brunswick, 2007). A recent report by the provincial Auditor General (Province of New Brunswick, 2016) highlighted several concerns regarding long-term care in the province, including: the number of seniors is expected to double in the next 20 years; there is an increasing demand for beds in senior care facilities and insufficient senior care facility bed capacity; the unsustainability of costs of long term care; and the negative impact on hospitals of long waiting lists for senior care facility beds. The report concluded, "a multifaceted solution is needed to provide sustainable care and services in the future, not as simple as adding more senior care facility beds to the existing system" (p. 13).

In 2012, organizations interested in aging, from across the province, spurred a collaborative initiative, *We are all Neighbours in Aging* with the goal of creating a more collaborative long-term care system for the province. This initiative started with the Summit for Healthy Aging that challenged the 300 participants in attendance to consider three questions: What is the future we wish to create? What are the barriers and enablers to creating that future? And how do we bridge the gap between the present and the future? (Summit for Healthy Aging, 2014). Today, this collaborative venture involves over 28 organizations and continues to sustain the public conversation about issues related to aging care and service delivery.

The past two decades have also seen the emergence of national groups advocating for improved care and services for the elderly. In 1973, the Canadian Association on Gerontology was formed to: " improve the lives of older Canadians through the creation and dissemination of knowledge in gerontological policy, practice, research, and education" (CAG, 2015). The Canadian Gerontological Nursing Association (CGNA) was formed in 1985; it's stated mission is, "to address the health concerns of older Canadians and the nurses who participate with them in health care" (CGNA, 2015). In 2002, the Canadian Alliance of Long Term Care (CALTC) was formed. This association is comprised of provincial associations responsible for long-term care and its purpose is threefold:

> 1) to share information, insights, and best practices on current and emerging long-term care issues,
> 2) Collaborate to address issues and opportunities that impact long term care, and
> 3) To take common positions on issues that have broad impact on participating associations. (CALTC, 2015)

The New Brunswick Association of Nursing Homes is a member of CALTC.

The Provincial Context

Currently, in New Brunswick, 16 % of the population is 65 years of age which is approximately 122,000 people. This is higher than the current national average of 14 % and it is higher here than anywhere else in Canada with the exception of Nova Scotia (Government of New Brunswick, 2017). These statistics demonstrate the importance of research on long-term care in the province, including my study on dementia care.

Today, there are 67 licensed senior care facilities in New Brunswick, most of which are not-for-profit (3 are for profit) and this equates to 4647 senior care facility beds province-wide. The average cost per resident is $113.00 per day, or $3437.00 per month. Residents must pay this amount unless they qualify for a subsidy (Province of New Brunswick, 2017).

The Senior Care Facility Setting

The senior care facility in this study has been operating for 35 years. It is one of 64 not-for-profit senior care facilities in New Brunswick, and one of 15 senior care facilities in Region 2, which covers the Saint John area (Government of New Brunswick, 2014). The senior care facility is licensed to operate by the Province of New Brunswick and is fully accredited by Accreditation Canada. In 2012, the senior care facility expanded with the addition of 100 more beds for a total of 190 beds. The senior care facility is comprised of four separate units; my study took place in the dementia care unit, which accommodates 25 residents.

Mission, vision, values, and strategic plan.

According to Yukl (2006), "the mission statement usually describes the purpose of the organization in terms of the types of activities to be performed for constituents or customers. In contrast, a vision statement tells what these activities mean to people" (p. 298), as well as, what an organization aspires to be, now, and in the future. The strategic plan identifies the goals and associated timelines for completion of each goal.

The senior care facility's Mission Statement states that it, "enhances the quality of life in New Brunswick by providing and supporting safe, caring, places to live for adults challenged by age or disability." The Vision Statement describes the senior care facility as being a caring community for staff and residents, respecting the rights of individuals, establishing strong working relationships with partners, striving to be the choice for long term care services, and attracting needed staff to provide care and services. And, the senior care facility's Strategic Plan (2012-2015) outlines four main areas of focus: quality, culture, finance, and organization. Quality: to strive for excellence across all services and programs; Culture: to attract and retain staff and volunteers who embrace the resident-focused xxx (to protect the identity of the facility) philosophy; Financial: to ensure diligent stewardship of resources; and Organizational: to maximize the use of data to improve operations. The mission, vision, values, and strategic plan provide a framework that facilitated an environment conducive to my study of BPGs and teamwork.

Yukl (2006) further described organizational values as statements that, "include key ideological themes considered important for an organization. The values usually pertain to treatment of customers, treatment of organization members, core competencies,

and standards of excellence" (p. 296). The senior care facility's stated values include: respect, excellence, and safety as well as stated attributes such as "strong working relationships", "caring community for staff and residents" and a desire to "attract and retain staff," drew me to this site. Importantly for my study, the topics of teamwork and research are included within the value of excellence, identifying both these areas as part of organizational excellence.

Physical environment.

The senior care facility has an open-air courtyard and two closed glass-covered courtyards. There is an outdoor walking path that surrounds the home. There is ample parking with designated parking for staff and visitors and a circular path at the front door to enable dropping off or picking up passengers. The building is well landscaped with ample signage. Inside, a large common area includes a living room, and a portable chapel for spiritual services. In a separate room off the main hallway, there is a movie theater. A canteen, staffed by residents and volunteers, serves coffee, tea, cold drinks, and small snacks. A welcome desk sits close to the main entrance and beside this desk is the office of the Director of Operations. A sign in book that looks like a guest book is on a stand close to the entryway. Hallways lead to resident care units or 'houses'. Each unit has resident rooms, dining room, living room, activity area, and bathing rooms. The décor and colours are home-like, and bright and cheerful. The home was decorated festively for Christmas during the data collection period.

Philosophy of care.

The senior care facility follows the xxx philosophy of care. XXX founded the xxx philosophy in San Fransisco in 1978 after she endured personal traumatic hospital experiences. Her mission was to personalize and humanize the hospital and senior care facility experiences by empowering patients/residents to become partners in their care, creating healing environments, and developing new models of care incorporating attention to the mind, body, and spirit. Since then, the xxx model of care has been implemented in more than 100 health organizations in the USA, Canada, and Europe (xxx, 2011). The xxx Philosophy is built on nine beliefs:

1) A resident is an individual to be cared for, not a condition to be treated;
2) Each resident is a unique person with diverse needs;
3) Each staff member is a caregiver, whose role is to meet the needs of each resident;
4) Residents are partners and have knowledge and expertise that is essential to their care;
5) Residents' family and friends are also partners, and their involvement is welcomed;
6) Access to understandable health information is essential to empower residents to participate in their care and it is the staff's responsibility to provide access to that information;
7) The opportunity to make decisions is essential to the well-being of residents. It is staff's responsibility to maximize residents' opportunities for choices and to respect those choices;
8) Residents' well-being can be enhanced by an optimal healing environment, including access to music and the arts, satisfying food, and complementary therapies;
9) To effectively care for residents, the home must also care for staff members by supporting them in achieving their highest professional aspirations, as well as their personal goals. (xxx, 2011, p. 4)

The specific xxx philosophy used in long-term care is called the xxx Continuing Care Model. This model includes the following components: recognizing the primary importance of human interactions; enhancing each individual's life journey; supporting independence, dignity, choice; incorporating family, friends, and social support networks

in the life of the community; supporting spirituality as a source of inner strength; promoting paths to well-being; empowering individuals through information and education; recognizing the nutritional and nurturing aspects of food; offering meaningful arts, activities, and entertainment; and providing an environment to conducive quality living (xxx, 2011). In my interviews with management I heard how the xxx model was adopted to fill an identified gap in care that existed in the senior care facility.

The process for introduction of the xxx Philosophy began in 2009 with introductory sessions with a xxx representative. This led to three full days of informational sessions by a xxx Consultation Services Specialist who came to the senior care facility in Fall, 2010, to meet with board members, staff, residents, families, volunteers, and community partners. In December 2010, two xxx representatives conducted an organizational assessment at the senior care facility, which led to a two-day leadership retreat to prioritize the recommendations from the report. Becoming a xxx affiliate has meant living out this philosophy each day and linking it to all that takes place in the senior care facility.

The Dementia Care Unit

The specific setting for this study was the senior care facility's dementia care unit. The unit has a code-entry door with security monitors to alert staff to any resident who may be close to the unit's entrance/exit door. The unit includes special features indicative of person-centered care. For example, the unit has a circular walking path with benches strategically placed for residents to rest if required. Each room is a spacious private room and has a window to the outdoors or to the courtyard. Some rooms have doors to the courtyard. Each room has a shadow box on the wall beside the bedroom

door that contains pictures or keepsakes from the residents' life. These boxes are useful in orientating residents to their specific rooms. Bedrooms each have their own half-baths, and shower and tub rooms are located on each side of the unit. The unit has a dining room for residents and a family kitchen that is locked by a keypad but is available for family use when visiting.

Funding and staffing.

The dementia care unit operates 365 days of the year and 24 hours a day. The 24-hour day is separated into a day shift, an evening shift, and a night shift. The staffing for this unit is made up of full-time staff, part-time staff and casual staff. The care staff includes registered nurses (RNs), licensed practical nurses (LPNs), and resident attendants (RAs). As well, there are support staff, which include dietary, housekeeping, and activity staff. Other professional staff include management, physicians, a nurse practitioner, an occupational therapist, a physiotherapy, and a pharmacist.

This dementia unit is funded at 3.1 hours of care per resident per day. On the day shift, this translates into five nursing staff (1 RN, 2 LPNs and 2 RAs) plus activity, housekeeping, and dietary staff. On the evening shift, staff includes: 1 RN, 1 LPN and 2.5 RAs. On the night shift, there is an RN who works between two other units and there is one LPN on the unit. Besides regular unit staffing, other staff such as the physicians, the nurse practitioner, volunteers, pharmacist, dietician, and occupational therapy/physiotherapy come to the unit to provide services as required. Casual employees replace full-time and part-time staff when they are absent due to sickness or holidays.

The staffing criteria for the senior care facility states: “staff possess a warm kind manner; staff should be sensitive to others; staff must be patient and allow people the time they need; staff have respect for people’s dignity; staff are flexible in dealing with residents and other staff; and staff possess a sense of humour, a willingness to learn, and an openness to new experiences.” All of these stated attributes are important for effective teamwork and are, therefore, relevant to my study.

Unit-based teams approach.

The senior care facility’s philosophy of care includes teamwork as a vital component of how care is provided. As explained in Chapter 2, the unit-based team approach most closely resembles that of my study. The team of people who provide care to the residents on the unit have not self-organized and have not been assembled externally. They are a team (organized by management and informally by themselves) because of the physical location in which they work. There is an expectation that the managers, staff, and family members on this unit will work together as a team. When a new employee comes to work on the unit they are part of the unit-based team and when they finish working on the unit they are no longer part of the team. The staff who are not regularly based on the unit, but come and go from the unit to provide a specific service, are also part of the unit-based team. Family members of residents and unit volunteers are also considered team members.

Some of the functions of the unit-based team include: admissions, resident assessments, care planning, care delivery, staff meetings, family engagement, palliative care, and discharging residents. The various activities of the team include: team leadership, unit meetings, communication across all shifts, embracing a common goal,

mutual accountability, follow through, and performance measurement. Katzenbach and Smith (2003) have said that each time a new person is added to a unit-based team it is difficult because, "you must reform the team in terms of all six elements of the team basics" (p. 275). The six elements these authors are referring to are: small size, a mix of complementary skills, a common purpose, agreed upon goals, compatible working approach, as well as individual and mutual accountability.

Chapter Summary

In chapter four, I have described the context for this study. In doing so, I have painted a picture of the specific senior care facility in which this study took place and located it within the system for long-term care in New Brunswick. I have explained important aspects of the senior care facility, including: the physical environment, the mission, vision and values, the philosophy of care, staffing, unit-based teams, and the residents being cared for. This differentiates this organization from other health care organizations such as hospitals, and provides a reference point for understanding the work of unit-based teams and teamwork in the study setting. The presentation and analysis of my research findings follows in the next two chapters.

CHAPTER FIVE

Presentation and Analysis of Findings

My analysis of the implementation of a HWE BPG on teamwork in a senior care facility in New Brunswick is based on qualitative information gathered from in-depth interviews with 12 participants: one director, one unit manager, three family members, and seven multidisciplinary staff members. I have organized my analysis of the interview transcripts into four themes: (1) Teamwork in a Senior Care Facility: "If you work on the unit, you are part of the team", (2) Teamwork Contextualized: "Making it work for us", (3) The Impact of Teamwork on Team Members: "We are here for the residents", and (4) The Work of Sustaining Teamwork: "We are working together like a team now." Further analysis of my findings in relation to the literature on teamwork follows in Chapter 6.

Teamwork in a Senior Care Facility: "If you work on the unit, you are part of the team."

This theme provides a sense of what teamwork looks like on the dementia care unit that is the study setting, from the perspectives of the participants in the study. I begin by presenting a picture of the team and follow with an analysis of the process utilized by senior care facility management and staff to improve teamwork on the unit.

A picture of the team and teamwork on the unit.

The implementation of an evidence-based BPG to improve teamwork was a first for the senior care facility sector in New Brunswick. It was also a new experience for

staff and management on the unit and the organization. As explained in Chapter 4, the senior care facility is comprised of various units, each providing care to a resident group with similar needs (i.e., cognitively intact or dementia care). Each unit is staffed separately, except for replacement staff who may work on several different units. The specific dementia care unit that was the study setting has a nurse manager in charge of the unit on each shift (days, evenings, and nights). The manager could be an RN or a LPN and each is regulated staff. Professionals such as physicians and nurse practitioners (NPs) are also regulated staff. Unregulated staff who are also part of the unit team include resident attendants (RAs) as well as dietary workers, housekeeping staff, maintenance staff and activation staff. Except for the physician and managers, all regulated and unregulated staff are unionized workers. Family members are also considered to be part of the unit-based team.

Even though the unit team was subject to change, management, and staff (regulated and unregulated) identified "the team" in similar ways. A manager stated:

> If you are working on that unit, you are part of that team. (P11)

Staff members concurred:

> The team is all the staff who work on this unit 24/7. (P5)

> If you work on [xxx unit], you are part of the team. That's the way it is. You can put in not to work on a certain unit if you don't want to work there. So, if you put in that you don't want to work [xxx unit], then obviously you are not going to be good for that unit. So the people that they wanna work [xxx unit], they pretty much know how to work there. (P9)

A staff member outside the nursing department also felt part of the team:

> I am not in the nursing department, but I consider myself to be part of the team that works on [xxx unit]. I think the team is anyone who works there on days, evenings, or nights. (P4)

For this staff member, the team includes all staff working on a 24-hour basis:

> We have staff on around the clock and all staff are part of the team, no matter what their job is, no matter if they are long term or new. (P2)

Although some unit members were peripheral to the team, they were available to be part of the team and helped as required. One example of this was the role of management. Even though management were not on the unit all the time, staff members saw them playing an important role on the team, as one staff member reported:

> The Director of Operations is the manager who is responsible for [xxx unit] and she is available to us whenever we may need her. She is a big part of the team on [xxx unit]. (P5)

The participants all referred to staff and unit managers/leadership team members as being part of the team, and the above quote indicates the Director played an integral role on the team and took an interest in what was happening on the unit.

I was also interested in whether family members of residents considered themselves to be part of the team. In response to my question on this topic, one family member said she felt included as part of the team:

> I did feel part of the team. They told me what was going on all the time and I was here a lot. They called if there was an incident. The reviews of Dad's care and medication included me. (P1)

This family member is referring to ongoing communication and how that made her feel included and part of the team.

Similarly, another family member stated:

> I felt part of the team. The staff talked to us and included us in decisions that were being made about Mom. (P7)

A third family member felt part of the team, and this included speaking up for what she felt her father wanted:

> The level of involvement of some family members and desire to advocate for their residents differed. I did feel part of the team, they did listen to me, but I had some battles for my Dad, but that was my role, to advocate for him. (P8)

The above quote suggests some tensions between staff and family members. Although most participants did not explicitly address tensions on the unit, some did occasionally mention work-related difficulties they were experiencing. I speak about these tensions as they arise throughout the chapter.

Although participants had similar understandings of what constitutes a team and its members, there were different understandings of the meaning of teamwork. Whereas the participants quoted above explained teamwork in terms of having input into decision-making on the unit, others preferred to rely on management to make decisions and sort things out based on staff reporting difficulties. As two staff members stated:

> I do recall that period and there was a lot of difficulty. Staff get set in their ways. If there is a personality clash, then the manager needs to fix it and that's what happens now. (P3)

> We didn't use to work as a team at all back then. People were just all there on their own, doing their own thing and there were lots of struggles and no one to take the lead and sort things out. I would say there wasn't any teamwork. (P10)

Also, although the participants inferred that the concept of team included all staff and family members, I explain later how the educational resources were not shared equally among all team members or between both regulated and unregulated staff, which again suggests different understandings of teamwork among the team members.

Understanding the implementation process provides some insight into how the team evolved as it did.

The implementation process.

1) Problem identified

The BPG implementation process began when the Director of Operations and the CEO identified problems with teamwork on the unit(indicated by reports from staff, high absenteeism, complaints from family members), which triggered the search for a tool (the BPG) to assist in resolving the identified problem(s). One regulated staff member associated the prior problems on the unit with leadership style:

> The nurse manager who had been on [xxx unit] did not have a good rapport with the staff. There are many long-term employees with strong personalities and there was a friction there and a lack of respect on both sides. There was not a lot of follow-through on the part of the RN. It got very tense. As a professional, I do not like to speak negatively about colleagues, but from what I understand, there was constant conflict and a change had to be made. (P5)

This staff member portrays the situation as escalating almost to the point of crisis. A manager also spoke about how problems among the staff and unit manager were creating a negative impact on the care of residents. This was the point at which changes in leadership, she said, had to be made:

> On [xxx unit], we were not seeing the outcomes that were positive for residents. Our stats were telling us that the team that was there needed help. There was a problem with attendance. There was a challenge there. I was indirectly part of that in the role I held at that time. Because of the continuous feedback from staff and families about outcomes that were not positive, I will put it that way; the process of communicating with our administration had to take place, then we tried mentoring and coaching with the person. Ultimately, a decision was made that this person was not well suited to working on this particular unit and there was a shift in leadership. We decided that this type of unique care requires a unique character. (P11)

This manager is portraying a process of becoming aware of problems on the unit, attempting to manage the problems and resolve them, and finally having to remove the person who was having problems working with other staff on the unit.

Another staff member characterized problems on the unit as resulting from employer and employee related difficulties:

> The work environment was very stressed. I don't think the communication was there. It was hard to get enough staff to come to work on [xxx unit]. (P2)

These short responses suggest that problems on the unit acted as a catalyst for management's plan to enhance teamwork through the implementation of the BPG. Although there was reluctance among the participants to dwell on the problematic period or share their perceptions, even with cueing, themes related to leadership, communication, and relationships between regulated and unregulated staff emerged in our conversations, indicating that the participants learned something about the nature of teamwork by recognizing what was missing previously. The problem was twofold: with leadership on the unit and teamwork.

2) Selection of RNAO HWE BPG

An important next step in the implementation process was the selection of the BPG. Prior to my study, the Director of Operations in conjunction with the CEO in the study setting identified problems on the unit they thought would be alleviated by an increased emphasis on teamwork. In response, these managers selected an evidence-based BPG developed by RNAO entitled, *Collaborative Practice Among Nursing Teams* (2006), as mentioned in Chapter 1, to guide them in their efforts to improve teamwork on the unit.

3) Summer Institute

The RNAO HWE BPG implementation process began by managers attending the RNAO HWE BPG summer institute.

4) Action Plan

The Director of Operations then developed an action plan and formed a group to oversee the BPG implementation process and operationalize the BPG recommendations.

5) Teamwork projects

The implementation group introduced teamwork projects that involved both regulated and unregulated staff on the unit. I look at each step, in turn.

The first RNAO BPG resource utilized by the senior care facility was the week-long RNAO Summer Institute on HWE BPGs, August 2009, attended by two senior care facility managers, the Director of Operations, and the Director of Nursing (who has since resigned). One of these managers was interviewed and the other was not because she no longer works at the home. In the documentation provided to me by the Director of Operations, the brochure from the summer institute outlines the purpose of this educational forum:

> To gain knowledge of the following key elements of healthy work places that will change you and your organization:
>
> - Critical attributes of a healthy work environment
> - Frameworks for workplace revitalization
> - Dimensions of an evidence-based organizational culture and
> - Review of the foundational HWE BPGs. (RNAO, 2009, p. 3)

This same document also states that by the end of the institute, participants should be able to:

1) Influence the development of and commitment to a tailored action plan for the implementation of HWE BPGs;
2) Maximize current leadership competencies to support HWE change initiatives;
3) Mobilize a strategic network of supports; and
4) Inspire self and others to achieve healthy workplaces. (RNAO, 2009, p 3)

The one person who attended the summer institute explained the value of it to her and how she came back to her workplace and carried out the above listed steps. My sense is that she inspired others to follow the BPG with the aim of improving teamwork on the unit. One of the managers who took part in the summer institute seemed to benefit from the experience. She spoke about how it had shaped her approach to the BPG implementation process:

> Our CEO, XXX, became aware of BPGs and we had a presentation about the topic at our leadership meeting. To learn more about this, I attended the RNAO summer institute with one manager who worked here at the time, and this taught me how to use the guideline as a framework to put around several things we needed to work on. We needed to build the pieces of the BPG into our everyday work we do here. At the same time, we were learning about BPGs, we were having serious problems on [xxx]. I decided in conjunction with others we would select [xxx] because the team that was there needed help and that was agreed. An action plan was developed and the Board then supported our plan to implement the BPG on teamwork. (P11)

This manager spoke about being familiar with her workplace and the problems occurring there. Although, using an evidence-based BPG to enhance practice was a new experience for her, she thought it might provide a solution to the problems on the unit. Following the summer institute, she decided to propose BPG implementation, developed an action plan, and sought Board approval of the plan, which was forthcoming.

The Director of Operations entitled her action plan for BPG implementation, *Research, and Evidence Based Best Practice Action Plan-Collaborative Practice Among Care Teams,* September 2009. I reviewed the action plan as part of the documentation

review. In my analysis of the plan, I found it to be general rather than specific and again reflected a hierarchal approach as it was targeted at the senior care facility's Board of Directors.

Initial steps in the action plan included educating the leadership team and the Board of Directors about the BPG and obtaining approval from the Board to proceed with BPG implementation. This occurred in September and October 2009. The intent was to provide enough information to the Board about how she intended to proceed and how the implementation of the BPG would guide staff and unit managers in the process of improving teamwork. More detailed planning would take place between the Director of Operations and the group she selected to lead the BPG implementation on the unit. A director and two RNs were the only members of the BPG implementation group; other regulated and unregulated staff members were not represented at the planning stage of the BPG implementation process. Consequentially, the thoughts, views, expertise, perceptions, and opinions of all regulated and unregulated staff were not considered. Vital knowledge that could impact efforts to improve teamwork was missing from the planning process.

In February 2010, the Director of Operations formed a BPG implementation group to lead the unit team. She selected two RNs to work with her to, "formalize a framework for best practice guidelines" (Action Plan, 2009, p. 1). Unfortunately, I did not pursue why the Director selected these staff members over others, other than to ascertain that her choice was based on her own assessment of who would be the best people for the project. In February 2011, the Director produced an action plan that identified the following categories of staff to be involved in the BPG implementation

process: RN days and evenings; and nursing, recreation, dietary, and housekeeping staff. Although this was the original plan, under the heading "date completed" in the action plan, I noted that the individuals in each category changed frequently creating the need for continuous recruitment of new team members and education about the BPG implementation process. I return to a discussion of staff turnover later in this chapter.

In March and April 2011, the Director worked with two RNs on selecting areas of focus from the BPG and planned a schedule of quarterly meetings with the RNs to discuss teamwork and progress on BPG implementation. I noted minutes were not kept from these meetings and they did not follow a regular schedule, instead they were held on an "as required" basis determined by the RNs in consultation with the Director.

The Director led the implementation process and educated two of the RNs about the things she learned at the summer institute. One of the two RNs resigned, eventually to work elsewhere, and another evening RN replaced her. The mobility of team members proved difficult at times, necessitating continuous education on the BPG for new members, as this manager stated:

> So, you know we are a 24-hour organization. Along with this we have this wonderfully young vivacious new RN who came on board for evenings. Her name was [xxx], and you probably saw some of her documentation, so I worked very closely with her because when we think about dementia from the day into the evening, many times they require a unique type of care at late afternoons to the evening. [xxx] really supported the BPG, and she was great. She bought into this in a big way. In the meantime, [xxx] carried on with her profession and received another opportunity outside of the organization and left us. But oh my! Opportunities again because low and behold who comes back to us but one of our faithful RNs. So, the whole presentation was done again with a new team. So, I met with [xxx] and [xxx] and presented them with packages and some research to discuss and the action plan. Then I met collaboratively with some selected individuals of the team and then every once in a while. We would go on and move forward and then great initiatives, which I'll be more specific here in a

> moment, were happening. After we moved into an environment here at the [xxx] and see what we see in the whole wellness aspect for staff, along with that whole collaboration, so here we are. And along the way we have included our families in this process. I did a little bit of a different introduction for the families [to the BPG]. A bit, I don't want to use a simplistic version, but it was a modified version of why we are doing it [BPG implementation] and would they like to be involved as a spokesperson and advocate for the residents. (P11)

From this excerpt, it is evident that this manager led the BPG implementation team and was engaged in ongoing re-orientation and education of team members. The two original BPG implementation group members changed, and the Director, in conjunction with the unit managers on days and evenings, gradually introduced other staff members and some family members to the process through various teamwork projects and initiatives. This movement of staff on and off the unit may have been part of the rationale for selecting a small team of managers to oversee BPG implementation.

To help improve teamwork on the unit, as explained in Chapter 1, the Director selected an RNAO BPG booklet entitled, *Collaborative Work of Nursing Teams (*RNAO, 2006). Each BPG developed by RNAO is documented in a separate booklet, and the specific BPG booklet for enhancing teamwork was included in the documents for review (Appendix F). The booklet is organized according to the following headings: *Background to the Healthy Work Environments Best Practice Guideline Project; Organizing Framework for the Healthy Work Environments Best Practice Guideline Project; Background Context of the Guideline on Collaborative Practice of Nursing Teams; Purpose and Scope; How to Use This Document; Recommendations; and the Process for Reviewing and Updating the Healthy Work Environment Best Practice Guidelines* (RNAO, 2006, p. 10). The booklet is 68 pages in length and includes a glossary of terms

and appendices outlining the process used to develop the BPG from applicable current evidence.

The BPG booklet is presented as a user-friendly guide to improving teamwork, and includes systematic information on how to use it. The authors take the position that teamwork is vital for fostering healthier work environments in health care settings. The booklet presents a summary chart of recommended actions as well as more detailed descriptions linking recommendations to current applicable evidence. The BPG draws upon both qualitative and quantitative studies. The theoretical basis for these, reflect both positivist and post positivist epistemologies.

In the in-depth interviews, I learned that the Director and the two RNs, i.e., the BPG implementation group, used only the instructions on how to use the document, the recommendations, and the evidence behind the recommendations. Unfortunately, I was not able to ascertain why these areas were selected to the exclusion of others. However, I learned that although this material was read by the Director and two RNs, it was not articulated, embraced, shared with, formally adopted, or documented for distribution to all team members, as became clear in the following excerpt from an interview with a staff member:

> I've never seen the book before [BPG booklet being held up], no, but not to say that our managers have not implemented that. (P2)

And similarly, from another staff member:

> I've heard about it [the BPG] but I never seen the book. (P4)

The other part of the BPG that was read by the Director and two RNs but not formally adopted was the *Conceptual Model for Healthy Work Environments*. As explained in Chapter 1, this model links together components, factors and outcomes deemed to be part

of a healthy work environment. Importantly, it also situates teamwork as one of the dimensions of a HWE and shows how it inter-relates with other dimensions of a HWE. Unfortunately, I did not explore this area further in the interview process.

One of the parts of the BPG that was embraced by the implementation group was the "How to Use This Document" section which provides an approach to be used for implementing the guideline. This section included the following seven steps:

1. Study the HWE organizing framework
2. Identify an area of focus
3. Read the recommendations and the summary of research for your area of focus
4. Focus on the recommendations or desired behaviours that seem most apt for you and your current situation
5. Make a tentative plan
6. Discuss the plan with others
7. Revise your plan and get started.

This list is prescriptive, providing a roadmap for the BPG implementation process. Where flexibility was encouraged, e.g., the sixth step in the process, "Discuss the plan with others," the interview transcripts reveal how this was done sporadically rather than consistently. Although the mobility of staff members through the unit made it difficult for me to track those members who knew about the changes being made to improve teamwork, clearly, some unit members knew about the plans and some did not.

From my own experience of teamwork, collaboration between management and both regulated and unregulated staff is an important element of any initiative to improve teamwork. The BPG booklet supports and encourages such collaboration stating:

> Take time to get input into your plan from people whom it might affect or whose engagement will be critical to success, and from trusted advisors, who will give you honest and helpful feedback on the appropriateness of your ideas. This is an important phase for the development of individual collaborative practice skills as it is for the development of an organizational collaborative practice initiative. (RNAO, 2006, p. 24)

Although the BPG recommends that there be collaboration with those who will be affected by the change as part of the process in this study setting, input was interpreted as getting feedback from other Directors and approval to proceed from the Board of Directors. Unregulated workers were not part of the consultation or collaboration process at the outset of the BPG implementation.

Although the focus was on teamwork, paradoxically, management took a hierarchal approach to implement the BPG. Perhaps this happened because management held a hierarchal understanding of teamwork, as mentioned above, where management remained in control, or it may have happened because of a need to control BPG implementation in the beginning as many changes were taking place at the same time. Some of these changes included: staff members leaving and new staff members being recruited; the construction and move to a new building; and the introduction of a new model of care. Unfortunately, I did not explore management's rationale for using a hierarchal approach. Nevertheless, as the next theme illustrates, the implementation group and the staff members made this BPG work for them in what gradually became a joint effort to improve teamwork on the unit.

Teamwork Contextualized: "Making it work for us"

Although, as I have indicated, the implementation group followed a hierarchical approach and decided which recommendations from the BPG were to be implemented, an important finding of this study is that the managers and staff contextualized the evidence-based recommendations on teamwork from the BPG as they deemed appropriate for the unit. One member of the implementation group described the process as follows:

> I have seen the tool and have read it but that was some time ago. What I can say is that we picked out of it what we thought would help us and we reviewed the research sections on each of these areas. We used that to start making changes on how we worked together as a team. We made it work for us in the circumstances we were dealing with. (P5)

This quotation suggests that the implementation group adapted the BPG for the setting, i.e., they followed a contextualized rather than a normative process. The group read the evidence-based recommendations in the BPG, considered them in relation to the specific context of the dementia care unit, and their understanding of the current problems the unit was having with teamwork, and they selected the areas of focus from the guideline. These areas were selected based on the priorities and needs of the dementia care unit identified by the implementation group Rather than relying solely on the evidence-based recommendations in the BPG, they used their experience and knowledge of their own work environment and the problems occurring within it to guide their selection of the specific areas to work on. The benefits of a contextualized over a normative process were explained in Chapter 1.

Although there are seven recommendation areas and nineteen sub-recommendations in the BPG document (RNAO, 2006), the group selected the following four areas of focus: improving communication strategies, embracing transformational

leadership, creating a culture of teamwork, and enhancing continuing education of staff. These areas are related to recommendations number one and two within the BPG, and comprise parts of the first two recommendations, not the entire recommendations. The BPG provided evidence-based recommendations to improve teamwork in relation to the four areas of focus; the managers read the evidence at the outset and again during the implementation process.

Once the group identified the areas of focus, they discussed strategies for implementation. Although the approach taken to BPG implementation was hierarchal initially, with a small group of three leading the BPG implementation, the process became more interactive and collaborative involving regulated and unregulated staff and family members as the process evolved. For example, this staff member explained what happened because of the family satisfaction surveys and audits conducted as part of the standards for Accreditation Canada (as an indicator measure of quality care delivery and resident and family satisfaction):

> I think we have a handle on what else we need to do and how we can improve because communication of the team is open. We were advised that out of our family satisfaction surveys, families were asking for more purposeful engagement with residents. We are now working with staff on days and evenings to improve on this and we have an audit to check it. (P5)

Although the family satisfaction surveys were not proposed in the BPG, the group used the BPG to guide the response or action to address the survey results and staff reported this as being helpful.

In our conversations, management referred to the BPG booklet both as a "tool" and a "guidebook," which suggests different levels of compliance. Nevertheless, they used it frequently throughout the implementation process. One unit manager described the process as follows:

> We built an education system with them. This was all a part under direction from the BPG, with that support so when a new staff comes in they're given the tools. From researching the BPG, as I see my tattered copy, I just continued to grow with that and so I would build pieces of the BPG into each phase if you will, or each opportunity to introduce changes. (P11)

Here the manager is referring to incorporating the BPG into projects or initiatives she and the implementation team introduced. Some examples of initiatives included: re-working roles to meet the needs of residents, developing an evening activity program for residents, redeveloping the admissions process, introducing a pet therapy program, holding a wedding on the unit, and initiating the cookbook project, all of which included staff involvement. Some of these initiatives are described later in the section on the impact of implementing the BPG.

The manager also told me how the Director and the two RNs used the BPG as a guide throughout the implementation process, referring to it as required. Importantly, neither the Director nor RNs commented about the BPG being directive, restrictive, or impeding their decision-making skills, as critiques of BPGs have indicated. They used the evidence-based knowledge in the BPG in conjunction with their own professional knowledge as well as their experience-based knowledge in their efforts to enhance teamwork. Therefore, besides using evidence-based knowledge, practice-based knowledge emerged as a way of knowing and was used as this process evolved.

For staff members who had not seen the BPG booklet, I asked them questions about the areas of focus for the home relating to teamwork they had been working on as part of the BPG implementation. For instance, the implementation group focused on improving communication on each shift as well as among shifts to ensure all team members had consistent information about the residents and about the day-to-day activities of the unit. This was one of the areas of focus under the BPG. I asked

participants if they were aware of, or involved in, improving communication on the unit. One staff member responded as follows:

> In the mornings, we have a little briefing to share vital information about what is going on in the day. We do have more in-depth meetings for care planning to come and share. Everybody has their input and sometimes you see something that someone else may have overlooked. (P10)

This response indicates that the participant knew about the effort to improve teamwork on the unit, was involved with it, and found it worthwhile in terms of the care delivery to residents. I also asked staff participants about other areas of focus in the BPG such as accountability, role clarity, continuing education, and leadership. I learned that the team had gleaned a lot about role clarity (understanding the roles of other team members and the blurring of roles through teamwork), as one staff member stated:

> Nothing is written in stone [regarding various staff roles] with dementia-you know your residents. If someone has a solution that works with a resident, we share it with all shifts and that brings the three shifts together. (P12)

This staff member is referring to how roles became blurred instead of being distinct and how role blurring involved collaboration across the three shifts a day. Another staff member talked about role blurring as, "overlap," which was her way of describing the invisible and changing boundaries between staff members' roles:

> Myself, as activity [staff], I might be doing a program, but there still might be people who need help with feeding, so I kind of overlap there. And then we get the nursing people who will, once their care is done, they will overlap in doing the newspaper programs or the flyers, or music or different things. So, they do overlap. It's like an interlocking system where they do help. (P10)

A third staff member spoke about her ability to understand the roles of others, and her ability to read the situation on a shift and respond appropriately. She portrayed a picture of each staff member filling in if necessary to ensure that resident needs are met:

> Perfect example is the housekeeper on our floor is very good. If we have a problem in the morning, nursing has a problem, somebody has to go to the hospital, somebody fell, the RN is not going to be able to come to the dining room right away. Because I'm the only person that's in the kitchen 7-3, the nurse, the RN, on our floor comes and serves the residents breakfast. If she has an emergency, the housekeeper will step up and she will work with me and she will serve the residents breakfast. (P4)

These staff members portray a flexible working environment where resident requirements dictate what work is done and by whom, based on an informal teamwork approach. Participants also talked about their perceptions of both individual and mutual accountability. One staff member stated:

> I think everybody is accountable in that they have their own group [of residents to care for] and I think that staff have overall accountability for the 25 residents. So, I think the accountability is for everyone because of the team, because it's such a small unit, everyone is there. I think people are not only accountable for their own residents but for all the residents of the unit. (P10)

The BPG implementation process thus began with a small group of three managers directing the team, and gradually evolved to include multidisciplinary staff (both regulated and unregulated) and family members, opening the process to create a more collaborative approach. A major finding was that although the BPG booklet provided a prescriptive list on how to implement the guideline, as well as a specific list of recommendations to improve teamwork, the team contextualized both their approach to implementing the BPG as well as their selection of which recommendations to implement to make it work for the dementia care unit.

The Impact of Teamwork on Team Members: "We are here for the residents"

The RNAO HWE BPG, as explained in Chapter 1, and the senior care facility Mission Statement, outlined in Chapter 4, speak to the importance of creating and sustaining a healthy environment for both staff and residents. According to RNAO (2006), "A healthy work environment is a practice setting that maximizes the health and well-being of nurses (staff), quality patient or client outcomes, organizational performance, and societal outcomes" (p. 13). Similarly, the senior care facility's Mission Statement (2015) states: "We are committed to providing our residents with quality, leading-edge care and services through teamwork, positive attitudes, technology, accountability, and cooperation." (xxx facility mission statement). I considered both statements when I asked participants about the impact of the BPG on staff, residents, and family members.

Staff and their work environment.

In my interviews with staff, I wanted to understand if a focus on teamwork had changed their way of working and their work environment and, if so, how. Both regulated and unregulated staff members responded positively to these questions. For this staff participant, there was more of a resident-focus now:

> When you walk through the lounge and there are residents sitting there, people acknowledge them now… speak to them, say good morning. There is more engaging with the residents…I see it. The staff know that we are here for our residents and that is more visible than ever before. (P11)

Resident-focus was mentioned as a common goal and a strongly held belief by almost every staff member interviewed. The following short statements reflect this sentiment:

> If the resident needs you, that's your priority. (P2)
>
> I am in dietary but I can step up and help a resident with anything. (P4)
>
> Sometimes these staff have a lot to say, but often it is because in their opinion, what is happening in a certain situation is not in the best interests of the residents. (P5)
>
> I just want for us as a unit to provide the best we can for the people who are entrusted to us while they are there. And I think that most of the time, we do that. (P5)
>
> I always hear really positive things from the family about the staff, about how loving the staff are, how caring they are to the residents. (P6)
>
> The staff are very flexible and change to meet the needs of the resident. The saying on xxx unit is that the residents can't change, we have to change. So we go with that and try our best to make them have a good day. I thought this philosophy was wonderful. It really makes you think about it. (P9)

These statements reflect the staff's focus on doing what is best for the residents. Other staff members spoke about the temporary nature of the length of stay and providing the best care during this time. This common goal of resident-focused care was exemplified in a family member's account of how a staff member attended to her father in the story of *a staff member who went out of her way:*

> Now Dad wasn't a computer person, but I do know that one of the ladies one day was cleaning when he was upstairs. She was on her break and Dad was roaming around. He would go with the chair all over the place. He could propel that chair that they had never seen anything like it. If you couldn't find him, he would be on another unit. He would just go with the chair. It was unbelievable. So she opened up the computer and brought up these pictures of animals and everything and she was showing him on the computer and they had a great time. That's someone who is there to clean his room and she goes out and takes the time to do that. That was something really good. (P1)

This story stayed with this daughter even after her father is gone. It shows how the staff member knew about the pictures of animals in her father's room and that he had been an

outdoors person most of his life. This staff member wanted to bring the resident joy and in doing so brought his family joy as well. These findings are consistent with the organization's stated values of compassion for all people as well as excellence in care provision.

As well as a heightened focus on resident-focused care, staff participants voiced greater satisfaction with their work responsibilities and the atmosphere at work, as reflected in these three excerpts:

> Most days are good days to come to work. (P2)

> I felt so good about providing activities on evenings. I took them (residents) off the unit, we folded clothes; we listened to music. They all got involved. They all chatted. I loved this role. I saw the other aspects of the people. (P9)

> Everyone loves coming to work on our unit now and that feels good when we hear that. (P4)

Staff also expressed enhanced pride in what they were learning and accomplishing:

> I think we have a handle on what else we need to do and how we can improve because communication of the team is open. We were advised that out of family satisfaction surveys, families were asking for more purposeful engagement with residents. We are now working with staff and days and evenings to improve on this area and we have an audit to check on it. A recent example of this is the bra washing program we initiated on evenings twice a week. (P5)

Besides pride, the same staff member spoke about her new feeling of being listened to and valued:

> When we moved to this building, there was a big adjustment- adjusting to new equipment and the increased square footage we had to cover. As well, initially we had two units to supervise which was not possible or safe. Senior management asked my opinion about this issue and listened to me, acknowledging the reality that everyone was struggling. I appreciated that and I stayed. I am happy to be an employee of [xxx senior care facility]. We have had a lot of change thrust at us, but it is all good change! (P5)

Similarly, another staff member appreciated the emphasis on teamwork and spoke about her involvement in making things better for the team and in the end for residents:

> I know that teamwork on [xxx unit] made a big difference to me. We rearranged the LPN team lead role to provide assistance to the Resident Attendants and that was positive. (P2)

The LPN who is speaking in the above quote was involved in the process of redeveloping the LPN role to share some of the work done by RAs. She felt proud to suggest changes and have them adopted. For another staff member, the work environment was "healthy" and "happy":

> The work environment is a pretty healthy place to come each day. The residents are the good thing about it. It is a happy place, and there is a lot of interaction between residents and the staff. (P10)

Although this person appreciates the staff-resident relations, she was silent regarding relationships with other staff members or with management. Another staff member was more forthcoming about difficulties on the unit:

> There is days and I won't lie to ya, sometimes after four days it is hard on you- hard on the head. You take that home with you. (P2)

For this staff member, the emotional and mental strain of this type of work is not something that stays on the unit but follows her after her work day is finished. Staff also identified communication processes as important in the work environment. The importance of communication came up in interviews with staff, even when the question was not about communication specifically:

> Everybody is your assignment on [xxx unit] and you just have to have really good communication. (P2)

> Your information is pretty well passed on within each shift but from shift to shift may be less accurate. (P10)

> I talk to family members often and I feel that I have a good relationship with them. They stop in to see me whenever they need to or want to. (P5)

> I think my input is heard. I am in dietary, not nursing, and sometimes I see things they do not see. (P4)

For the staff in this study, communication was a key element of effective teamwork. Sharing their knowledge to resolve resident care issues and communicating across shifts helped staff members trouble-shoot resident issues, prevented problems from occurring on the unit, and provided continuity in care delivery. Staff also identified communication as an opportunity to build relationships. For example, some staff working in departments outside of nursing saw themselves as bringing a different disciplinary perspective to the problem or issue. For one participant, even the brief informal meetings with RNs were beneficial for staff members who may be otherwise engaged and unable to attend a meeting:

> Just because of the way the day is unfolding, all staff may not be able to get to the huddle and I go to the staff who do not get a chance to go to the meeting and check in with them. (P5)

Although the participants above felt that their voices were now being heard and their input valued, for one regulated staff member, communication could still be challenging at times:

> Communication, sometimes, is very opinionated. It is open but at times it is challenging to get your point across. I would like to see more of a pride of ownership. Staff get overwhelmed with tasks and don't consider how can we do things differently. For me it is the challenge and the satisfaction of figuring out what works to help a resident. If they [staff members] could just relax a bit and see things differently. There is a certain rigidity- a lot of it is union stuff. (P6)

The comment above perhaps reflects a situation of team members not fully understanding each other's position on specific issues. Besides talking about challenges with communication, this participant's comment also reflects the push and pull between

necessary tasks such as bathing, dressing, and feeding, and the desire to provide individualized attention as needed. Although union regulations were rarely mentioned, they seemed to be a sticking point for this participant. Unfortunately, I did not inquire about this further.

Responses to my questions to managers, staff, and family members about the impact of the BPG on the interaction between staff members and residents were overwhelmingly affirmative. In the example below, a manager comments on her observations of a closer interaction between staff and residents as an element of an improved work environment:

> I think that the environment is very good on [xxx unit]. I have some staff who have been there for a long time and there are some strong personalities. We all have our faults. Sometimes these staff have a lot to say, but often it is because in their opinion, what is happening in a certain situation is not in the best interests of the residents. (P5)

An important part of this quote is how, according to the manager, staff feel they can speak up to ensure that residents are protected and decisions are made in the best interests of residents. She also acknowledges that staff speak from their experience, in some cases, many years of experience.

As well as feeling free to speak up when necessary, staff, generally, felt that their input was heard, as these participants pointed out:

> Well, like I said, we will kind of all bring our ideas together and you'll say what works for you and she'll say what works for her, and then we try them. And if it works, it works, and if it does not we come back and revamp it all over again.(P2)
> I think my input is heard. I am in dietary, not nursing, and sometimes I see things they do not see. (P4)

These staff members are suggesting that being heard and having their input valued enables effective teamwork and the provision of quality resident care.

However, for some participants, the level of staff involvement in actual decision-making on the unit was contentious. For example, some staff felt left out of decisions regarding the change in policy and practice of using psychotropic medications to control residents' behaviours. A current trend in gerontology, as explained in Chapter 1, in relation to treating behavioural issues in dementia care is to reduce psychotropic medications and use alternatives to these such as distraction and redirection techniques. However, several participants spoke against this change in policy and expressed their own perceptions about it. The two excerpts below capture the general feeling of staff members about this change:

> They are trying to go with this drug-restraint-free thing. But medication is ordered for a reason. Like come on…. there's medication out there that can be useful, but they just don't want to give it. Now I work part-time in another senior care facility and they don't have a problem. (P3)

> In my opinion, I feel like they wait when people are going into their meltdown zone like when they're getting more agitated. I find they wait too long to give the PRNs (medication to be given on an as required basis). (P4)

These participants' comments bring up questions surrounding the extent of involvement of staff in decision-making, the education that is provided to staff, and the assistance given in learning about alternatives to medication use, including an understanding of when to use the alternatives.

Another topic related to hierarchal decision-making that staff brought forward concerned the timely transfer of residents off the unit (as explained in Chapter 4), and their perceptions about current problems with this process:

> Residents need to be moved off the unit in a timely fashion.
> We have had a gentleman on our floor for months since the fall. Doesn't walk, doesn't even participate in the programming. He is just leaving today. We don't have the equipment (to care for him safely). (P3)

> We try to get residents transferred off the unit when they no longer meet the criteria, but it isn't easy to get them moved out when they need to be. We need to have more input on this. This can pose problems on the unit. (P5)

These staff members want to have more of a voice in decisions about who is transferred off the unit. According to one staff member, one resident no longer met the criteria for the unit and could be more safely cared for elsewhere. However, this decision is not just one that affects the unit but would also involve the rest of the senior care facility in terms of coordinating efforts to find alternate placement in another area of the senior care facility. Another participant mentioned that team input was lacking in terms of this issue, causing care delivery concerns, and impacting teamwork on the unit. The impact of an emphasis on teamwork was also linked to the impact for residents who live on the unit.

Resident impact.

A common goal identified by all team members interviewed was the provision of resident-focused care and services. Knowing this, an important question to ask is, 'What was the impact of an enhanced emphasis on staff teamwork on the residents who live on this senior care facility unit?' Based on the responses from management and staff, one positive impact on residents in this study was the introduction of new programs, especially the evening activity programming.

With an increased emphasis on teamwork, and following the results of the family surveys, staff members and the unit manager identified a problem area and acted upon it by introducing evening activity programming to the evening shift, a time when sun-downing occurs, and residents can become restless and agitated. An activation staff member explained the activities in a report on evening activities included in the documentation review:

> Over the past year on [xxx unit], I personally witnessed the time and energy that staff spent redirecting and managing challenging behaviors on our unit. As all of our residents are confused and disoriented with lower cognitive ability, we faced many challenging behaviors head on with the admirable intention of maintaining a safe environment for all our residents. As the year moved on it became obvious that although our residents were safe and well cared for physically, something was missing. All of the evening staff made great efforts to do small actions each shift that brought smiles to our resident's faces and moments of laughter in the air. Something was missing despite their efforts. As we, the front-line care team, began to discuss this gap, this absence of something vital, we discovered that what our residents needed was activity. They required something to do in the evening to spend their time in a meaningful way. At the same time, we realized that a large part of the time and energy we were spending managing challenging behaviours would be better spent and more meaningful to our residents if we engaged our residents in activities they could enjoy. We have since made numerous adjustments with group assignments, workload, and culture to incorporate a scheduled evening activity routine on [xxx unit]. All staff are encouraged to continue the small informal activities and meaningful moments as per their usual routine. This programming however is an enhancement to what is already being done. It has helped to decrease the number of aggressive incidents and decreased the amount of time residents spend attempting to elope. Residents have been laughing, smiling, and even dancing more than they ever have. Sedentary residents have been emerging more and mobilizing more on the unit. Residents who have had difficulty settling for bed are now going to bed and staying settled for the duration of the night more than before. (Documentation-evening activities, June 2010)

This excerpt paints a picture of the staff on the unit working collaboratively, taking initiative, and filling an identified gap in resident care. By adjusting their routines and with a common goal of resident-focused care and a teamwork approach, the evening activity program appeared to be a success.

Evening activities listed in the unit's Activity Journal also included: looking through newspaper flyers, participating in circle exercises, baking banana cake, participating in a walking group, playing tic-tac-toe toss, looking at old pictures, making a pizza, folding linen, and painting. An example about making pizza was written by an activation staff member:

> They liked making pizza. AG [a resident] told me that she never made pizza before. BD [another resident] said that she always went out on Saturday with her

> boyfriend to Vito's. AG got the pizza dough and poured it into the bowl and mixed the water with it. BH [a resident] spread the dough on the pan. BB [a resident] buttered the pan. BD poured the sauce. Then they all spread the sauce and put the toppings on! While waiting for the pizza to cook, they all talked about their families, laughing, and drinking tea. They all had pizza except BB. She does not like pizza. Bd[a different resident than BD above] had pizza and pop in his room. After they were done eating, we washed the dishes together. (xxx unit Activity Journal, June 24, 2010)

This excerpt from the report suggests that the activity of making pizza brought back residents' memories about having pizza in the past and stimulated conversation and engagement. This staff member reported residents were engaged and felt part of the activity. The positive atmosphere that was created was evident. An equally important point to note is how individual choices were respected in terms of a resident who wanted to eat his pizza in his room. However, some staff members were better than others at sensing when to engage a resident in activities or take them for a walk. This staff member's story about *the man with a look in his eye,* became known in a staff meeting which the manager attended:

> I said okay [a staff member] - stop. What do you mean he had a look in his eye? And she looks at the team. They are all full-time and she say, 'so you guys know what I mean right?' Two of them did and one of them is like- 'Uh no'…I said, A look in his eye, that's where you alter your plan. They got it and they realized—Oh my goodness. It was down to 90 seconds where someone's eye was not on them and that 90 seconds id when we had the violent occurrence. It was amazing to see the collaboration, and then they [the staff] realized it. Oh yeah, she is casual, but she made that comment. What do you mean that he had that look in his eye? That is excellent. That is information we need for his care. Does everybody know now? You got to make sure everyone else knows [all other staff]. We see that look in his eye. Don't avoid him. You got to distract him. You got to do what you got to do for him so that he is comfortable and he has what he needs and comes down from that loss of control. (P11)

This story highlights several aspects of teamwork that were the focus of the BPG, including enhanced communication, respect for all members of the team, and using

teamwork to promote safety for residents and staff members. As well, a safer environment with fewer incidents and accidents is less expensive for the organization. This excerpt also highlights the use of practice-based evidence being shared among the team to improve care planning and delivery for one resident.

Another impact on residents, based on staff comments, was related to the relations occurring among staff on the unit. Staff members below explained how residents notice, recognize, and react to the atmosphere created by staff relations on the unit:

> We are working as a team all the time and the residents can feel that. You see them relaxed and smiling when we are having a good day at work. (P9)

> You can tell when the unit is well organized for the shift. You can just tell…the residents are happy, well hydrated, and they are dry. They are being paid attention to. If you have a good leader, the day is much smoother. If you have a nurse leader who is negative, saying "we are having a terrible day," residents can feel that atmosphere. (P6)
>
> If the residents see the staff smiling and getting along, most of the residents are right there with us, a part of that feeling. (P2)

Conversely, staff members reported that residents can also sense tension on the unit and respond accordingly:

> When you get a couple of people over there [staff] who are stressed with each other, residents can become aggressive or can be found crying in a corner. (P2)

> If a new staff comes onto the unit who does not seem to belong – the cold shoulder can be given to a newcomer- you can feel the tension….and the residents do feel that. I have seen it. (P3)

> Yes…if there is tension on the unit the residents feel it and I have told other staff when you act out, the residents feel it. (P4)

> Residents can pick up on tension in the environment. They become very quiet. They put a hand on your arm and ask if you are okay. They know that something is off. (P10)

When an issue affected staff, it affected residents. (P7)

These comments on the ability of residents to sense the atmosphere on the unit and react to it by reflecting it back to staff is an important finding of this study. It is indicative of the impact of teamwork on the recipients of care, the residents. If there is an atmosphere of ease among the staff, there is an atmosphere of contentment for residents. If tensions arise between staff members, the staff told me repeatedly that residents can feel this and display concern, sadness, and even fear.

Most participants interviewed, whether they were staff, managers, or family members, explained, each in their own way, how residents have benefited from the increased emphasis on teamwork on the unit. The benefits of working as a team reportedly included: greater interdependence, enhanced communication, and having a common goal. Additionally, most participants reported that an emphasis on teamwork had, for instance, improved the atmosphere on the unit and facilitated the introduction of programs or new practices to meet residents' needs. Nevertheless, at times, conflict arose among staff when trying to work together as a team. One unregulated staff member offered a rationale for some of the staff conflicts on the unit:

Interviewer: In your opinion, do conflicts arise between staff at times, and if so why?

Participant: There are times when conflict happens. One person thinks that they are doing a better job than the other person.

Interviewer: Why? Why do they think that?

Participant: I don't know …. but it happens all the time! (laughing) I think it is because certain residents are better with certain staff and how they relate to them,

> for instance the resident could be better with me than with you and this can cause hard feelings among staff. That's what I think. (P9)

This participant is suggesting how a resident with dementia may relate to some staff and not others, and how this may have more to do with the resident than the staff members involved.

Moreover, not all teamwork efforts had a positive outcome for residents, as shown in the following case where management decided to discharge a resident from the home. At the end of one interview, when I asked if there was anything else the participant (a regulated staff member) would like to tell me that I had not asked about, she told me the story of a man who required more care than the home could safely provide. This is the staff member's story of *the man who could not stay*:

> I think that I would like to mention one resident we admitted from home who was a prominent person in this city. He appeared to be a good candidate but for us turned out to be an aggressive and unpredictable person. He was a huge man. We were waiting for a bed for him on the CAM [Cognitive Assessment and Management] unit at xxx hospital but in the meantime, had to send him to the emergency room as we could not handle this man. He eventually got into the CAM unit for assessment, then he came back here. Nothing had changed really. We had to discharge him. He went back to the CAM unit and is still there. It was so hard to admit that we could not manage this man. It was hard for the family. It was hard too for the staff and our management to feel we had failed. There was a lot of backlash from one of the family members. Most of the family were insightful but one was not. That one was very vocal in the community which was hurtful. We had special education sessions on care mapping and handling difficult behaviors. That situation was very very hard. There is no doubt in my mind that we made the right decision, no doubt. (P5)

To maintain a safe environment for other residents and staff, this man could not stay on the unit and be cared for in a safe manner. The team members were intimidated by the man's size, and their attempts to divert his attention and de-escalate difficult behaviours were unsuccessful. However, another participant felt that the man should have been

allowed to stay and other strategies could have been used to care for him. This participant felt that a decision had been made prematurely, and that all team members should have been involved in the decision to discharge him. Having more people involved in the decision would have been more reflective of a teamwork approach.

Family member impact.

As mentioned earlier, managers, staff, and family members considered family members to be part of the team caring for their resident on the unit. In this section, I tell the story of a family member whose father was a resident of the unit and lived with dementia. She explained how she participated as a team member in holding her wedding on the unit. Here is her story of *the man who wanted a navy-blue suit:*

> *Interviewer:* I understand that you were married in [xxx unit]. Could you tell me about how that came about?
>
> *Participant:* I knew my Dad didn't have a long time to live. He had advanced dementia and he had to come to live at the villa for his own safety. His Mom had dementia, his sister had dementia, and his brother had signs of dementia and died last week. The guilt was such a big thing on me. I am the youngest of six kids and when Dad did all the legal stuff, I was named the person to handle all the medical decision-making. This is where my Dad lived. He had to, he did not want to. Some people [staff] were so set in their ways and other staff was so good. One woman was so good to my Dad. She came in on her day off to get him ready for the wedding. They loved each other. I had been seeing my boyfriend for some time and we just decided to get married. I wanted my Dad to walk me down the aisle. He wanted a navy-blue suit and a light blue shirt to wear

> that day. When I bought it, I had a bit of a hard time as I knew it would also be the suit he would be buried in. I made all the arrangements with the senior care facility staff and management. They were great. It was going to be held outdoors in the courtyard and all residents and staff were invited to be there along with our friends and family. The morning of the wedding, it was pouring rain, so we moved the wedding inside. There were cupcakes, there was music, there was excitement! What I remember most of all is the smile my Dad had and how he sat in his seat without any problem. All the residents came and there were no incidents or problems. When it was finished, we had tea and cupcakes but then quietly all left the unit to let things return to normal. It was so special to us and I was so happy with the effort from everyone to make it a success. (P8)

Telling this story appeared to bring back beautiful memories for this participant. She said that she organized all the details but felt indebted to the staff for all they did to come together as a team to make this occasion special. She spoke about how "normal" it felt, everyone taking their places and watching the ceremony.

A tremendous amount of teamwork was required to assist residents in getting ready for the wedding ceremony and to prepare the area for guests, as one of the participants who attended the event explained:

> My perception of the wedding is that it was a fine example of planning and teamwork. The event was amazing. Twenty-three of the twenty-five residents with dementia were there. They sat there with the family and were as comfortable, content, and appropriate as could be. To have an event like this was the icing on the cupcake. It was so emotional. To see the limo pulling up and the bride coming into [xxx unit] …. this was a lot of work to pull off but together we made it happen. (P11)

From this participant's reflection, the team effort was certainly worthwhile. The team had a common goal or purpose to work towards together, and I heard how each person fulfilled their role to make the event happen. The residents would have had to be washed, dressed, and fed in preparation for this event. The timing alone would have been difficult if management, staff, and family members had not worked together. The order and organization and the happiness of the event may have also had a positive effect on the other residents.

The Work of Sustaining Teamwork: "We are working together like a team now"

As the senior care facility mission statement says, the home provides a service to the elderly and is staffed by people who provide care to residents twenty-four hours a day, every day of the year. Providing nursing care includes interactions between several people including: family members, volunteers, staff, managers, residents, union representatives, visitors, suppliers, regulators, and others. Sustaining teamwork is crucial to the ongoing work of the senior care facility and the fulfillment of its stated mission. Findings related to the work of sustaining the team include: building relationships on the unit, fostering self-confidence and agency of team members, and providing a culture of continuous learning.

Building relationships on the unit.

In exploring the implementation of the BPG and its impact on sustaining teamwork on the unit, the findings reflect the importance of mutual appreciation and respect between and among management, staff, and family members. Although an

emphasis on teamwork might suggest less focus on senior management, an important finding in this study is that whereas participants still looked to management for leadership they also emphasized the importance of a collaborative management style. Management and staff seemed to reflect similar perspectives on leadership. For example, a manager described what she does to enhance teamwork on the unit:

> I am a very hands-on nurse. I have different responsibilities than other staff, and I have timelines to meet but if they are having a hard day and need my help, I am there. I make a practice of feeding residents in the dining room each morning. I am interested in relationships with everybody and I think it is a good way to cultivate teamwork. (P5)

Another manager explained how she assists on the unit when needed:

> We [senior management] will bring in the resources when they [staff] need them for the residents. (P11)

The staff I spoke with also agreed with the management's leadership style and how it enhanced teamwork on the unit. One regulated staff member expressed her appreciation in this way:

> We have such a good place here. We have room to grow but we have support from administration. We can move forward and be on the top of our game. (P6)

From this person's perspective teamwork means management enabling staff agency while providing support to staff when needed.

As explained previously, when problems were identified on the unit, management was attentive to the situation and took steps to address the problems, one of which was to pursue RNAO BPG implementation. Other examples included implementing programs suggested by staff such as the pet therapy program and the new admission process discussed earlier. Also, when family surveys called for more purposeful engagement of residents, especially in the evenings, management introduced evening activities. These

processes required investment of time and effort as well as human and financial resources. A family member also expressed appreciation for the role management played:

> The management here are progressive and up-to-date. There was really good teamwork with most of the people. I think the day staff had a good core and they worked together and (xxx), the manager was fantastic. (P8)

However, the perception from some staff was that management were rarely seen and only came to the unit if there was a party taking place or a picture being taken. Two staff members expressed their views as follows:

> You are lucky to get them (senior management) on the unit. I don't know if they are scared. (P3)

> If there's a picture and there's a party, there's usually a manager around somewhere. (P2)

Nevertheless, from both perspectives, visibility of management on the unit was mentioned as something that impacts and sustains teamwork as it speaks about their interest in the unit and the staff working there.

In addition to management presence on the unit, findings emerged about the importance of attentiveness of managers to input from staff. As noted previously, in their efforts to sustain teamwork, staff appreciated having senior management listen to their concerns as well as having input into decisions that affected the unit, as one regulated staff member explained:

> When we moved to this building, there was a big adjustment, adjusting to new equipment and the increased square footage we had to cover. As well, initially, we had two units to supervise which was not possible or safe. Senior management asked my opinion about this issue and listened to me, acknowledging the reality that everyone was struggling. I appreciated that and I stayed. (P5)

This participant elaborated further stating:

> I am at the age where I have certain expectations about how I work, what I produce, and if I am not given what I need to do that, then I cannot go home satisfied. While I was still out with him [her husband who had become ill], I think that they-I think that the administration realized that they needed to look at everything. I did have a call from both the director of nursing and the CEO telling me that there were some changes. When I came back, I would have the choice of which unit I would be responsible for, but it would only be one unit. I did say to the CEO, if you hadn't made that change, I am not sure that I would be coming back full time. I think I would have had to make some serious changes. (P5)

This staff member is talking about safety, professional practice, and trying to manage through a difficult adjustment period. She was making suggestions to management about how to manage these risks to retain staff and sustain teamwork. Management responded by listening to her concerns and acting on her suggestions. They followed her recommendation that one RN could safely manage one unit but not two. This validated her opinion and she was appreciative of this response from management.

For staff, having a leader who is involved in the day-to-day work of the unit also helps sustain teamwork. A regulated staff member characterized her thoughts on leadership style:

> The two unit managers, xxx and xxx, they are excellent, excellent. They are quite good at problem-solving and saying we can have a family meeting with this one or we've tried this and checked her over. They are all doing the preliminary stuff now that they have never done before. (P6)

This same participant continued:

> There has been a huge change in both the acuity and dependency of residents we are admitting. Both nurse managers, days, and evenings, are excellent now. They are learning from experience. They have established a good rapport on the unit. (P6)

These comments reflect both the presence of clinical excellence and improved communication and collaboration on the unit. Similarly, two other staff members, regulated and unregulated, described the current leadership style as positively affecting the work environment:

> We are working together like a team now and I think it has a lot to do with the change in the RN. It is almost like a family now. (P3)

> It is a good work environment right now, good leadership and the team pulling together as one. (P4)

The word *now* is used in both above excerpts implying that things were not always that way. These participants inferred that teamwork was enhanced after a change in leadership and BPG implementation. I sensed this same perception throughout the participant interviews. A change in leadership and the implementation of the BPG are not mutually exclusive. Management's choice of the RN mentioned at the beginning of this chapter infers a preference for an RN who practices transformational leadership as articulated in the BPG.

Fostering self-confidence and agency of team members.

The degree of self-confidence and agency of each team member also had an impact on teamwork on the unit. By self-confidence I am also inferring reciprocity in relationships, trust, and cooperation. One regulated staff member talked about noticing the self-confidence of another team member and how this had an impact on her work:

> We have a nurse, she is casual. I just love her. Her name is xxx and she is a xxx nurse (specific specialty). Very confident and very professional and so it does not really matter what is going on. Things are relaxed when you go in there. Things are handled. She had a little lady yesterday with late stage dementia who had stopped swallowing and she passed me a note as I was tied up doing something.

> And she said I am going to start a med on this resident. And that is all she needed to do and I went down to see her once I was done what I was doing and she was right. She has confidence in herself. (P6)

This participant is referring to another team member's knowledge, experience, background, interpersonal skills, self-confidence, and decision-making skills. This staff member noted the congruence between the thoughts and actions of herself and the staff member and how comfortable that was for her. Both staff members in this case were regulated staff members.

Another regulated staff member, however, inferred that her level of education was less than other staff and she perceived that her role, therefore, was possibly less important:

> I am only dietary. I am not nursing and I didn't take any special courses.(P4)

This staff member felt that her role was not as important as the role of the RN. We talked about food and the dining experience and how important that is to the residents. She expressed her joy in talking to the residents and we shared a laugh about how residents on the unit seem to forget about their food dislikes and eat everything, which can be surprising to family members. Nevertheless, if this person saw a problem that potentially negatively affected residents she did not hesitate to speak up and displayed confidence, proceeding to fix the problem. An example of this was her response to regular staff taking every weekend off in the summertime:

> It had to be fixed. I am not going to take this. I don't want to work here under these conditions. We are all supposed to be adults. You're here to do a job, just do it. I don't care if she is your best friend, I don't have any friends here, you're here to do a job, right. (P4)

For this staff member, the team membership stability was being disrupted by various replacement staff who were not familiar with the type of teamwork that is expected on this specialized care unit. Although she was an unregulated staff member, this participant demonstrated agency by speaking up when she felt it was important for her to do so.

An example of the importance of understanding a person's background and life experiences in sustaining teamwork surfaced during a discussion I was having with a staff member about continuing education materials provided to staff on the unit. One book on the unit's library shelf was Lisa Genova's (2007) novel, *Still Alice,* a story about a woman who is living with early-onset Alzheimer's Disease. This staff member could not relate to the novel:

> I got half way through it, and it didn't interest me at all. It didn't interest me at all because the woman is a professor, and it revolves around her life. And it does not matter who you are, but it's always about someone who has money. You know what I mean. (P3)

The novel did not speak to the staff member's life experiences or her own background or upbringing. It bothered her that Alice had no problem paying for expensive medical tests. Alice also had an equally successful husband and three successful children, which this participant found unrealistic. Ironically, I was thinking to myself how much I enjoyed the book, as it was an account from the person herself for as long as she could tell her own story. Our disparate views of the novel struck me and made me ask why? The answer to this question lies in the past experiences, separate realities, and privilege each person brings to their life, including their work-life. These differences can be the root cause of tensions in the workplace. Understanding such differences between and

among staff, management, and family members may be the first step in sustaining teamwork and providing a healthy work environment for all.

Being valued for the role a team member fulfills also arose in relation to self-confidence and self-efficacy. I asked a resident attendant if she felt valued for the work she does. She responded by saying:

> I feel like I am an important person to the residents and to family members, but sometimes not by other staff. (P9)

Positive feedback for this team member came from the residents and their family members. However, in the bigger picture of the unit, staff, and management, and the organization, she reported feeling undervalued. This feeling could negatively impact teamwork.

Family members also need self-confidence and a sense of agency to play their role on the team. For example, this family member advocated for her father, *the man who wanted to wear jeans*:

> It is their home and it's their life and if my Dad wants to wear jeans like he did all his life, then put jeans on him, and if there too hard for you to get on, that's too bad, deal with it. Sometimes I would walk in and they would say, "He is okay with those sweatpants." And the minute it was he and I, he would say, "xxx, give me a pair of jeans." I told the staff, "He might not tell you, but I am telling you for him." I did feel part of the team, they did listen to me. But I had some battles for my dad. But that was my role to advocate for him. (P8)

For this family member to feel part of the team that cared for her father, she needed to be able to express her points of view and ask staff to respect her father's wishes, and she did so. It was obvious that advocating for her father was not easy at times but she always did what the situation required. In response to my question about her involvement with her father's care, another family member explained:

> We (her family) looked at it as a good thing that Dad came here, that he was safe and we didn't have to worry about him and we were happy that this was going to be his home and we were going to make it like that. But I know there were families that felt, "I don't want to really bother them…" and I would say, "No go ahead, you're allowed to do this." Like I know the kitchen in xxx has to be locked but I would say, "It's okay…. you can go in if you want. You can have a glass of juice with them (residents). It's not just for them." We would go into the kitchen and maybe have lunch with them or have supper with them or buy lunch tickets so we could eat with them. But I found that a lot of people were a little bit different, but we just went through it and decided this is what we are going to do. (P1)

This participant is referring to the varying degrees of agency among family members and how this may have influenced their actions or involvement or lack thereof on the unit team.

Maintaining a culture of continuous learning.

A culture of continuous learning is a stated professional component of a healthy work environment (RNAO, 2006) and according to the evidence-based recommendations in the BPG, management can support and sustain the work of the team through the provision of educational opportunities for team members. Possibly due to the focus on BPG implementation, participants noted heightened attention to education topics relevant to the team's work on the unit. This staff member recognized the importance of keeping up to date:

> And xxx (CEO) where she is involved with the accreditation, she always has got the most recent guidelines there for us so that's really good. (P6)

Another staff member found the care mapping sessions extremely valuable for the team:

> We at [xxx senior care facility] have partnered with xxx [Consulting Services] and all our staff take mandatory in-service education online. Some staff are not very computer savvy, but some are quite good on computer and have gone on to do all the courses. This past summer we needed education on care mapping for dementia and had an excellent eight-hour session with two ladies who came here,

> and a follow up day as well. Staff are all trained on the U-first training and we have refreshers too. (P5)

The care mapping session occurred, according to interview participants, because of the situation of "the man that could not stay" when team members identified a need for more detailed education on caring for people who exhibit difficult-to-manage behaviours. Staff also found other sessions such as U-First orientation (an Ontario-based program that uses case studies to foster an understanding of dementia care) to be beneficial for staff and supportive of teamwork and team development. As mentioned previously, these evidence-based practices were being shared outside the study setting to other units across the organization. This occurred through the mobility of part-time and casual staff from one unit to another within the home.

Summary of Major Findings

In this qualitative study, I investigated the implementation of an evidence-based intervention (RNAO HWE BPG) to improve teamwork on a dementia care unit in a senior care facility in New Brunswick. I organized my analysis of the management and staff participants' interview transcripts into four themes: (1) teamwork in a senior care facility setting; (2) teamwork contextualized; (3) the impact of teamwork on team members; and (4) sustaining teamwork. The following major findings of the study were drawn from each theme.

Under the first theme, although the BPG recommended a collaborative approach to BPG implementation, management followed a hierarchical approach when selecting the BPG implementation group, deciding who should participate in RNAO summer institute training, and who should be consulted in designing the action plan. Vital

knowledge of all staff was not considered in the initial stages and this may have impacted efforts to improve teamwork on the unit. Also, and perhaps because of an initial hierarchical approach, although management, staff, and family members considered themselves team members, there was not a consistent understanding of the meaning of teamwork on the unit; some team members still looked to management to make decisions and sort out problems.

An important finding under the second theme was that management utilized a contextual approach to BPG implementation rather than a normative one, customizing the process to fit the specific needs of the senior care facility. Rather than accepting the BPG in its entirety they selected relevant aspects, implemented some of it, and set some aside. As noted by one participant, "We made it work for us." Another important finding was that although the implementation followed a hierarchal process initially, it became more collaborative and included staff and family members as the process evolved, leading to more input from staff, role sharing, and blurring of roles of team members.

Under the third theme, an important finding was that the BPG implementation impacted team members in a positive way. Staff appreciated the enhanced focus on resident care and reported satisfaction in working together for the benefits of the residents as reflected in the words of one staff member, "*The residents can't change, we have to change.*" Another very important finding is that residents could sense the atmosphere among staff on the unit and react to it, which I refer to as a reflection-in-a mirror effect. This denotes a link between staff working well together as a team and resident contentment; the inverse of this circumstance was also reported to be the case. This builds on and adds to previous research linking quality of work environment for staff and

quality living environment for residents or patients (Backhaus et al., 2016 and Sikorska-Simmons, 2006).

In relation to the fourth theme, management and staff expected management to play a major role in sustaining teamwork, through their attentiveness to input from all staff and their presence on the unit. Also important was an understanding of how the different life experiences of team members can impact teamwork necessitating the fostering of self-confidence and agency of team members. Continuing education for all was found to be crucial for sustaining teamwork.

In the following chapter I link my findings to the relevant literature, and show how my work supports, refutes, and in some cases extends previous work.

CHAPTER SIX

Building Knowledge by Situating the Findings

I began this work with an interest in evidence-based BPGs and their potential usefulness in senior care facilities. At the outset, I identified three significant gaps in the literature: (1) no known studies had reported outcomes related to implementing HWE BPGs in a senior care facility setting; (2) no known studies had determined that BPGs are normative or non-normative; and (3) no known studies existed on the contextualization of BPGs in senior care facilities. I wanted to explore both the process used to implement the BPG and the resulting impact on the working environment. As the study evolved, my focused broadened to understanding teamwork in a senior care facility and the processes needed to enhance and sustain teamwork in this setting.

Through this research, I am contributing to knowledge about the use of HWE BPGs in senior care facilities. I learned that management and staff produced a non-normative interpretation of the BPG. In combining evidence-based knowledge with practice-based knowledge they engaged in multiple ways of knowing and demonstrated agency by contextualizing the BPG recommendations to make the guideline work for them. Also, although management initially followed a hierarchical approach to BPG implementation, over time, a more collaborative process, which included more staff and family members, evolved. Although, as expected, some tensions and contradictions were evident in the BPG implementation process, participants reported enhanced team members' satisfaction, increased resident-focus, and a positive impact on staff teamwork and resident contentment. In addition, I learned that both staff and management expected

management to play a significant role in sustaining teamwork. Building the self-confidence and agency of staff and continuing education were important in terms of sustaining teamwork in this senior care facility.

In this chapter, I analyze my qualitative findings by linking back to "concepts and theories identified in the literature review" (Kirby, Greaves, & Reid, 2010, p. 23) relevant to the HWE BPG and the process of enhancing teamwork in senior care facilities. A comparison of my qualitative findings with those of other researchers enables me to triangulate the knowledge gleaned from this study, which strengthens the validity of my research findings. I have organized my discussion under three headings: (1) diverse ways of knowing, (2) key components of teamwork in dementia care, and (3) reciprocity between teamwork and organizational culture.

Diverse Ways of Knowing

As discussed in Chapter 3, there are various epistemologies, each offering different theories of, and ways of acquiring knowledge or diverse *ways of knowing.* Evidence-based practice (EBP) in nursing originates from evidence-based practice in medicine, which is heavily based on a positivist epistemology (Ingersoll, 2000). One concern with a positivist epistemology is that the evidence is gathered from randomized clinical trials, thereby excluding other types of evidence or ways of knowing (Ingersoll, 2000). However, as outlined in Chapter 2, more recent work regarding evidence-based nursing practice encompasses forms of practice-based knowledge (Bostrom, et al. (2010); Profetto-McGrath, 2005). Bostrom et al. (2010) identify an ongoing gap in the use of evidence-based knowledge in the care of older adults, while Profetto-McGrath, (2005) focused on critical thinking as an important part of evidence-based practice. Estabrooks

(1999) found that the nurses' main sources of knowledge, was practice-based knowledge related to their nursing educational background. Nurses use of literature rated at the bottom of knowledge sources. Similarly, other scholars in nursing propose that EBP can include many ways of knowing, from empirical knowledge to practice-based theory development (Reed, 2008); and empirical, ethical, personal, and aesthetic ways of knowing (Carper, 1979). Further, Fawcett, Watson, Neuman, Walker, and Fitzpatrick (2001) argue that knowledge gained from using some or all of these ways of knowing can contribute to enhanced quality of life for recipients of care.

In my study, participants selected knowledge based on empirical ways of knowing from the BPG for improving teamwork in the study setting. However, participants also employed other ways of knowing from the ethical, personal, and aesthetic modes of inquiry. One situation that exemplifies all three of these modes of knowing is the situation of *the man who could not stay*, outlined in Chapter 5. The man's aggressive behaviour posed significant care challenges. Staff had to examine their care obligations to him and his family (ethical), as well as moral obligations to staff and other residents and their family members. Beliefs and values were examined by the staff who were caring for this man in order to clarify the collective thoughts of the team. In terms of the personal mode of inquiry, the staff worked through the interpersonal relationships between the staff and the resident in this situation. From the aesthetic mode of inquiry, safety issues were raised in relation to what was important in this resident's behaviour and the potential effects of his behavior on others. This was like an 'aha' moment that makes nursing an art, uncovering something new based on the circumstances.

In an examination of EBP and reflective practice, Mantzoukas (2006) outlines five steps in reflective practice:

> (1) the description or framing of feelings, situation, and context;
>
> (2) the analysis and evaluation of the situation by using various types of knowledge;
>
> (3) verbalizing understandings, drawing conclusions, and developing a hypothesis or action plan about the specific situation;
>
> (4) implementing the action plan; and
>
> (5) evaluating the outcomes of the action plan and integrating the unique situation with other types of knowledge and experiences. (p. 220)

Manzoukas found that EBP used in conjunction with reflective practice could be beneficial. My study surfaced similar findings: staff met to discuss difficult or challenging situations such as residents who exhibited aggressive behaviours and they worked through the steps of reflective practice to address these problems. One example of this was the *man who had a look in his eye*. One staff member identified this look as a trigger to this man's aggressive behaviour. This observation was shared, discussed, a plan developed and implemented to address the issue. Therefore, using the BPG alone did not resolve this issue for staff. Rather, staff used reflective practice in conjunction with the recommendations on communication and ongoing education in the BPG to help resolve the issue.

Although evidence-based BPGs have been implemented to enhance nursing practice, as explained in Chapter 2, critical scholars have questioned the normative structures embedded in the RNAO HWE BPGs (Holmes et al., 2008). However, an

important finding in my study was that management utilized a contextual approach to BPG implementation rather than a normative one. This means that managers selected areas of focus from the BPG, thereby customizing the process to fit the specific needs of their dementia care unit and the senior care facility. This finding supports the work of Johns (2006) who found that context can have both subtle and powerful effects on the implementation of BPGs, and Rouseau (2001) who pointed to the global nature of organizational research and therefore the importance of recognizing diversity in terms of work and work settings. Also, Kaner, Bach, and Pettichord (2002) favoured contextual practices over best practices and argued that the value of any practice is dependent on its context.

Critics who view the RNAO BPG as normative have also hypothesized that critical thinking skills of staff and managers are negatively affected by using a BPG. For instance, Holmes et al. (2008) stated that people are acting without thinking for themselves. My research findings do not support this position. Participants in my study used many ways of knowing, which reflected their ability to think critically. Evidence of this came from various in-depth interviews that made me think the staff was encouraged to use their own critical thinking skills and experiential knowledge. For example, one staff member stated, “The residents can’t change, we have to change.” Also, staff generated ideas for change through the huddle held on each shift as a quick communication strategy. In addition, staff also expressed that there were good working relationships with the current unit managers as well with the leadership team member responsible for the unit. I was told that both staff and managers were interested in building good working relationships. Participants voiced that there was flexibility in the

BPG implementation process and they customized it to meet the needs of the senior care facility. From what I was told by research participants, these healthy relationships encouraged staff to think critically and have input into decision-making.

Although leadership team members and unit managers used a contextual versus a normative approach to BPG implementation, a curious element of BPG implementation in my study was the choice by both to use a hierarchical process at the outset rather than a collaborative one. This was contrary to the senior care facility's goals to take a collaborative approach to improve teamwork and does not follow the RNAO BPG recommendation to follow a collaborative process from the very beginning as explained in Chapter 1 of this dissertation. According to Yukl (2006), with transformational leadership followers are motivated to more than they intended to be, therefore this leadership style would not be congruent with a hierarchical approach as it expects compliance of followers..

Also, Gerrish (2001) and Wicke, Coppin, and Payne (2004) raised the concern that hierarchical rather than collaborative team structures can impede teamwork. Although I did not explore further why the senior care facility in my study did not follow a collaborative approach initially, my sense is that their decision was related to ongoing staff turnover on the unit and multiple initiatives underway simultaneously. The use of a collaborative approach from the beginning could have changed the way management and staff contextualized the BPG, e.g., the areas of focus may have been different, thereby affecting the outcomes of BPG implementation.

However, as BPG implementation evolved, other staff members such as dietary workers, resident attendants, licensed practical nurses, activation staff, and family

members were included in the process. This honored the collaborative approach proposed in the BPG. Although the process began in a hierarchical manner, selecting staff to lead the initiative based on role and title, it evolved into a collaborative process becoming richer with input from more people in the work environment. My point is that initial hierarchical approaches are not necessarily fixed and inflexible, but they can be subject to change (Yukl, 2006).

Key Components of Teamwork in Dementia Care

Maximizing teamwork in dementia care means articulating and embracing several components of teamwork. Key components that stood out in my study include: (1) having a common goal; (2) supporting interdependency and blurred roles; (3) encouraging trust and accountability; and (4) favouring leadership flexibility.

A common goal.

In my study, most staff, managers, and family members identified the provision of quality resident care as the common goal of team members in the senior care facility. The importance of having a common shared goal or purpose has been identified as essential to teamwork by researchers in the fields of business administration (Katzenbach & Smith, 2003) and nursing (Brannick, Salas, & Prince, 1997; Kalish, Weaver, & Salas, 2009).

In dementia care, specifically, Slone, Prather, Robinson, and Olin (1996) found that a “free-flowing” type of teamwork was based on having a common goal of resident care where solutions unique to individual resident challenges were identified by team

members and shared among the team. My research supports these findings, as evidenced by the story of *the man with a look in his eye,* narrated in Chapter 5.

Participants in my study stated that the nature of the teamwork on the dementia care unit was dramatically different than on other units. They attributed this difference to the unique needs of residents with dementia. Participants frequently mentioned that providing resident-focused care as the common goal brought the team together to accomplish their work. I also noted how staff always used the word 'resident' when they identified the common goal, and management described staff members as being like family members to the residents.

The importance of embracing quality resident care as the common goal in dementia care cannot be overstated. I say this because of another important finding that arose in my study. The residents could sense the atmosphere among staff on the unit and they were observed responding to it, which I refer to as a reflection-in-a-mirror effect. If there was joy and happiness among the staff, residents mirrored these emotions. If there was tension, they could sense this and showed concern and fear. Therefore, there was a link noted between staff working well together as a team and resident contentment. Previous research in a hospital setting found that relationships exist between a quality working environments for staff and quality care for patients (Aiken, et al., 2002; Cho,et al., 2003; and Estabrooks, et al., 2005). Similarly, in an exploration of the relationship between the quality of care for residents and the quality of work environment for staff in senior care facilities, Sikorska-Simmons (2006) found that greater resident satisfaction was associated with greater work satisfaction among staff and more positive staff views

of organizational culture. My study, specific to dementia care in a long-term care setting, supports and extends this previous research.

Interdependency and blurred roles.

The converse of embracing a common goal would be the maintenance of isolating factors that have been found to exist in senior care facilities. As discussed in Chapter 2, Gubrium (1997) characterized different ‘‘worlds” of people in a senior care facility and the different “places” in which these worlds exist. He found that these worlds and places were isolating, as people were each in their own ‘world’ instead of integrating and working as a team. In contrast to Gubrium’s findings, in my study, as presented in Chapter 5, participants painted a picture of nurses feeding residents in the dining room, housekeepers helping residents look at pictures on the computer, resident attendants leading evening activity programming, and dietary workers assisting with housekeeping activities for residents as required. I found that there were not separate ‘worlds’ and ‘places’ on the dementia care unit, but one place with a common resident-focused goal, which necessitated everyone helping out when needed. Participants told me that the implementation of the HWE BPG had a positive effect on teamwork, which in turn helped to combine ‘worlds’ and ‘places’ in the facility.

In my study, participants also indicated that although their work assignments were clear and distinct, there was also flexibility of roles and a crossing over or blurring of roles, to meet the specialized care needs of residents on the dementia unit. Participants provided many examples of how roles were blurred at times to meet immediate resident needs. They also described the flexibility to go back and forth between these different roles as an important element of teamwork on the unit. The degree of interdependence of

the team differed within a shift and between shifts but the participants in my study relied on each other, and despite being unionized, blurred their roles to work as a team and meet the unique needs of residents. Nevertheless, a lack of helping other team members did, at times, cause tension when the workload was heavy and felt unmanageable. Although the degree of interdependence of team members varied over a 24-hour period, participants, for the most part, indicated there is more interdependence of team members now than there was before the BPG implementation.

The interdependence of team members has been identified in the literature as a key component of effective teamwork in dementia care. Havig, Skogstad, Veenstra, and Romoren (2013) defined the degree of interdependence of the team as "blurred roles" and "co-acting (p. 2), where "the care workers within a subunit collaborate closely to accomplish the tasks" (p. 5). Similarly, Tyler and Parker (2011) referred to blurred roles as "working interdependently" and the "coordination of tasks" (p. 47), and D'Amour and Onadasan (2005) pointed to the importance of staff members being clear about their own role and the roles of others, while being able to blur roles as needed. These authors would seem to be in agreement that understanding how the roles of each staff member intersect, as well as the degree of flexibility and cross over in roles, is important for the interdependence of team members. The findings of study are consistent with this literature.

Trust and accountability.

A culture that supports effective collaborative teamwork is one that is based on trust (American Association of Colleges of Nursing, 2002; Arcangelo, Fitzgerald, Carroll, & David, 1996; Johanna Briggs Institute, 2005; Onandasan & Reeves, 2005).

In my study, I heard how trust impacted communication between residents and staff, staff and staff, staff and family members, staff and managers, staff on one unit to staff on other units, and between staff on other shifts. For example, as mentioned previously, participants in my study valued new communication strategies such as the "huddle", a short stand-up meeting, held on each shift daily. The huddle required trust on the part of staff and managers as they were sharing important information about the residents and seeking solutions from each other. Although the huddle was perceived by some participants to take time away from their work, most staff took part in this and they told me it was a valuable part of their day. Most participants found the huddle valuable for talking as well as for listening and learning. The huddle is one part of a new way of working on the unit.

Trust has also been identified as a key component of mutual accountability, which has also been viewed as a key component of teamwork (Gerrish, 2001; Goode & Rowe, 2001; Hyrkas & Appelqvist-Schmidlechner, 2003; Johanna Briggs Institute, 2005; Katzenbach & Smith, 2005). For Katzenbach and Smith (2003) a sense of mutual accountability requires team members to: own the team's goals, purpose, approach, and services provided; measure progress towards their goals; feel responsible for their success or lack thereof; and to have a sense that, "only the team can fail" (p. 116). In my study, there was a sense of both individual and mutual accountability; however, there was variation in the degrees of both held by team members. This was dependent on the role of the staff members and the degree to which they embraced teamwork as a way of organizing work. Trust and communication are also key components of leadership flexibility (Vogelsmeier, 2008).

Leadership flexibility.

Vogelsmeier (2008) found that flexible leadership positively influenced the work environment in high performing senior care facilities and the presence of teamwork also influenced effective communication, relationship building, and organizational performance. The results of my study support these findings, as exemplified by the story of *the man who wore the blue suit*, narrated in Chapter 5. The family member who wished to hold her wedding on the dementia care unit trusted the manager and staff to take her wishes seriously and honour her request. Planning and communication for this event involved flexible leadership and collaboration among staff, managers, and family members.

Indeed, much of the previous literature on effective teamwork favours leadership flexibility. Specific leadership styles can vary from transactional to transformational leadership and other forms in-between these two extremes. Yukl and Mahsud (2010) stated: "Flexible and adaptive leadership involves changing behaviour in appropriate ways as the situation changes" (p. 81). They also stated that flexible leadership is essential in organizations today because of the pace of change and changes in the workforce such as (increased diversity, emphasis on teamwork, social networking, visibility of leader's actions, ethical actions, and changing cultural values). Katzenbach and Smith (2006) also supported leadership flexibility, recommending that leaders set the broad performance requirements but leave "solution space" (p. 117) for the team to set their own specific performance goals and schedule. Other researchers, Caldwell, Truong, Linh, and Tuan (2011) in the field of business administration, found that a flexible

leadership style offered a more positive working environment for staff and enhanced organizational performance.

Cummings et al. (2014) found that the workshop "Coaching for Impressive Care" implemented with managers in long-term care was a method or intervention that improved staff effectiveness and performance. This work highlights the need for managers and staff to be aware of the same information when part of the same team. In my study, the overlapping and synergistic processes of teamwork and leadership reflected the need for informed managers to be able to achieve effective teamwork as well. The findings of my research agree with and further the above positions. In my study, the two key leaders referred to most frequently were the unit managers and the leadership team member responsible for the specific unit that was the study setting. Participants described the new unit manager as a relationship builder who enhanced teamwork on the unit. They also described the leadership team member as a leader who allowed team members space to make decisions, and who came to the unit to help as needed. Although as I explained in Chapter 5, the leadership team member relied on a hierarchical approach to BPG implementation at the outset, this leadership team member became more collaborative, flexible, and adaptive as the process evolved. From what I was told in participant interviews, these managers were both moving towards transformational leadership.

Scott-Cawiezell, Main, Vojir, Jones, Moore, Nutting, Kutner, and Pennington (2005) found that attributes of transformational leadership were key elements in higher performing senior care facilities. Their work points to the importance of valuing staff, insuring that there are effective communication processes in place, demonstrating

flexibility in the workplace, and maintaining a high standard of resident care. In my study, participants commented frequently on management and staff caring about each other and being resident-focused, and therefore reflected previous work on the importance of transformational leadership styles in senior care facility settings.

However, tensions regarding the transitioning from traditional hierarchical approaches to transformational leadership were also evident in my study. Although some staff members wanted more input into decision making on the unit, others preferred to rely on management for direction and did not appear ready to move in the direction of self-organization. Management appeared to support this position. As previously stated, although there was a reliance on a hierarchical approach initially, this became more of a collaborative approach eventually. This suggests that changing historical hierarchical management practices in senior care facilities is context driven and not a seamless process.

Reciprocity Between Teamwork and Organizational Culture

Organizational culture can be defined as a system of shared values and beliefs which govern how people behave in organizations (Yukl, 2006), and includes shared assumptions and relationships between group members (Schein,1992). In senior care facilities, specifically, organizational culture has been shown to be influenced by: size of home; not-for-profit or for-profit status; model of care used; organizational structure; and mission, vision, and values (Anderson, et al., 2005; Brannon, et al., 2010; Tempkin-Greener, et al., 2009; Tyler & Parker, 2011).

In the senior care facility in my study, the key values and beliefs that shaped the culture of the work environment included: valuing teamwork as a way to organize work;

acknowledging varying degrees of agency, self- confidence, and self-efficacy among team members; and valuing continuing education for staff and managers. I discuss each of these in turn and relate what I found in my study to previous literature.

Valuing teamwork.

Teamwork is a complex concept whose definition has often been implicit rather than explicit in healthcare settings. As explained in Chapter 1, part of the problem in understanding "teams" and "teamwork" is that these words have been used loosely and have become almost too familiar (Katzenbach & Smith, 2003).

Xyrichis and Ream (2008) argue: "The value of teamwork without a common understanding of what this concept represents endangers both research into this way of working and its effective utilization in practice" (p. 232). This lack of conceptual clarity has been blamed for diverse research results and has led some researchers to question its value (Baker, et al., 2006; Leatt et al., 1997; Zwarenstein & Reeves, 2000).

In my study, as discussed in Chapter 5, it became clear during the in-depth interviews that participants held different perceptions of what was meant by the words "team" and "teamwork", i.e., team members did not share a clear consistent understanding of teamwork. Whereas one staff member perceived teamwork as the care planning, care delivery, communication and decision-making processes, and how things were done to help residents, another staff member viewed teamwork as helping another with 'her' assigned residents; and still for another it was "all hands-on deck". These examples portray various implicit conceptualizations rather than a clear consistent understanding of teamwork. This finding supports previous research, which found that a

lack of conceptual clarity around teams and teamwork can create confusion, variation, uncertainty, and disruptions (Katzenbach & Smith, 2003).

Acknowledging degrees of self-confidence and agency of team members.

A key issue that arose frequently in my study was the degree to which team members' self-confidence and agency, i.e., people's ability to think for themselves and act in ways that reflect their life experiences (Cole, 2015), affected their ability to engage in teamwork. Although, in my study similarities in the backgrounds of some of the participants enabled them to work well together, I became aware of the impact of personal-socio-cultural differences in self-confidence and agency of staff on the unit.

For example, one staff member with less formal education than other workers expressed her feelings of inadequacy; another a staff member could not relate to a book that was being shared on the unit, as it did not reflect her working-class life experiences. Participants also exhibited varying degrees of agency. The two extremes were noted when one staff member said that she had no trouble speaking up if something was affecting residents in a negative way and she saw it as her responsibility to do so, whereas another staff member stated that she prefers to let others speak up or let leadership team members handle issues that may arise. These differences impacted the interpersonal relationships among management and staff on the unit. Nevertheless, staff and management overcame their differences and demonstrated agency in many ways, including supporting multiple ways of knowing, working together towards the common goal of resident-centered care, and contextualizing the BPG to make it work for them. Previous scholars who have explored the relationship between social forces,

relationships, and human agency (Cole, 2015) also found varying degrees of agency among team members. In addition, a lack of agency can lead to conflict among team members, which can interfere with teamwork (Cox, 2003; Joanna Briggs Institute, 2005).

Long and Long (1998) identified five workplace factors that are dependent on effective interpersonal skills: (1) a sense of appreciation at work; (2) personal well-being under stressful conditions; (3) enlisting the support and respect of others; (4) good communication in the workplace; and (5) conflict avoidance (p. 23). Katzenbach and Smith (2003), however, stated that conflict is necessary for effective teamwork; but, instead of just enduring the conflict, the key is to make it constructive and use it to make better decisions. These authors also found that using open communication and respect for each other's opinion can mold conflict into common goals. My study supports these findings.

Valuing Continuing Education on Teamwork

Maintaining a culture of continuous learning and support through educational programs on teamwork has been recognized as crucial at the unit level (CNA committee, 2002; D'Amour & Oandasan, 2005; Henneman, et al., 1995). Also, the HWE BPG recommends the provision of funding for continuing education as one strategy to facilitate effective teamwork on an ongoing basis.

Unfortunately, in my study, beyond the initial HWE BPG institute for management explained in Chapter 1, there were few ongoing educational opportunities offered for staff and managers and during the time I was there, none related to teamwork or creating a healthier work environment. My understanding was that continuing education was limited due to lack of replacement staff for the unit. Although team

members saw the BPG implementation itself as educational, most participants stated that they would welcome more continuing education on various topics, including teamwork. The turnover of staff, advances in knowledge, and the need for staff and managers to be current all contribute to the importance of continuing education. In addition, I found that both management and staff expected management to play a major role in the provision of a program of continuing education related to teams and teamwork.

Recently, as mentioned previously, other researchers have become interested in: "Who is looking after Mom and Dad? Unregulated workers in Canadian long-term care homes" (Estabrooks, et al., 2015). This study justifies the need for continuing education on teamwork in long-term care facilities. The authors concluded that vulnerable and frail residents in long-term care settings are being cared for, in large part, by care aides who have limited educational preparation. Identified needs for better training and more opportunities for continuing education were made to prevent burnout and staff turnover.

Chapter Summary

In this chapter, I have discussed the major themes emerging from my study: (1) understanding diverse ways of knowing; (2) articulating the key components of teamwork in dementia care; and (3) understanding reciprocity between teamwork and organizational culture. I have shown how each theme connects to previous literatures, which when considered together further knowledge about the implementation of HWE BPGs in a senior care facility setting. In the next chapter, I draw conclusions from my study and suggest implications and recommendations for establishing teamwork in a long-term care well as for nursing education and further research.

CHAPTER SEVEN

Using New Knowledge to Initiate Change: Conclusions, Implications, and Recommendations

The purpose of this qualitative research study was to explore the impact of an RNAO evidence-based Best Practice Guideline (BPG) on the meaning and experience of teamwork for management and staff on a dementia care unit in a senior care facility in New Brunswick. Prior to my study, the senior care facility management had identified a lack of teamwork on the unit and selected the BPG relating to teamwork as the intervention to help address the problem.

I designed this study using focused ethnography, a qualitative methodology that allowed me to explore the senior care facility's efforts to enhance teamwork with the goal of improving the working environment for management and staff, and ultimately the living environment for residents. I insured congruence between epistemology, theoretical perspective, the selected methodology, and methods to answer the research questions. By this, I am referring to my adherence to a constructivist epistemology, an interpretive theoretical perspective, a methodology of focused ethnography, and methods that flow from that methodology, i.e., in-depth interviews, documentation review, and using journal notes to record observations and interpretations. In this final chapter, I draw conclusions from my study, and discuss the potential implications and recommendations for policy, practice, nursing education, and further research.

Conclusions of the Study

Based on the findings from my study, as outlined in Chapter six, I have drawn six main conclusions:

First, I conclude that an RNAO HWE BPG can have a positive effect on teamwork in a senior care facility if it is implemented using a contextual rather than a normative approach, making the BPG applicable to the setting and meaningful to all team members. The finding that supports this conclusion is that leadership team members used a contextual rather than a normative approach, customizing the process to fit the needs of the senior care facility.

Second, the BPG can have a bridging effect, linking the evidence on teamwork to the practice of teamwork, which can fill a gap by using research evidence to improve practice in a senior care facility setting, especially one with limited access to research. This means changing the evidence-based recommendations in the BPG into everyday policies and practices in the facility. This conclusion is based on my finding that several ways of knowing existed concurrently and contributed to the team effort to improve teamwork as the BPG implementation process evolved. These multiple ways of knowing included: evidence-based practice (RNAO, 2006); reflective practice (Mantzoukas, 2006); practice-based theory development (Reed, 2008); knowledge produced in context (Carver, 2002).

Third, the quality of life for residents is impacted by the quality of work environment for staff. The basis of this conclusion is the finding that residents could sense the atmosphere among staff on the unit and react to it, which I have named the

reflection-in-a-mirror effect. This conclusion supports Armstrong's (2010) statement, "The conditions of work, are the conditions of care" (p. 12).

Fourth, staff and managers self-confidence and social capital affects the degree to which they can play their role as team members. This supports the work of Long and Long, (1998), and is based on my findings that staff members in the senior care facility exhibited a wide variety of differences in background, education level, self-confidence, previous life experiences, and abilities. However, in my study, such differences were not necessarily detrimental to teamwork. Participants were able to work together, combining their individual strengths, towards the common goal of resident-centered care.

Fifth, having a common team goal is conducive to effective BPG implementation. Managers, staff, and family members all spoke about the importance of resident-focused care, and how they worked together to achieve this goal. This conclusion supports the work of Katzenbach and Smith (2003) who stated that a common purpose or goal is one of the attributes of effective teamwork.

Sixth, having a flexible leadership style strengthens the capacity for teamwork. This conclusion is based on the finding that both managers and staff expect managers to play a major role in sustaining teamwork on the unit. Flexible leadership is important for teamwork because decisions and practices change based on situational changes (Yukl & Mahsud, 2010).

Implications and Recommendations

Based on the conclusions of my research, I suggest that several implications or possible future effects of this study are evident. Specifically, I discuss implications for

policy, practice, education, and further research and make recommendations for each as appropriate.

Policy.

Policies and procedures for senior care facilities in New Brunswick are based on the provincial Nursing Homes Act and Standards, as discussed in Chapter 4 of this dissertation. They are meant to provide both conceptual and operational clarity for staff and managers in their daily work and guide the day-to-day operations of all departments in the senior care facility. One conclusion reached in this study was that the BPG had a positive impact on teamwork in the study site. Although a teamwork approach is supported in the senior care facility policy, the facility lacks an evidence-based approach to developing policies and procedures about teams and teamwork as a way of organizing work. In order to sustain teamwork in the future, I suggest that the procedures related to teams and teamwork need to be incorporated into senior care facility policy. Also, since participants had differing understandings of teamwork, and this is a collaborative venture, I suggest that priority be given to having team members working collaboratively to define the concepts of team and teamwork suitable to the setting. Other collaborative procedures might include: compiling a list of the teams existing in the organization; constructing a flow chart of communication processes; articulating problem-solving processes; documenting approaches to conflict management; and creating policies on decision-making in relation to teamwork. I would point staff and managers to the BPG recommendation that suggests team members work collaboratively to develop teamwork definitions, processes, policies, accountability, decision authority, and a professional teamwork model (RNAO, 2006). However, I would add the caveat, from the findings of

my study, of the importance of contextualizing the BPG for each workplace based on individualized organizational needs.

Findings of my study and that of previous literature have also outlined various definitional struggles surrounding the concepts of teams and teamwork. As stated in Chapter 1, Katzenbach and Smith (2003) define a team as, "a small number of people with complimentary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable" (p. 45); they also describe a team as having a shared commitment and cooperation among team members that evolves over time. Katzenbach and Smith's definition is one of many that could be shared with all team members and could be used to enhance teamwork in the setting. The implication of not having a specific definition of teamwork is that members of the team understand the concept differently leading to confusion and misunderstandings. By collectively developing definitions of, guidelines for, and practices related to teamwork, managers and staff may be able to bring consistency to teamwork in this senior care facility setting.

Another important conclusion related to policy was that resident quality of life is impacted by the quality of the working environment for management and staff, which in turn is influenced by the degree to which managers, staff, and family members work together as a team. I recommend, therefore, that efforts to maintain a positive working environment for staff through teamwork continue, knowing that this can translate to a positive living environment for residents. If the common goal of managers and staff is to provide quality resident-focused care, monitoring and enhancing a teamwork approach in the working environment should be a priority. As Wicke, Coppin, and Payne (2003)

concluded, “There may be considerable potential to improve the working lives of staff and quality of resident care by effective teamworking” (p. 197). This conclusion also provides a strong rationale for the provision of resources, both human and non-human, to enhance teamwork processes and practices in the senior care facility setting. It also speaks to the need to assess team member performance through the annual performance appraisal process.

A second policy gap was identified in relation to the conclusion about the quality of life of residents being impacted by the quality of work environment for staff. During the in-depth interview process, more than one participant told the story of *the man who could not stay*, and the tension this created on the unit for staff and residents. Although the Nursing Home Act, and Regulations about the discharge of a resident if they are potentially harmful to themselves or others, was ultimately used to transfer this resident, the policy and procedures may need to be updated to provide clearer direction to management, staff and family members.

Practice.

Under practice, I make recommendations regarding: understanding teamwork in the context of the concept of a healthy work environment; budgeting resources for future BPG implementation initiatives; fostering self-confidence and agency among team members; developing both leadership team members and unit managers as flexible leaders; and maintaining staffing stability on the unit. Based on the current and future demographic shift towards an aging population in Canada, and considering that many of these elderly Canadians will require long-term care, the conditions of work for staff that practice in senior care facilities are vitally important. We know that the recruitment and

retention of senior care facility management and staff is facilitated by having a satisfactory working environment (Karsh, Booske, & Sainfort, 2007). My study points to the importance of teamwork as one work environment component useful in creating healthier working environments in senior care facilities. I recommend that the leadership team members, managers and staff who took part in the implementation of this RNAO HWE BPG revisit the Conceptual Model for Healthy Work Environments for Nurses, depicted in the BPG booklet and explained in Chapter 1 of this dissertation. This would position teamwork within the concept of a healthy work environment as a whole.

In relation to the practice of implementing a BPG in a senior care facility, I suggest that the organization budget more resources to assist with BPG implementation. For example, the RNAO BPG Toolkit and the Best Practice Champions Network provide information that could be useful in BPG implementation including: identifying facilitators and barriers to BPG implementation; and a six-step model for BPG implementation. The Network also provides a day-long educational workshop as well as ongoing additional support and resources to facilitate BPG implementation. Although the BPG toolkit and Network may be useful as a guide, my study has shown that the contextualization of the BPG for specific settings is most important.

Nursing home practice involves team members with differences in educational backgrounds, work experiences and life experiences. One finding from my study was that this diversity impacts self-confidence and agency, which further impacts each person's ability to play their role as a team member. This finding points to the importance of leadership team members and managers acknowledging and working sensitively with staff to value each person's input and to achieve a consensus on common

purpose and goals. This would require the senior care facility to allot time for staff to engage with each other and to share their knowledge and experiences in an open and non-threatening environment and to budget for staff replacement when necessary so that staff can participate in these sessions. It would also require that all disciplines be involved in care planning, care delivery, and problem-solving, and top-down decisions and problem-solving in isolation be avoided. The fostering of self-confidence and agency among team members is necessary to maximize the participation of all team members.

My study also pointed to the importance of flexible leadership in sustaining teamwork. This finding is supported by Yukl, (2006), as well as Armstrong and Laschinger (2006), and Laschinger and Leiter (2006) who found that leaders help shape the working environment and create conditions for safe quality care for patients. Therefore, I suggest that managers access more opportunities to develop as flexible leaders and model these behaviours in practice. This recommendation agrees with previous research on the importance of transformational and relational leadership styles in promoting healthy work environments (Cummings, et al., 2010).

In what could be an extreme example of flexible leadership, and certainly worthy of consideration, Anderson et al. (2005) added the concept of "self-organization" for senior care facility teams, stating: "Self-organization occurs when people are free to interact, exchange information, and adjust behaviour to meet the immediate needs of the environment" (p. 104). This approach includes less rule enforcement, more open communication, empowerment of staff and relationship focused management behaviours. In other words, this approach allows team members to operate as flexible leaders on their own unit. Brannon, Kemper, Heier-Leitzell and Stott (2010) also recommended a shift in

cultural practices in senior care facilities such as changing excessive hierarchy and restrictive policies.

A second recommendation related to teamwork and staff relations is the importance of stability in unit staffing. This recommendation flows from my research participants' concerns about the increased employment of casual staff, especially on weekends in the summer, which created tensions on the unit. Scheduling mostly full-time staff, with some regular part-time staff may facilitate teamwork and provide a staffing pattern that is more resident-focused and fosters positive staff relations (Bowers, Esmond, &Jacobson, 2009; Moyle, Skinner, Rowe, & Gork 2003).

Education.

Many of the findings of my study point to the importance of further education for all team members. In relation to my findings and that of other scholars (Katzenbach & Smith, 2003) on the lack of consistency and understanding of teamwork, I suggest the leadership team and staff develop an education plan for leaders, staff and family members on conceptual understandings of team and teamwork, policies and processes related to teamwork, and steps to sustain teamwork in the long term. In this way team members can come to a shared understanding of teamwork in this senior care facility. I base this recommendation on the varying perceptions of managers, staff, and family members about the concept of teamwork and its meaning in this facility.

In this study I found that practice in the senior care facility has evolved based on several different *ways of knowing.* Evidence-based knowledge that formed the basis of the BPG recommendations along with practice-based knowledge from staff members and unit managers brought about enhancements to teamwork in this setting. If multiple ways

of knowing are to continue to be valued and supported, as also recommended by Carper (1979), Mantzoukas (2006), and Reed (2008), I recommend that the facility develop an ongoing education program on multiple ways of knowing for leadership team members, unit managers, staff, and family members. Understanding and valuing multiple ways of knowing will enhance staff members' sense of worth, and thereby, contribute to effective teamwork and quality of life for staff and residents. I also recommend that the facility should formalize their support of multiple ways of knowing in policy, practice, and ongoing education. Also, in relation to continuing education, I suggest that staff embrace professional responsibility for their own ongoing education.

Also, as my study has shown, management plays an important role in initiating and sustaining teamwork. I suggest, therefore, that the leadership team arrange for educational sessions to enhance this synergetic relationship between management and teamwork, and the congruence needed between these two processes to achieve success. In addition, managers might benefit from an educational program on flexible leadership and its fit with teamwork. For management, staff, and family members I suggest that education on the linkages between teamwork and a healthy work environment is an important next step to complete the learning process by putting the concept of teamwork in the context of the whole.

Education for other senior care facilities on the use of evidence-based BPGs is also indicated since, in the study setting, the BPG was found to be a helpful tool. Although the qualitative findings from one senior care facility cannot be generalized, the results may be of interest to other senior care facility managers and staff and may prompt them to consider using a BPG to enhance their work environments. An important finding

from my study, however, was how the team in the study setting contextualized the BPG to make it work for them in the context of dementia care. The non-normative implementation of BPGs could provide an important point of discussion. Further, based on the fact that there has not been an uptake of HWE BPGs in New Brunswick senior care facilities, I recommend that this topic be discussed at provincial senior care facility association meetings, and presented to governments and community groups interested in care and services for the elderly. I am suggesting that all efforts be made to take these research findings to those who may find them useful to improve working and living environments in long-term care settings.

Specifically, in relation to the practice of dementia care, I heard from interview participants that it is important to emphasize in orientation and training programs that it is incumbent on staff to adapt to residents and their needs using a teamwork approach. As one staff member noted, "The residents can't change, we have to change." Teamwork is especially crucial with residents who have dementia so that managers and staff work together to find consistent, appropriate, and engaging ways to respond to difficult situations.

In addition, it is important that researchers share knowledge on the importance of teamwork with educators who prepare future health professionals for their role in the workplace. I suggest, therefore, as part of the dissemination of this research, that meetings between the researcher and the organization's representatives be organized with nursing educators at universities and community colleges to discuss the importance of teamwork as a curriculum topic. This may, in turn, necessitate changes in curriculum and pedagogy in nursing faculties. Specifically, I suggest that concepts about working as a

team in a senior care facility should be introduced before clinical placements of RNs, LPNs, and care aides, and instructors monitor these practices throughout those placements.

Research.

In recent years, as discussed in Chapter 2, important research has been conducted on various key components of healthy work environments in long-term care settings. (Cummings et al., 2014; Estabrooks et al., 2015; Estabrooks, et al., 2016). In these studies researchers have contributed to our understanding of: the importance of leadership coaching to improve the working environment in long-term care; the influence of work environment characteristics on best practice use; understanding the unregulated workforce in long-term care; and developing ways of making research results useable to stakeholders in long-term care facilities.

My study adds to this research by contributing knowledge about what processes are being used to implement BPGs, and the impact of doing so, and specifically in the context of teamwork and long-term care. In my study, the BPG was used as a starting point, a source of information, and as a guide in the process to improve teamwork on a dementia care unit. Importantly, it was contextualized in conjunction with practice-based knowledge. This is meaningful because the BPG became a tool to move research evidence to practice, and vice versa, for senior care facility staff and managers. Further research is needed with more senior care facilities using various methodologies to understand the complexity of implementing BPGs in long-term care in Canada. Based on the changing demographics, the importance of this topic cannot be over-stated. Perfecting teamwork in senior care facilities comes from ongoing research and

innovation. Longitudinal studies are needed, specifically, to analyze teamwork in this setting over time.

Research with students in BN, LPN, and PSW programs to explore their level of knowledge about teams and teamwork might also be beneficial, and could inform curriculum on this important topic. Gaps related to teamwork in students' education can then be identified and addressed through curriculum development, and nursing theory and practice. Equally important, as my study has shown, is the building of personal and social capital among prospective nurses. It is imperative that nurse educators explore ways to support students in fostering self-confidence and agency, not only for their personal and professional growth but also for optimal team functioning.

Caveats and Limitations

Being mindful of caveats and limitations of this research is relevant because of the importance each limitation has, potentially, on the research results. In this section, I will identify the potential limitations, reflect on the nature of the limitations, and suggest how the limitations could be overcome in the future.

I have identified two possible limitations of this research: the sampling approach and the sample size. In relation to the sampling approach, I used purposive sampling. This necessitated a dependence on a leadership team member within the organization. I needed her to suggest potential participants who were involved in the BPG implementation process and held knowledge about the process to improve teamwork in the facility. I provided a written purpose of the research to this person as well as other specific criteria. She provided a list of names of people who were invited to participate in the research study. The limiting factor to this approach was that I did not have

knowledge of who was excluded that may have held knowledge that would have been beneficial. I was dependent on my contact in the organization to provide a sample that reflected the purpose of the research. However, the richness of the data, and examples provided, led me to conclude that the participants who did participate met the criteria I had established and were knowledgeable about the subject of the research. In relation to the sample size, this was a small study including 12 participants on one unit of one New Brunswick senior care facility. Because of this, the results are not widely generalizable. They are applicable to the home in the study and may be of interest to other senior care facilities. Despite these potential limitations, I was able to answer the research questions established at the outset of this study. These limitations could be overcome through future research. Larger studies on this topic with bigger samples over a longer timeframe, such as longitudinal studies, could build on this research. As well, different research methodologies could be used in future studies.

Concluding Thoughts

In light of the current and future demographic shift towards an aging population, re-conceptualizing the ways in which we care for the elderly is vital. The importance of my research on this topic is magnified by the shortage of staff in senior care facilities and the reports of serious problems recruiting and retaining staff to care for the elderly. Embracing a teamwork approach can maximize the efforts from available staff and as this study and others have found, can positively affect resident care. Creating a healthier working environment is complex; however, focusing on teamwork can be beneficial. For instance, previous research (Armstrong et al., 2009; Berta, 2006; Castle, 2006) and this research study have established that enhancing the practice of teamwork in long-term

care can positively affect the quality of care of residents. Armstrong (2010) pointed out that the relationship between the conditions of work and the conditions of care in senior care facilities requires further exploration. My hope is that my study will help fill this gap and lead to the enhancement of teamwork and promising workplace practices in long-term care facilities, which ultimately will enhance the quality of senior care.

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Appendix A: Interview Guide for staff, managers, or family members

Jennifer L. Dobbelsteyn, Nursing Home Research Study, 2014

Research purpose- The purpose of this research is to gain an understanding of how the use of an evidence-based best practice guideline impacts staff teamwork, the work environment, and care provided to residents of a dementia unit of a nursing home.
Research Questions

1. What social and political factors have arisen during BPG implementation?
2. What process has been used to implement this guideline?
3. How has the use of this HWE BPG influenced staff teamwork?
4. What has been the impact on the work environment?
5. How has implementing a best practice guideline impacted residents and families?
6. What have been organizational and societal outcomes of BPG implementation

Participant……
……
Date……
……
Interviewer……
……
Informed Consent
signed…….....

<u>Guiding Questions</u>

1) What is your job in the nursing home? Could you describe it? How long have you worked at this nursing home?
2) What is your understanding of what the best practice guideline is?
3) I would like you to tell me about your experience working with the group to implement the best practice guideline. What was the process or approach used? I am interested in your experiences and insights. Could you tell me about this?
4) What are your thoughts on the tool you used- the BPG?
5) Has working with other staff on this unit changed since implementing the BPG? How would you characterize any changes? What is your perception of this?

6) What has been the impact on your work environment (staff satisfaction, empowerment, respect, etc.)?
7) What would you say has been difficult for you throughout the process? How did you overcome difficulties or barriers?
8) What worked well in your assessment?
9) Are there things that were surprising to you?
10) Has there been any effect on the care of residents? How would you describe this?
11) Are there any other things you would like to tell me that I have not asked about?

(Adapted from Van den Hoonaard, 2012)

Appendix B: Letter of Invitation for Staff, Managers, and Family Members

Dear ---------- ,

My name is Jennifer Dobbelsteyn and I am a graduate student at the University of New Brunswick. I am researching work environments and teamwork in nursing homes. As part of this research, I am looking for people to work with me to explore this topic.

.

I am inviting you to meet with me to talk about your experiences and perceptions about the topics of teamwork, best practice guidelines, and healthy work environment on xxxx at xxxx Nursing Home. This will involve an interview, and possibly a follow up meeting to confirm that I have interpreted what you have told me correctly.

If you agree to participate in this study, the interviews will take no more than 60 minutes. The date and time of the interview will depend on your availability. If more time is needed, this would be discussed and decided jointly. If you are in agreement, I will tape record each session to insure accuracy in recording information.

If you agree to participate, I would like to collect information from you about your employment and years of experience with the home or your years of association with the home if you are a family member. Everything you tell me will be kept confidential. You can refuse to answer any questions or stop participating in the interview or meetings at any time if you choose to do so. Nursing home management will not be advised who has agreed or not agreed to participate in the study.

The data that comes from this study will be serve three main purposes: 1) to fulfill the thesis portion of my PhD degree, 2)potentially for scholarly publication, and 3)for a report to staff and management of xxx nursing home.

If you have any questions about this research, you can contact me at (506)471-1710 or email me at j.dobbelsteyn@unb.ca. Also, you can contact my PhD Supervisor, Dr. Stephen Grant at (506)458-7327 or Dr. Linda Eyre, Assistant Dean, School of Graduate Studies, UNB, at (506) 453-5161.

After reading this information letter, please call me at (506)471-1710 to indicate your interest in participating in the study. If you prefer, you can email me at j.dobbelsteyn@unb.ca.

Thank you for considering this invitation to participate in this study,

Jennifer L. Dobbelsteyn, RN, PhD(c)
School of Graduate Studies, UNB

Appendix C: Informed Consent for Family Members of Residents

My name is Jennifer Dobbelsteyn and I am a graduate student at the University of New Brunswick. I am doing research on best practice guidelines, teamwork, and healthy work environments at xxxx. As part of this research, I would like to talk to family members of residents who live on xxxx at xxxx and have knowledge of the process undertaken to improve teamwork among staff on this unit. Your participation in this study is completely voluntary.

If you agree to participate, I will ask you to provide some information about your family member who is living at xxxx. I may want to know things such as how often you visit and what observations and perceptions you have about the working of the team on this unit, their interactions with each other and with your loved one. I will ask about your knowledge of the work to implement the best practice guideline and what has resulted from that work.

Your participation in this study will be completely confidential. All that you tell me will be kept in confidence and will not affect the care of your loved one in any way. Your name and all identifiable information will not be included in any reports. The management or staff of xxxx will not know whether or not you are participating in the study. I will set up meetings with you at your convenience and in a place you are comfortable. There will be no cost to you involved with participating in this study.

The meetings or interviews will take no longer than 60 minutes, but will depend on how much information you have to share. I may need to talk to you more than once; however, you can stop the interviews at any time or refuse to answer any questions. The results of this study may increase our knowledge about team work in nursing homes and creating healthier work environments for staff and living environments for residents.

This project has been reviewed by the Research Ethics Board of the University of New Brunswick in Fredericton and is on file as REB 2014-096. As well, this study has been reviewed by the Ethics Committee of xxxx nursing home.

If you have any questions about this research, you may speak with my PhD Supervisor, Dr. Stephen Grant at (506)458-7327 or Dr. Linda Eyre, Assistant Dean, School of Graduate Studies, UNB, (506)453-5161.

SIGNED IN AGREEMENT:_____

DATE:
_____

Appendix D: Informed Consent for Staff or Managers

My name is Jennifer Dobbelsteyn and I am a graduate student at the University of New Brunswick. I am doing research on best practice guidelines, teamwork, and healthy work environments at xxxx. As part of this research, I would like to talk to staff and managers who work on xxxx and have knowledge of the process undertaken to improve teamwork among staff on this unit. Your participation in this study is completely voluntary.

If you agree to participate, I will ask you to provide some information about your work at xxxx. I may want to know things such as how long you have worked at the home and what observations and perceptions you have about the working of the team on this unit, and the interactions with each other. You are able to agree or disagree with any of these aspects of the study.

Your participation in this study will be completely confidential. All that you tell me will be kept in confidence and will not affect your job in the home. Your name and all identifiable information will not be included in any reports. Management or staff will not be told whether or not you are participating in the study. I will set up meetings with you at your convenience and in a place you are comfortable. There will be no cost to you involved with participating in this study.

The meetings or interviews will take no longer than 60 minutes, but will depend on how much information you have to share. I may need to talk to you more than once; however, you can stop the interviews at any time or refuse to answer any questions. The results of this study may increase our knowledge about team work in nursing homes and creating healthier work environments for staff and living environments for residents.

This project has been reviewed by the Research Ethics Board of the University of New Brunswick in Fredericton and is on file as REB 2014-096. As well, this study has been reviewed by the Ethics Committee of xxxx.

If you have any questions about this research, you may speak with my PhD Supervisor, Dr. Stephen Grant at (506) 458-7327 or Dr. Linda Eyre, Assistant Dean, School of Graduate Studies, UNB, (506) 453-5161.

Signed agreement: _____

Dated: _____

Appendix E: Admission and Discharge Criteria for Dementia Unit in Study Setting

Admission Criteria

Residents will be considered a candidate for admission to the dementia care unit when

he/she has been observed to:

- Be a risk to themselves, i.e., wandering off the unit and attempting to exit the building;
- Require increased rehabilitation and interdisciplinary support to function. May be emotionally unstable or be fearful and anxious;
- Is unable to cope with the demands of his/her environment and suffers memory loss;
- When mentally impaired resident's behaviour (wandering into other resident's rooms, into other's belongings) causes undue hardship to other residents or the wing (Nursing Home Policy # 13, 2007)

Discharge Criteria

The criteria for discharge from the dementia care unit are as follows:

- A change in diagnosis is made from irreversible to reversible;
- The resident's deterioration has reached a stage when he/she no longer benefits from the environment and the programs offered on the unit i.e., no longer a risk or a security problem;
- When a transfer has been requested by family or responsible party
- When a resident expires (Nursing Home Policy # 13, 2007).

Appendix F: Documentation list

1) Research and evidence-based best practice action plan- Collaborative practice among care teams, April, 2009
2) Research proposal from Jennifer Dobbelsteyn, November 1, 2014
3) Nursing procedure 13- Alzheimers Unit application, assessment, criteria referral and transfer, August 2007
4) xxxx continuing care slide presentation, undated
5) xxxx philosophy 2 page handout- undated
6) Adopting Feline Friends program, July, 2011
7) xxxx activity journal, June, 2010
8) Strategic plan xxxx, 2012-2015
9) Welcome to xxxx, family handout, undated
10) Xxxx lifestyle Booklet, undated
11) xxxx Dementia Unit slide presentation, undated
12) RNAO Center Membership, undated
13) RNAO BPG- Collaborative practice among nursing teams, 2006
14) Schedule for 4th Annual Creating Healthy Work Environments Summer Institute, 2009
15) The Rocmaura Research Study: A longitudinal investigation of a specialized care unit, 1999
16) xxxx Evening Activity Binder
17) The ABCs of BPGs- A workbook for nurses about BPGs
18) Emails to and from xxxx
19) Report on xxxx Evening Programming, June 2010
20) Meeting minutes

Registered Nurses' Association of Ontario
L'Association des infirmieres et infirmiers autorises de ('Ontario

Speaking out for nursing. Speaking out for health.

June 4, 2015

Jennifer L. Dobbelsteyn
32 Chateau Drive
Fredericton, NB

E3G5X3

Dear Jennifer Dobbelsteyn,

As developers of the *Collaborative Practice Among Nursing Teams* best practice guideline, the Registered Nurses' Association of Ontario hereby grants you permission to use the following documents in your education resources:

Registered Nurses' Association of Ontario. (RNAO). Collaborative Practice Among Nursing Teams

1. **Organizing Framework for the Healthy Work Environments Best Practice Guideline, 2006, p. 14**

It is understood that the above content and the indication that it is adapted/modified from the above Best Practice Guideline published by the Registered Nurses' Association of Ontario remains with the content. Please reference as follows:

Registered Nurses' Association of Ontario (2006). *Collaborative Practice Among Nursing Teams.* Toronto, Canada: Registered Nurses' Association of Ontario.

With best wishes,

Heather McConnell RN, BScN, MA(Ed)

Associate Director, Guideline Implementation and Knowledge Transfer
Registered Nurses' Association of Ontario
158 Pearl Street
Toronto, Ontario, Canada, M5H 1L3

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OFFICE OF THE VICE-PRESIDENT (RESEARCH)

October 22, 2014

Jennifer Dobbelsteyn

School of Graduate Studies - IDST Program

University of New Brunswick

UNBF - Campus Mail

Dear Ms_Dobbelsteyn:

Lc iilipaeLs

teamwork, the work environment, and resident care in a nursing home: A focused ethnography, **REB File # 2014-096**

The above project is approved as modified.

Approval is valid for a period of three years from this date.

Annual Reports for this project are due on the 15th January of each year, provided that this date is at least six months after the date of project approval. **Final reports** are due 90 days after project completion. Both of these reports can be found on our website at http://www.unb.ca/research/ors/forms/index.php#ethics.

Although your application was processed via Expedited Review, for your information we are providing a list of current Research Ethics Board members.

Sincerely,

R. Steven Turner, Chair

Research Ethics Board

REB Members:	Joy Haines Bacon, Community Representative
	Barbara Burnett, Community Representative
	Jeff Landine, Faculty of Education
	Tracey Rickards, Faculty of Nursing

Curriculum Vitae

Candidate's full name: Jennifer Lynn Dobbelsteyn

Universities attended: University of New Brunswick, Bachelor of Nursing, 1989; Athabasca University, Master of Business Administration, 2000; and University of New Brunswick, PhD Interdisciplinary Studies, 2018.

Publications:

Dupuis, M, Dobbelsteyn, J, & Ericson, P. (1996), Special Care Units for Residents with Alzheimer's: Investigating the Perceptions of Family Members and Staff. *Canadian Nursing Home Journal* (Sept/Oct):4-7, 9. (Republished with permission in CHA Anthology of Readings in Long Term Care, 1997)

Dobbelsteyn, J & Dupuis, M. (2000).Investigating the Viability of Case Management in Long Term Care. *Canadian Nursing Home Journal (*October) Vol. 11, Number 3. Pg.13-16. (republished with permission in CHA anthology of Readings in Long Term Care 202)

Dobbelsteyn, J. & Donovan, C. (2001).Accreditation: The Quest to Improve Resident Care. *Canadian Nursing Home Journal* (December), Vol. 12, Number 4, Pg. 11-15.

Dobbelsteyn (2002). Feeling Worthy- Creating or maintaining one's feeling of worth in the long term care work environment. *Canadian Nursing Home Journal* (Sept/Oct.) Vol.13, Number 3, Pg. 19-21.

Ericson, P., Dobbelsteyn, J., & Dupuis, M. (2002).New Online Course- Professional Nursing Practice in a Nursing Home Setting," Info Nursing (May) p. 7.

Dobbelsteyn, J. (2006). Nursing in First Nation and Inuit Communities in Atlantic Canada. *Canadian Nurse* (April) Vol. 102, number 4, p. 32.

Unpublished Research Studies

Dobbelsteyn, J., Sainz, B., Golding, S., and Jones, A. (2017). Moving Forward: Exploring Organizational Culture and Analyzing Readiness to Deliver Quality Hospice Care in a Community-Based Setting. Submitted to International Palliative Nursing Journal and currently under consideration for publication.

Paterson, B, Sock, L., Dobbelsteyn, J, Simon, R., Levi, D., Leblanc, D., & Levi, Y. (2006). Coming Home: A Participatory Action Research Study to Address Problems and Challenges Experienced when First Nations People with Chronic Kidney Disease are discharged from an Urban Hospital and Return to their Rural Reserve Community (funded through the Atlantic Aboriginal Health Research Foundation).

Conference Presentations:

October, 2008- Travelling from "A" (current working environment) to "B" (healthy working environment): Take the bridge. Nurses: The Solution in Health Care Transformation, co-hosted by the Registered Nurses' Association of Ontario (RNAO) and the Beijing Nightingale Consultation of Culture, Beijing, China.

June, 2009 Panel presentation on interdisciplinary studies, UNB. Between the Tides, STLHE, UNB, Fredericton, NB

September 2009- April 2010- Series of presentations on Health Promotion to Aboriginal inmates at Dorchester Penitentiary

May, 2011- Interdisciplinary Research Opportunities. UNB Faculty of Nursing Research Day, Fredericton, NB.

November, 2012- Two roads, one destination: PhD Interdisciplinary Studies, The Dream of Future Generations, The Challenge of our Generation, NBHRF Conference, Fredericton, N.B., 2012.