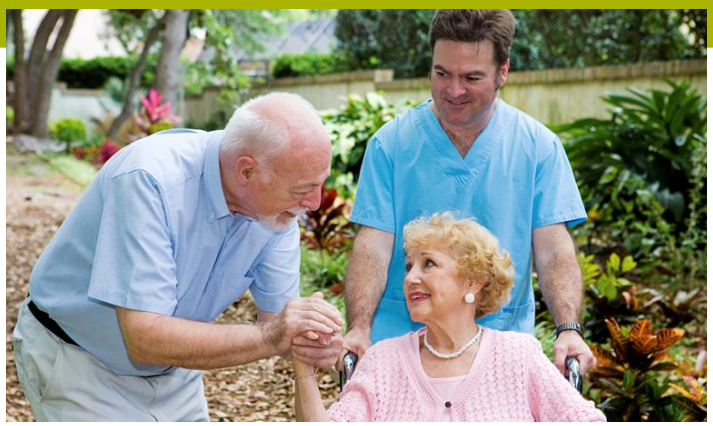

CARE AND CONSTRUCTION

Workshop with Representatives from the Long-term Care Sector

Final Report

March 2014

Care and Construction Project
Nova Scotia Centre on Aging
Mount Saint Vincent University
166 Bedford Highway
Halifax, NS B3M 2J6
(902) 457-6218
careandconstruction@msvu.ca
www.careandconstruction.ca

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada
Nova Scotia Health Research Foundation
Health Association Nova Scotia — Leadership. Services. Support.
Mount Saint Vincent University
Centre on Aging Nova Scotia

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Executive Summary

Prompted by changes in the Nova Scotia long-term care (LTC) sector, a team of researchers and sector representatives came together to develop a research project to assess how differences in model of care impact nursing home resident quality of life (QOL). This Care and Construction project used a mixed-methods approach to gather data from nursing home residents, family, and staff using surveys, interviews, focus groups, participant observation, and activity monitoring.

The Care and Construction research project team, in collaboration with Health Association Nova Scotia, hosted a one-day workshop with representatives from Nova Scotia's LTC sector. The purpose of the workshop was to share results from the project about what influences nursing home resident QOL and to have participants identify actions based on the results.

Four key results about resident QOL were shared with participants:

- Looking at all three perspectives, nursing home residents, family, and staff, **model of care has an indirect effect** on resident QOL through relationships and homelikeness
- **Positive relationships** are associated with better resident QOL
- A more **homelike environment** supports better resident QOL
- Some elements of the **working environment** support better resident QOL from the staff perspective

Small group discussions and a panel presentation by sector representatives identified implications of these key results for the sector. Finding ways to support positive relationships and to enhance homelikeness within current facilities and funding structures and at the same time making changes to those structures were two key implications identified. Participants and presenters stated that these results are timely as decisions are being made about the future of continuing care in the province and about changes to specific LTC facilities.

In concurrent sessions focused around the three areas of relationships, homelikeness, and working environment, participants worked to identify specific actions to be taken to implement change. Across the sessions, common actions were identified:

- **Policy**: Revise policy and regulations to support outcomes related to resident QOL (e.g., relationships, homelikeness, staff leadership) in addition to outcomes of quality of care.
- **Practice:** Encourage positive communication between residents, staff, and family and find ways to balance risks with supports for resident QOL.
- **Education:** Provide ongoing education for all staff on resident-centered philosophies of care and support team development.

Based on results from the workshop evaluation, the workshop was successful in meeting the objectives for the day. Most participants indicated they gained knowledge about what influences resident QOL and ideas about how to alter their practice.

Care and Construction Project

In Nova Scotia, the long-term care (LTC) sector has been undergoing significant changes with a number of new and replacement homes having been opened over the last five years. These homes include new models of care with shifts in staff scope of practice and innovative physical designs (e.g., home-like settings replacing hospital-like wards). Prompted by these changes in the sector, a team of researchers and sector representatives came together to develop a research project to assess how differences in model of care impact nursing home resident quality of life (QOL).

With funding from the Canadian Institutes of Health Research (CIHR) and the Nova Scotia Health Research Foundation (NSHRF), the project, *Care and Construction: Assessing Differences in Nursing Home Models of Care on Resident QOL,* was launched in 2011. This project used a mixed-methods approach to gather data from nursing home residents, family, and staff using surveys, interviews, focus groups, participant observation, and activity monitoring. More detail on the background of the project and the results can be found on the project website (www.careandconstruction.ca).

Purpose of this Report

On November 27, 2013, the Care and Construction project team, in collaboration with Health Association Nova Scotia, hosted a knowledge translation workshop. The main goals of the workshop were:

- To share results from the Care and Construction research project with a broad spectrum of representatives from the LTC sector
- To support LTC representatives to identify implications and actions for the sector based on the results.

This report is intended to further support workshop participants and other stakeholders from the LTC sector to move forward in actions identified at the workshop. Numerous ideas for action were identified by workshop participants during discussion sessions and are summarized in the 'Now what?' section of the report. The documentation of these identified actions and the research results that support them can be a resource to support further advancement within the LTC sector in Nova Scotia.

Overview of the Workshop

One of the main objectives of the Care and Construction project is to facilitate the dissemination of knowledge and the application of research to strengthen LTC sectors throughout Canada. As part of this objective, a one-day workshop was organized for the LTC sector, specifically representatives from the areas of policy, practice, and education.

The workshop was held at the Best Western, Chocolate Lake, in Halifax, NS. It was scheduled in conjunction with the Continuing Care Council's Fall Assembly (held in the same location on November 26, 2013) to better reach a large audience from the sector and to reduce travel costs for those attending both events. Close to 70 representatives were in attendance throughout the day.

Workshop activities were developed using a number of known knowledge translation tools. The planning followed Lavis's knowledge translation model to address the questions of What?, So what?, and Now what?.[1] With this framework as a guide, a variety of activities were planned to provide participants the opportunity to not only hear results but to engage in interactive and reflective discussions about the results (see Appendix A for the full workshop agenda). Activities were designed in consultation with both sector representatives and researchers from the team.

Workshop Objectives:

- To share research results with those working in the LTC sector in policy, practice and education settings
- To provide an opportunity for sector representatives to reflect on the implication of results for their settings
- To identify actions for policy, practice, and education related to the three key result areas
- To generate new research questions relevant to the LTC sector in Nova Scotia by identifying information gaps
- To foster collaboration and relationship building within the sector.

What? – Research results

Activities in this section were designed to share background information on the project and to communicate the main messages from the research results to workshop participants. The aim was to share information in a relevant and accessible manner while also demonstrating the rigour of the research process.

Answering the 'What?'

Primer document: A background document was sent to participants prior to the workshop. It summarized the project's rationale and design, the key messages from the results, and posed questions for further discussion at the workshop.

Presentation of results: An overview presentation was designed for the sector audience to share what was learned through the research. See Appendix B for a detailed outline of the presentation.

Dr. Janice Keefe, Professor at Mount Saint Vincent University and Nominated Principal Investigator for the Care and Construction project, presented a detailed overview of the results from the project entitled, *Care and Construction: What have we learned?* In answer to the main research question, "To what extent and in what ways do differences in nursing home model of care impact resident QOL?," Dr. Keefe concluded that, from the perspective of residents, family and staff, model of care has an indirect effect on resident QOL through relationships and homelikeness. Specifically, New-Full-Scope homes and New-Augmented homes, compared to traditional homes, are perceived to have increased positive relationships and homelikeness which in turn are associated with higher resident QOL.

[1] Lavis, JN, Roberson, D, Woodside, JM, McLeod, CB, Abelson, J. (2003). How can research organizations more effectively transfer research knowledge to decision makers? *Millbank Quarterly 2003, 81,* 221-222.

Important elements of positive **relationships** included friendship and companionship for residents with other residents, family and friends; openness and respect in relationships between residents and staff; and respect and open communication between family and staff. Findings from the case study highlighted reciprocity between residents and staff, continuity, and the opportunity for family to be part of the team as important elements of how relationships support resident QOL.

Key results:

- Across the three perspectives, **model of care indirectly effects resident QOL** through the elements of relationships and homelikeness
- **Positive relationships** are associated with more positive resident QOL
- A **more homelike environment** supports more positive resident QOL
- Some elements of the **working environment** support more positive resident QOL from the staff perspective

Homelikeness, as defined by the study, includes feelings of home, cleanliness, and involvement of the outside community within the home. The case study findings also highlight the role of resident control over their routines and physical space as being part of homelikeness.

From the staff perspective, some elements of the **working environment** were identified as influencing staff perceptions of resident QOL. This included clarity about what is expected in their job, use of skills, and the type of leadership given by their supervisors. The case study also revealed the importance of consistent staffing assignments to support familiarity with the residents.

At the conclusion of the presentation of research findings, participants were given the opportunity to ask questions of Dr. Keefe. These questions and Dr. Keefe's responses are detailed in Appendix C.

So what? – Implications for the sector

Following the presentation of results, participants were asked to address the following questions in small, table discussions:

- What surprises you about these results?
- What is the relevance of these results for…
  … the LTC sector?
  … your organization/facility?
  … your role?
- What further questions do these results raise?

Answering the 'So what?'

Small group discussion: Participants were asked to reflect on the results in small table discussions. Notes from these discussions were posted on the wall for all participants to read.

Panel of sector representatives: Three sector representatives from the project team shared reflections on the implications of the results for policy, practice, and education within the sector.

Participants shared a number of comments and reflections after the presentation of results. These are summarized in the following table.

Table 1: Reflections and implications identified by workshop participants

Reflection	*Participants' comments*
Surprise with indirect effect of model of care	• "Surprised that model of care/facility-type was less important when other factors are considered" • "Surprised staff in full-scope model find the overall QOL is higher, however been noted that staff are resisting this model along with unions"
Importance of relationships and leadership	• "Reinforces idea that this is a human service based on relationships; This will be most important factor" • "The leadership strongly impacts the culture and therefore relationships within the facility" • "We can provide quality resident life experiences within building that may be old" • "Even a traditional home can generate a positive relationship and homelikeness" • "If relationships are important, then time for CCA to spend with resident would have an increased QOL"
Challenges of new models and new expectations	• "Family expectations are much higher than ever before. New facilities create higher expectations (because the facility looks like a hotel)" • "How do you find the time to build relationships when staffing ratios set where they are today (most time is spent on tasks to be completed)?" • "How do we ensure that health needs of people are met in the current climate that emphasizes social relationships and aesthetically pleasing surroundings?" • "In the New-Augmented model, staff sometimes isolated, since fewer staff in a unit"
Applicability of results for the future	• "Research is based on the current reality of LTC BUT technology is changing where people may be able to live and stay at home much longer…Are we assessing an obsolete LTC model?" • "Be cautious when planning for the future to ensure we build what will be the future demand, i.e., will people "buy" what we are selling?" • "The health of incoming LTC residents must be assessed. The LTC sector will be receiving more physically and mentally challenged residents. How will pod-design affect these new and more challenging residents?"

Panel reflections from sector representatives

A panel presentation entitled, *What do the results mean for policy, practice and education,* was chaired by Marian Casey, Director of Clinical Services for Shannex and Care and Construction project team member. The panel included three other members of the project team representing the three areas. Donna Dill, Director of Monitoring and Evaluation of the Continuing Care Branch of the Nova Scotia Department of Health and Wellness, discussed implications for policy. Debra Boudreau, Chair of the Continuing Care Council and administrator of Tideview Terrace, shared reflections for the sector. Tracy Bonner, Director of Education and Quality Improvement for Rosecrest Communities, discussed how results can be used to inform education.

Table 2: Implications identified by panel of sector representatives

Area	*Implications*
Policy Donna Dill, NS Department of Health and Wellness	• Important information to help inform the next phase of LTC facility replacement • Need to focus on ways to support relationships and leadership in current and new facilities
Sector Debra Boudreau, Continuing Care Council	• Need to support small change within current facilities, e.g. supporting privacy within shared rooms • Findings from family members perspective are important as these are the future residents • Need to lobby our funders to support staffing ratios that are more consistent with developing relationships and positive leadership
Education Tracy Bonner, Rosecrest Communities	• Need to incorporate these findings into facility-based education for staff • Change is more successful when staff have an understanding of the need for change and the philosophy of care is more engrained at all staffing levels • Leadership capacity building with those who work closest with residents is key to change

Workshop participants were given the opportunity to ask questions of the panelists following the formal remarks. These questions and responses are detailed in Appendix D.

Now what? – Areas for action

In concurrent sessions, workshop participants identified actions in the three main result areas of relationships, homelikeness, and working environment. In small group discussion, participants identified a number of actions to take based on results from the project.

Actions identified by participants in the concurrent session focused on relationships are outlined in Table 3.

Answering the 'Now what?'

Concurrent sessions: Participants chose from three concurrent sessions based around the three key results – relationships, homelikeness, and working environment. Facilitators encouraged participants to identify actions that would support the study results. Participants worked in small table groups and full session discussions to identify actions for policy, practice, and education.

Large group debrief: Facilitators from the three sessions presented summaries of the actions identified to all workshop participants in a final, large group session.

Table 3: Actions identified by workshop participants to support Relationships

Area	*Actions to support relationships*
Policy	• Revise policies to be outcomes based, specifically related to QOL outcomes • Develop consistent policy templates that can be used and tailored by individual facilities that address these outcomes • Address the different perspectives in revising policies (i.e., differences for residents, family, staff, and general public) • Develop communication strategies that support relationships between the different perspectives
Sector	• Establish a better link between practice and resident-centered policies • Standardize the admission process • Establish family ambassador program to support communication • Address problem relationships between staff and residents and between staff and other staff; address team functioning challenges • Conduct personality assessments of staff; these can be used as a tool to provide job counseling to find a role that fits their personality and ensure that staff are not in roles that do not fit their personality • Support self-directed teams among staff (e.g., allow teams to negotiate their own time off schedules) • Encourage leadership to model and provide coaching to support positive relationships (there is a challenge to find time for this among leadership due to administrative responsibilities) • Support leadership to maintain focus on overall goal of supporting resident QOL in the midst of managing specific crises • Provide activities and practices that support resident-to-resident relationships (e.g., identify appropriate table mates)
Education	• Engage in team building, specifically for CCAs (could be a monthly practice) • Promote positive stories of LTC in the media and with general population • Share training resources between facilities • Provide education on resident-centered and family-centered philosophies • Provide leadership and mentorship training • Provide conflict management training for all staff • Provide cultural diversity training to address challenges that arise among a multicultural workforce

The second concurrent session focused on the results related to homelikeness. The actions identified in this session are outlined in Table 4.

Table 4: Actions identified by workshop participants to support Homelikeness

Area	*Actions to support homelikeness*
Policy	• Incorporating concepts of homelikeness into policy, licensing, regulations (e.g., fire marshal and Department of Agriculture regulations) • Promote collaboration between different government departments to identify inconsistencies in policy and regulation to better support homelikeness • Develop a clear definition of homelikeness at the policy level • Review philosophies of care to see how they support choice and control over routines (e.g. resident-centered care) • Ongoing review of policies and practices that address change within the sector and within facilities
Sector	• Share ideas within the sector and across sectors (e.g. home care, private sector) so others can capitalize on ideas that have worked • Encourage staff to share personal interests with residents • Consult with residents and family to find out what is homelike for them and what their needs are • Find balance of risk (or perceived risk) with homelikeness • Make facility space available for community groups when not in use by residents; Local communities are a resource for continuing cultural traditions and ongoing leisure activities for residents. Engaging community to increase awareness of the realities of LTC and connect the facility to the community. • Explore opportunities to engage community members. May find a community member who can be a champion for homelikeness or share their expertise in the area. • Reduce signage in the buildings • Review access to outdoor spaces • Have rolling walls to allow for privacy in shared rooms • Acknowledge needs of those with dementia and include 'wayfinding' features in homes • Make spaces for children
Education	• Provide leadership development among staff regarding the importance of homelkeness for resident QOL • Support creativity among staff to provide homelikeness within current constraints • Involve staff in changes, specifically those changes that directly impact staff • Engage in team building with staff

A number of participants choose to focus on actions which could support the working environment. Findings from the staff perspective identified a number of elements of the working environment which were associated with higher staff assessments of resident QOL. These findings guided the group in identifying appropriate actions as outlined in Table 5.

Table 5: Actions identified by workshop participants to support Working Environment

Area	*Actions to support working environment*
Policy	• Determine consistent baseline for what is considered good care. For example, some nursing homes are accredited but others are not. • Review current standards to understand how they were developed and the rationale for them (e.g., how was the standard of one shower per week determined) • Ensure consistency between measures and the desired outcomes (e.g. to promote the values of relationships and homelikeness this needs to be part of what is evaluated as 'good care') • Review funding to support changing philosophy of care and changing physical designs (e.g. what are appropriate staffing levels in more spread out facilities?) • Review philosophy of care to support a resident focus rather than task focus • Engage in ongoing review of policies to address changes within the facility • Support policy and practice that is focused more on supporting residents and less on avoiding risk
Sector	• Encourage discussions with unions to understand the value of full-scope practice • Review job descriptions and performance reviews to reflect full-scope practice and the values of relationships and homelikeness to ensure expectations are clear • Involve staff and unions in the discussions • Promote a collaborative practice model that views all staff and clinicians as part of the team • Institute consistent staffing assignments (there can be challenges filling these staffing roles) • Capitalize on the expertise currently in the LTC sector by sharing between facilities
Education	• Provide ongoing education to support a transition from a task-oriented approach to a resident-centred approach • CCA training needs to clarify the different scopes of practice within new models of care • Provide training to all staff, not just front-line staff, in a resident-centered philosophy • Educate family and the general public about living and providing care in the LTC setting • There are challenges in providing ongoing training as resources to fund training are limited and ensuring all staff within the 24/7 operation are able to attend training is difficult

A number of actions were identified across the three sessions. A common action identified for policy, was to revise policy and regulations to support outcomes related to resident QOL as well as outcomes of quality of care. Common actions identified for practice were encouraging positive communication and finding ways to balance risks with supports for resident QOL. Providing ongoing education for all staff on resident-centered philosophies of care was a consistent action identified by all three groups. Supporting team development was another common action for education.

Summary

Overall, the experience of participants at the workshop demonstrated that the objectives for the day were met. Discussions among participants generated a number of ideas for action based on the results from the study. Responses to the survey evaluating the workshop indicated that most participants gained knowledge about what influences resident QOL and ideas about how to alter their practice based on results. All who completed the survey agreed that the workshop was a good use of time and the results presented were relevant to their work.

Participant comments about the workshop:

"I did hear some information and ideas that I will bring back to our organization that reinforces what we are doing and support some new initiatives."

"There is now solid NS research that supports what I know, which increases validity and allows it to be heard and considered in a different way."

"Even though we are an older facility, the results show me that the path towards better relationships is with continuity."

"Excellent session with great representation from sector and government."

Appendix A: Workshop agenda

Care and Construction Project - Sector Workshop

Wednesday, November 27, 2013

Best Western, Chocolate Lake
Lakeview Room A
20 St. Margaret's Bay Road, Halifax, Nova Scotia

8:30 am	Registration (coffee/tea)
9:00 am	Welcome and Overview of the Day – *Bernadette Gatien, Health Association of Nova Scotia*
9:15 am	Care & Construction: What Have We Learned? - *Janice Keefe, Nova Scotia Centre on Aging*
10:15 am	So What? - *Reflection and small group discussion at tables*
10:45 am	BREAK
11:00 am	Panel: What do the Results Mean for Policy, Practice and Education - *Marian Casey, Shannex (Moderator)* - *Donna Dill, Continuing Care Branch, Department of Health & Wellness* - *Debra Boudreau, Continuing Care Council* - *Tracy Bonner, Rosecrest Communities*
12:15 pm	LUNCH
1:15 pm	Now What? Results to Action - *Concurrent sessions* ○ Relationships ○ Homelikeness ○ Working environment
2:30 pm	BREAK
2:40 pm	Report Back from Concurrent Sessions
3:10 pm	Closing Remarks - *Ann McInnis, Northwood* - *Dr. Janice Keefe, Nova Scotia Centre on Aging*
3:30 pm	Conclusion

Appendix B: Care and Construction: What have we learned? presentation outline

Janice Keefe, Nova Scotia Centre on Aging
Sector Workshop Presentation – Halifax, NS

PROJECT BACKGROUND

Slide 1: Project rationale

- Nova Scotia's long-term care undergoing significant changes
    - New innovative physical designs
    - Changes in staffing approach
    - Resident centred care
- Provides context to understand how these changes contribute to nursing home resident QOL
- Work with decision-makers to make evidence-based recommendations for the future of Continuing Care in Nova Scotia.

Slide 2: Time Line – From Concept to Project

- New and replacement facilities being constructed and opened throughout Nova Scotia, 2008 - 2015
- Stage 1: Northwood hosted 'Research Day,' May 2008
- Stage 2: NSCA hosted interdisciplinary planning workshop, Jun 2009
- Stage 3: NSHRF Funding for Building Alliance, Apr 2010 -Mar 2011
- Stage 4: Application to CIHR, Nov 2010
- Stage 5: Care & Construction Project Implementation, 2011 - 2014
- Future Research and Partnerships 2014 Onward
    - Post Doc Applications
    - PhD Thesis
    - Master's Theses

Slide 3: Research Question

- To what extent and in what ways do differences in the nursing home model of care impact resident quality of life?

Slide 4: Defining Quality of Life

- Resident quality of life
    - Food (4 items)
    - Care and Support (12 items)
    - Autonomy (9 items)
    - Activities (4 items)

Slide 5: Defining Models of Care

	New – Full-scope	New – Augmented	Traditional
Physical Design	**New** Small, self-contained households	**New** Small, self-contained households	**Traditional** Floors/units
Staff Approach	**Full-Scope** CCAs responsible for all tasks, including dietary and housekeeping	**Augmented** CCAs provide care needs and limited dietary and housekeeping	**Traditional** CCAs provide only care needs, other staff for dietary and housekeeping

DATA COLLECTION

Slide 6: Research Approach

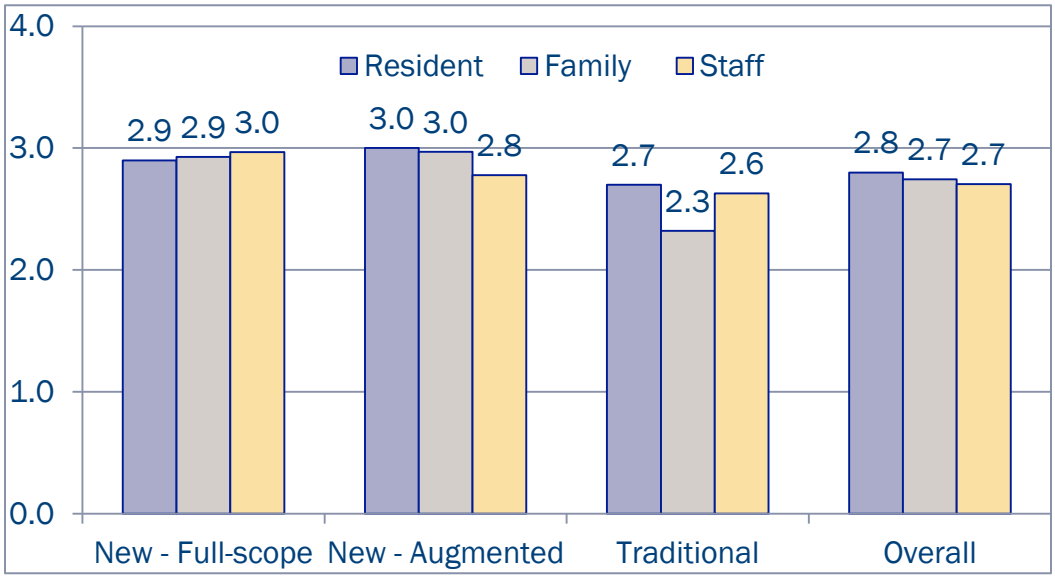
- Residents
  - Surveys
  - In-depth interviews
- Family Members
  - Surveys
  - Focus groups
- Staff
  - Focus groups
  - Surveys with all staff
  - Surveys with senior administration
- Nursing Home Context
  - Profiles
- Case Study
  - Care constellations
  - In-depth interviews
  - Participant observation
  - Activity monitoring
  - Data collection over time

Slide 7: Overview of Study Participants

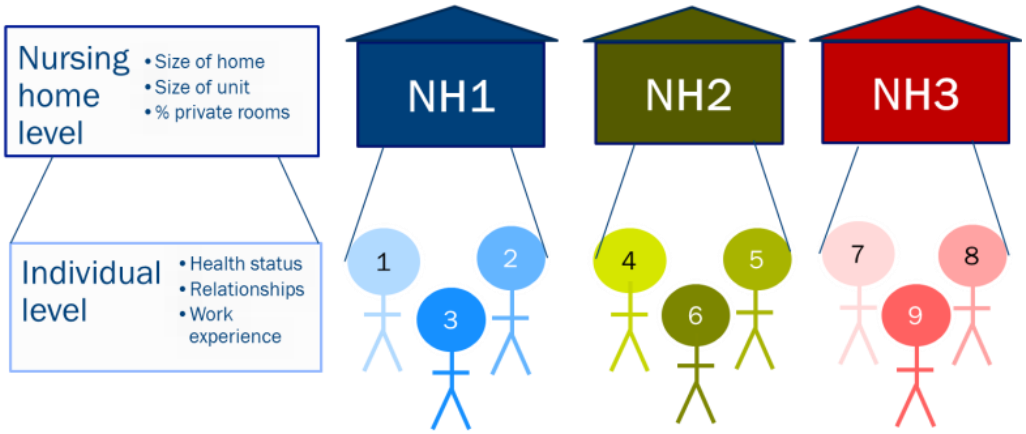
	Survey	Follow up	Case study	Nursing Home Profile
23 Study Sites				
Residents	319	15	6	-
Family member	397	21	6	-
Staff	442	-	6	-
Senior Administration	23	-	-	23
36 Additional sites				
Staff	420	-	-	-
Senior Administration	-	-	-	34

OVERALL RESULTS

Slide 8: Overall Positive Resident Quality of Life



Slide 9: Survey Multilevel Analysis



RESIDENT PERSPECTIVE RESULTS

Slide 10: Resident Survey

- Residents (n=319)
- 73% female
- 43% aged 65 to 84 years old;
  39% aged 85 years and older
- 18% married or common law
- 23% have no high school education;
  26% have some university
- 14% lived in current NH < 6 months;
  46% for 2 years or more
- 80% residents had mild or no cognitive impairment

Slide 11: Multilevel analysis – Resident

- Having a partner is associated with lower QOL
- Higher health status is associated with higher QOL
- Perceptions of homelikeness is associated with higher QOL
- Personal relationships are associated with higher QOL
- More staff bonding with residents is associated with higher QOL

Slide 12: Exploring facility characteristics – Resident

- Higher percentage of private rooms in the facility was significantly associated with higher resident QOL

FAMILY PERSPECTIVE RESULTS

Slide 13: Family Member Survey

- Family members (n=397)
    - 78% female
    - 55% are retired
    - 78% aged 65 years and older
    - 64% are the son/daughter of resident in nursing home
    - 26% were primary caregivers prior to admission
    - 61% visit more than once a week
    - 51% visit for 1-2 hours
    - 74% speak to the resident more than once a week on the telephone
- NH Resident related to family members
    - 77% female
    - 5% aged 64 or less
    - 54% aged 85 or more
    - 11% lived in NH less than 6 months; 42% for 2 years or more
    - 51% experience difficulty due to cognitive ability challenges

Slide 14: Multilevel analysis – Family

- Residents with greater cognitive challenges were perceived to have lower quality of life
- Open, respectful and supportive relationships are related to higher resident quality of life
- Support for resident-to-resident relationships is related to higher resident quality of life
- Perception of more homelikeness is related to higher resident quality of life

Slide 15: Exploring facility characteristics – Family

- A smaller number of residents per unit is associated with higher resident quality of life
- A smaller total number of residents in the facility is associated with higher resident quality of life.

STAFF PERSPECTIVE RESULTS

Slide 16: Staff Survey

- Staff (n=862)
    - 91% female
    - 43 years old average age
    - 59% are direct care staff (CCA, LPN or RN)
    - 66% full time staff, 26% part-time staff
    - 8 years, 4 months average time at current nursing home

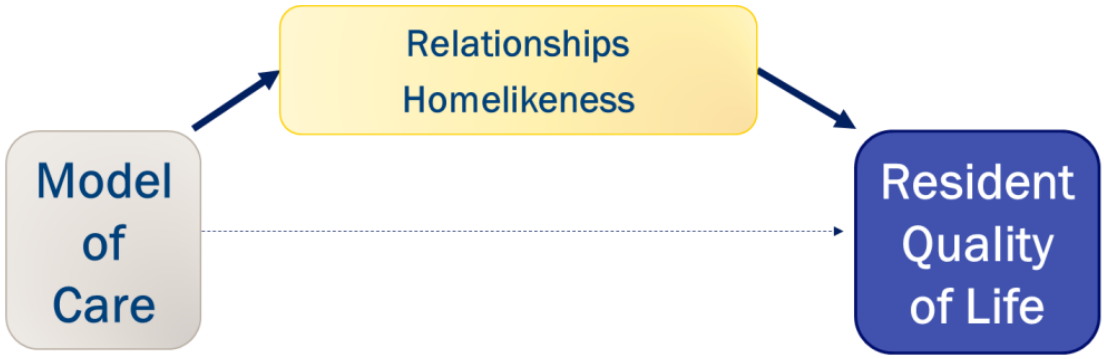
Slide 17: Multilevel analysis– Staff perspective

- New- Full scope staff perceived higher resident QOL than staff from Traditional
- Respectful resident-staff relationships associated with higher resident QOL
- More homelikeness associated with higher resident QOL
- Increased role clarity associated with higher resident QOL
- Increased skill use associated with higher resident QOL
- More job influence associated with lower resident QOL
- Greater transformational leadership among supervisors associated with higher resident QOL
- More experiences of resident challenging behaviours associated with lower resident QOL

KEY MESSAGES

Slide 18: The Role of Model of Care

- Model of care has an indirect effect on resident QOL through relationships and homelikeness



Slide 19: Key result – Relationships

- Regardless of who we talked to – residents, family or staff - relationships are key elements in supporting resident QOL.
- Resident personal relationships
  - Friendship and companionship
  - Playing an important role in other people's lives
  - Space for and staff support of relationships
- Resident – Staff relationships
  - Openess & communication
  - Mutual respect and friendship
- Family – Staff relationships
  - Friendliness and respect
  - Able to share concerns and questions
  - Communicate in a way family can understand
- Case study
  - Reciprocity between residents & staff
  - Familiarity & continuity
  - Family being part of the team

Slide 20: Key result - Homelikeness

- Across the perspectives homelikeness was a key support for resident quality of life.
- Feels like home
  - Attachment
  - Warmth
- Looks like home
- Clean
- Involvement of the outside community
- Case study
  - Relationships are the pathway to homelikeness
  - Resident control over routines and personal space

Slide 21: Key result - Working Environment

- For staff, certain elements of the working environment support positive perceptions of resident quality of life.
- Knowing what is expected
- Learning new things
- Using many skills
- Transformational leadership
  - Receiving encouragement and recognition
  - Being treated as an individual
  - Encouragement to problem solve
  - Being trusted
  - Sense of cooperation
- Case study
  - Familiarity with residents through consistent staffing assignment

Appendix C: Questions from the audience to Dr. Janice Keefe following the presentation of research results

At the conclusion of the presentation of research findings, participants were given the opportunity to ask questions of Dr. Keefe. Questions are presented here followed by a summary of Dr. Keefe's response in italics.

Some questions clarified the parameters of the variables discussed in the presentation:

- What size of facility makes a difference?
  Response: The smallest number in the study was a home with 36 beds all the way up to 476 beds. We do not have an absolute cut-off but smaller in that range was better.
- Did you look at the integration of dementia with non-integration of dementia? (Specifically how this related to family perceptions of quality of life)
  Response: We only talked to family about their family member living in the home and not the others. It may be that information from the case study could speak to this. There was uneasiness and fear from the resident perspective for those with cognitive impairment but this was not identified by the family members in the case study.
- Did you consider the location of smaller homes in smaller communities in the analysis and the implications on staff based on their community knowledge of the residents?
  Response: We have facilities from both rural and urban areas but we have not controlled for this as a characteristic. That is something we could look at.
- Did you look at the impact of private vs. shared bathrooms?
  Response: We did ask the question but we did not include it in our model. We could look at that.
- Is there a statistical difference between the three models on overall quality of life?
  Response: There is a statistical difference between the scores when not controlling for other variables but when you do you see that the model of care is no longer significant
- Can you build a traditional home that will be as good?
  Response: The new design is of value as it supports relationships and homelikeness but you can also have a traditional facility that supports those elements as well.

Some questions probed the possibility for additional research questions:

- Can we compare QOL in this study to people receiving the same level of care in their home?
  Response: The interRAI instrument is specific to nursing homes so we would not have data on that. It would be good to do this type of comparison. We would like to look at making comparisons with other nursing homes from other provinces, especially now that we have these data from the family and staff perspective as well.
- Is there a way to duplicate this survey in PEI?
  Response: We could talk about replicating the study in PEI but one issue is gaining access to using the interRAI quality of life tool for additional research purposes.

One question related to the applicability of the results for the future:

- Resident survey where 80% have mild to no cognitive impairment, is it representative of other people in the facility? I am curious about the future and using these findings for residents in years to come?
  Response: This is a challenge for this type of research as we could only complete surveys with those who could give their consent. Since we were including the family perspective we decided not to include substitute decision makers for the resident perspective. Persons with cognitive impairment were included in the family and staff perspectives.

Appendix D: Questions from the audience to the sector panelists

Questions to the panelists are followed by a summary of the responses in italics.

Why do you think the family members in the study were more likely to focus on the physical design of the facility than the other two perspectives did?
Response: *One possible explanation provided is the acclimatization of residents and staff to the setting as they are there most often. It was also pointed out that some family members do visit very often so for them this acclimatization would happen. The experience is different for each family member.*

How do we match the responsibility for providing health care to residents with the responsibility to support quality of life, specifically through a homelike atmosphere?
Response: *Each of the panelists highlighted the importance of finding a balance and challenging staff to think outside the box. There is a need to educate staff about the value of supporting residents. Donna Dill highlighted the fact that the department is willing to work with facilities to help document reasonable risk associated with exceptions to established regulations that support homelikeness.*

What one feature would be the most important for a new facility in your opinion?
Response:

- *small units or households*
- *all on ground level (or only have offices and administration on a second level)*
- *all private rooms*
- *elimination of carts*
- *open concept kitchens*
- *smaller individual houses (e.g., the greenhouse model) rather than large multi-household facilities*
- *to find an ideal staffing ratio*