ORIGINAL RESEARCH

To What Extent are Alberta Nursing Homes and Supportive Living Facilities Integrated with Their Community? A Sequential Quantitative-Qualitative Study

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ABSTRACT

Background

Nursing homes and supportive living facilities (continuing care homes [CCH]) are often regarded as separate from their communities. Although occasional studies highlight volunteering or intergenerational activities, there is little systematic evaluation of the existence of activities in CCH that may promote community integration.

Methods

Study Design: The study utilized a sequential quantitative-qualitative approach: cross-sectional survey followed by semi-structured interviews. Setting: All registered long-term care (nursing home) and supportive living facilities (Levels 3, 4, and 4 Dementia) within Alberta. Subjects: The survey and interviews were conducted with directors of care. The survey was distributed to 334 facilities. Data saturation in the interviews was reached with seven participants.

Results

140 responses were received; 116 were analyzable (34.7% response rate). The range of activities varied widely. Prior to Covid-19, the most common were spiritual activities entering CCH (96.5%) and volunteers entering CCH (93.0%); CCH rarely had activities such as child daycare (5.2%). 12.9% of spiritual activities entering CCH had not been restarted following the pandemic, but homes were planning to restart this activity (16) or start it as a new activity (1). There was no statistically significant relationship between any activity and facility owner-operator model, size, type, or geography (urban/rural) at any survey time category. Four themes emerged from the interviews: resident quality of life and well-being, home's capacity and openness, sources of support, and planning and programming for implementation.

Conclusions

This study addresses a knowledge gap regarding community integration in CCH and provides insight on the types of community-integrated activities occurring in Alberta's CCH.

Key words: continuing care, long-term care, Covid-19, recreation activities, community engagement, older adult

INTRODUCTION

Long-term care (LTC) and supportive living (SL) facilities (continuing care homes [CCH]) have historically been regarded as black boxes, operating separately from the communities in which they are situated.[1-3] Despite calls to improve the quality of care for older adults in CCH, there have been limited advances;[4] CCH continue to be criticized for concentrating on the provision of physical care, while neglecting residents' social or cultural needs.[5-7] Older adults may equate living in CCH to "being in jail" or feeling like "mice in our cages" due to an overwhelming sense of institutionalization.[8[p.328]] Isolation of CCH is fueled by negative societal perspectives that may stem from common ways to describe life in CCH (e.g. using "end up" when referring to entering continuing care) and their largely negative portrayal in the media.[9,10] Although meaningful relationships are the most frequently cited contributor to feeling at home in a CCH,[8] loneliness is common, with higher rates in CCH residents than in community-dwelling older adults.[11,12] Similarly, social isolation disproportionately affects the psychological and cognitive health of older adults in CCH.[13] Therefore, efforts to increase CCH residents' quality of life, the "degree to which a person is healthy, comfortable, and able to participate in or enjoy special occasions and activities,"[14] may involve strengthening the connection between CCH and their communities.[15]

Previous research suggests close relationships between CCH residents and community members are critical to improving residents' quality of life and increasing social integration.[15] Community integration refers to individuals' physical, psychological, and social presence within their community[16] and may occur through two broad approaches. "Going out" entails residents leaving the CCH and entering the community for purposes such as visiting loved ones, entertainment, or pursuing individual interests.[17] "Bringing the outside in" involves community members or organizations entering the home, either directly or indirectly (e.g., through virtual means).[18] Common examples include volunteers and visits from local schools.[19,20]

Increasing community integration appears to be one way of improving the quality of care for older adults in CCH. However, there is little research on the degree to which CCH are integrated into their surrounding community. Studies highlighting one activity, often time limited, are more common, such as the Friendly Companion Program involving adult and youth volunteers within a nursing home.[21] The coverage of novel or unique activities is sparse; however, endeavours—such as an intergenerational ballet program—have demonstrated the benefits of unconventional approaches.[22] A more comprehensive understanding of community integration in CCH may aid planning and highlight opportunities and barriers. Given this study's timing (2022), the additional impact of Covid-19 on community integration must be considered; this study aimed to examine the extent of community-integrated activities occurring in Alberta CCH.

Research Questions

1. To what extent are Alberta LTC and SL facilities integrated with their community?

   In Alberta, SL refers to licensed settings where older adults can be as independent as possible with 24-hour safety and security services and accommodation assistance, while LTC/CCH homes include additional 24-hour health and personal care services.[23,24] SL3 includes 24-hour personal care and support services from Health Care Aides.[25] SL4 includes additional 24-hour professional health services from Licensed Practical Nurses and Registered Nurses, while SL4D provides a home-like design for residents with dementia in a secured therapeutic environment.[25]

2. What are the potential benefits, risks, harms, and barriers to implementation of community-integrated activities to the CCH and the residents?

METHODS

Setting

All registered LTC and SL facilities (Levels 3, 4, and 4 Dementia) within Alberta.

Participants

Emails were distributed to directors of care, who could pass it on to a delegate within the CCH to participate in the survey, interview, or both.

Survey Design, Data Collection Methods, & Data Analysis

A cross-sectional survey (Appendix A) was emailed to all Albertan directors of care by M.G. Directors of care were free to delegate completion of the surveys as they wished. Each email contained a secure link to REDCap (https://project-redcap.org), a data management system at the University of Alberta that housed all survey data.[26,27] Email addresses were acquired by telephoning facilities or through publicly available information.[25] The survey was open for responses from June to September 2022 and distributed to 334 homes. Demographic information was collected (Table 1). Respondents were asked about community-integrating activities that occurred in their home prior to the Covid-19 pandemic restrictions, at the time of the survey (2022), and any planned over the next two years.

All responses were anonymized upon completion. Frequencies and percentages of yes/no responses were assessed for each question. Comparative analyses were conducted with chi-squared testing to determine any relationships between the extent of community-integrated activities and facility type, size, owner-operator model, and geography at any of the survey time categories.

Interview Design, Data Collection Methods, & Data Analysis

In the survey, respondents could indicate an interest in semi-structured qualitative interviews about the potential benefits, risks, harms, and/or barriers to implementation associated with community-integrating activities. M.G. then emailed interested individuals. Interviews were conducted in English, at a time convenient to participants, over Zoom software, and following a semi-structured interview guide (M.G.).

Interviews were analyzed using a conventional content analysis approach[28] with iterative coding. Each interview was audio recorded, de-identified, and transcribed verbatim (M.G.). M.G. and S.R. independently coded two transcripts, creating codes aligning with the secondary, interview-specific research question. From their codes, the researchers developed an initial coding framework together that was used by M.G. to code the remaining transcripts, including reassessment of the first two. Together, M.G. and S.R. determined which codes could be combined, collapsed codes into categories, and further collapsed categories into themes.

Ethics

Ethics approval from the University of Alberta Health Research Ethics board (Pro00119622) was received before the start of any procedures. Voluntary response to the survey was viewed as consent. Written and verbal informed consent was obtained for all interview participants.

RESULTS

Survey

Respondent Characteristics and Response Rate

Of 203 SL facilities, 17 did not respond and five declined to participate; of 169 LTC homes, 14 did not respond and two declined. The survey was distributed to 181 SL facilities and 153 nursing homes, and 140 responses were received. Twenty were incomplete and removed; four responses were excluded as the site was not SL3, SL4, SL4D, nor LTC. The remaining 116 records were analyzed, for a response rate of 34.7%. The demographic characteristics were diverse (Table 1).

Main Findings

The range of community-integrated activities varied widely (Figure 1), including arrangements where the CCH offered residency to populations other than older adults (Figure 2A) and/or offered services on site (Figure 2B). Before Covid-19 restrictions, the most common activities were spiritual activities entering CCH (96.5%) and community volunteers entering CCH (93.0%, Figure 1). CCH rarely had activities such as offering residence to young families (7.8%) or child daycare (5.2%, Figures 2A and 2B). At the time of the survey (2022), spiritual activities entering CCH continued to be the most common (83.6%). However, this had not been restarted by 12.9% of respondents; CCH were planning to restart the ceased activity in the future (n=16) or start it up as a new activity (n=1). All community-integrated activities were reduced at the time of the survey, compared to before Covid-19 (Figures 1 & 2). This decrease was more drastic for some activities than others; for example, dining facilities open to the community fell by 36.5%, whereas daycare for older adults fell by 2.6%. For activities planned over the next two years, many CCH wanted to re-implement ceased activities. Some CCH intended to begin new activities that were not present before Covid-19; the percentage of "Yes" responses to residents volunteering in the community was 31.9%, compared to 23.5% before Covid-19. There was no statistically significant ($p < .05$) relationship between any activity and facility type, size, owner-operator model, or geography at any survey time category (Table 2).

Qualitative Interviews

Respondent Characteristics

Data saturation was reached following seven interviews, each lasting less than 45 minutes. All participants were female; demographic characteristics are shown in Table 1.

Main Themes

Analysis resulted in 99 codes, collapsed into 16 categories, and from which four themes emerged: 1) Resident quality of life and well-being; 2) Home's capacity and openness; 3) Sources of support; and 4) Planning and programming for implementation (Appendix B).

1. *Resident quality of life and well-being.* Participation in community-integrated activities had multiple benefits for residents, providing opportunities to interact with people outside of those seen daily and to retain a sense of normality. Following an activity, staff observed that responsive behaviours amongst residents decreased and some continued to talk about the activity days after its occurrence. Residents appeared happier and activities helped ease the

TABLE 1.
Demographic characteristics of survey respondents and interview participants

		Survey Respondents		*Interview Participants*	
	Demographic Characteristic	*Frequency (n=)*	*Percentage (%)*	*Frequency (n=)*	*Percentage (%)*
Occupation	Recreation therapy manager	N/A	N/A	1	14.3
	Director of care			1	14.3
	Site administrator			2	28.6
	Resident care manager			3	42.9
Facility Type	Supportive Living Level 3 (SL3)	16	9.1	0	0
	Supportive Living Level 4 (SL4)	45	25.6	3	25
	Supportive Living Level 4 Dementia (SL4D)	33	18.8	2	16.7
	Nursing home (LTC)	68	38.6	5	41.7
	Other	14	8.0	2	16.7
Facility Size	Small (up to 79 beds)	50	43.1	3	42.9
	Medium (80-120 beds)	27	23.3	3	42.9
	Large (>120 beds)	39	33.6	1	14.3
Facility Owner-Operator Model	Private, for profit	38	32.8	3	42.9
	Private, not for profit	37	31.9	1	14.3
	Voluntary, not for profit	10	8.6	0	0
	Public	31	26.7	3	42.9
Facility Geography	Small population centre (1,000–29,999)	59	50.9	3	42.9
	Medium population centre (30,000–99,999)	15	12.9	1	14.3
	Large population centre (100,000+)	42	36.2	3	42.9

transition into a CCH (Quotes 1 and 2, Table 3). However, Covid-19 restrictions halted many activities, and the effects were detrimental to residents' well-being (Quote 3, Table 3). Despite attempts to work around the restrictions (e.g., virtual programming), staff noted lower levels of resident engagement and satisfaction with the altered activities.

2. *Home's capacity and openness.* The home's ability to offer any community-integrated activity was dependent on openness to the idea of the activity and physical capacity to offer the activity (including the space, design, and internal resources, such as staffing). Many staff were open to a broad range of activities, including those that opened the home to the community and those that involved the community coming into the facility (Quote 4, Table 3). However, the home's physical limitations often prevented the activity from being implemented (Quotes 5 and 6, Table 3). Community integration was dependent on the presence, knowledge, and experience of the recreation therapist within the CCH. All participants cited the recreation therapist as responsible for planning and implementing community-integrated activities; the types of activities were influenced by factors such as the recreation therapist's lack of awareness of opportunities, unfamiliarity with the community, or strong networking and creative planning abilities. This discrepancy in the ability of CCH recreation therapists was emphasized by one participant, who suggested that variation could be alleviated through the creation of a standardized resource for recreation therapists in Alberta (Quote 7, Table 3).
3. *Sources of support.* CCH experienced a bidirectional relationship of support with the community. The home could receive, or was receiving, support from a variety of sources in the community, including individual members and organizations, residents' families, and volunteers (Quote 8, Table 3). This support included financial (e.g., donations, funding), manpower (e.g., volunteers), and personal/emotional (e.g., families, volunteers). In some instances, an activity was completely dependent on external support and could not run without it; outings were not possible without volunteers, and a program integrating CCH with local high schools ended when government funding stopped. The CCH supported the community through many ways, such as organizing events for community members. One home acted as a hub for community activities, hosting activities that did not directly involve their residents but still allowed residents to connect with community members (Quote 9, Table 3). Another home echoed the same sentiment for an increase of community integration through indirect interactions between residents and community, such as a play structure on-site that would increase the CCH's appeal to younger generations. Additionally, CCH supported their communities by acting as a source for information, even for levels of care that weren't offered by the homes themselves (Quote 10, Table 3). As this reciprocal relationship benefited both CCH and the community, staff were keen to improve and maintain it (Quote 11, Table 3).

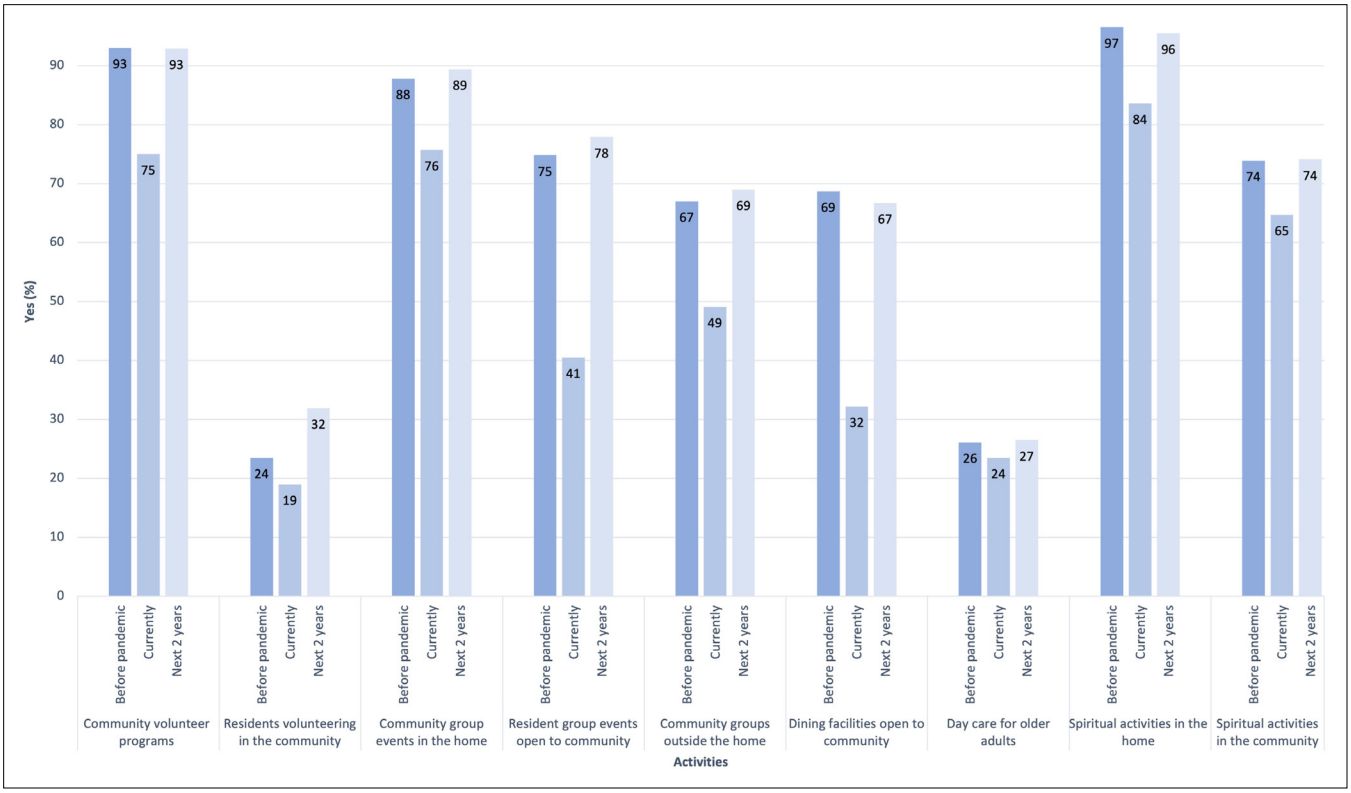
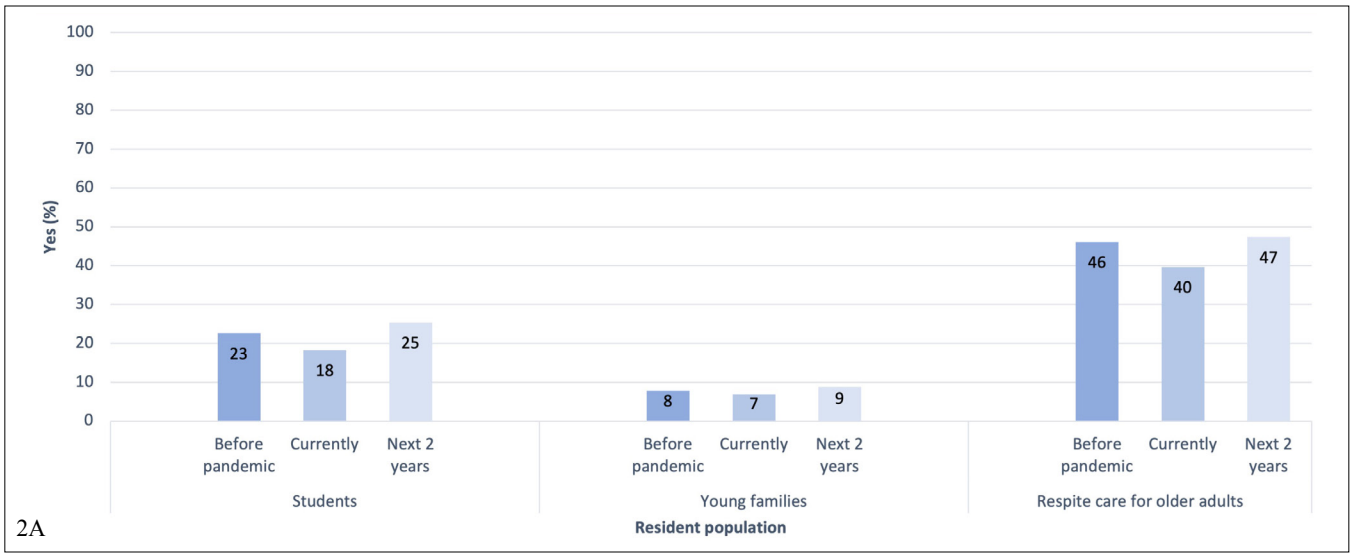


FIGURE 1. Percentage of "Yes" respondents for community-integrated activities



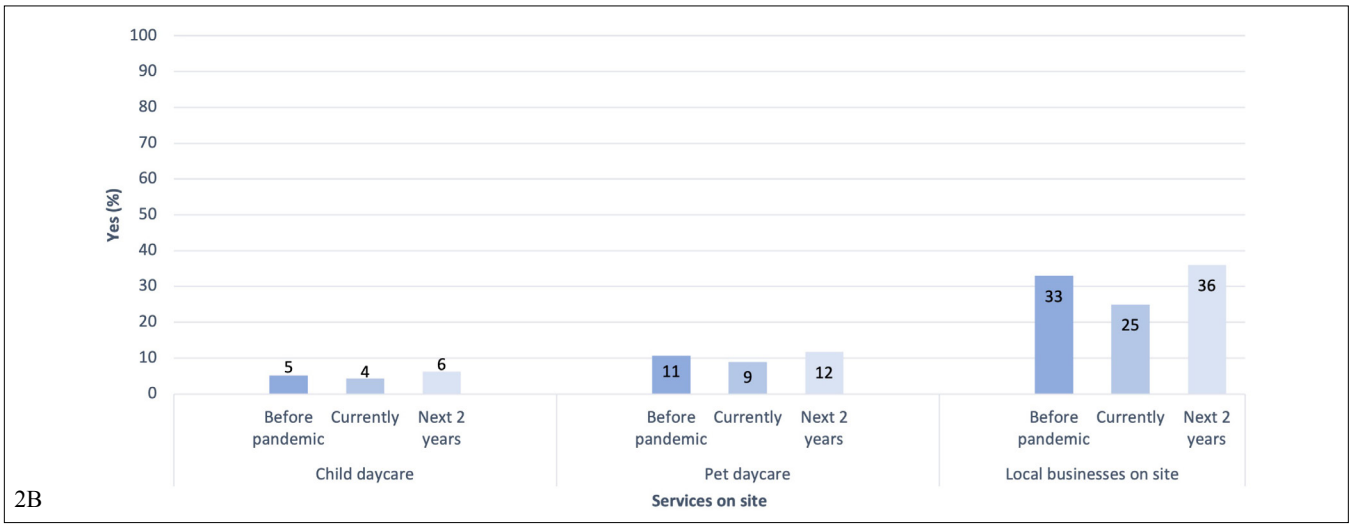


FIGURE 2. Percentage of "Yes" respondents for other resident populations

4. *Planning and programming for implementation.* After an activity was deemed feasible, many factors had to be considered in subsequent planning and implementation. Covid-19 had a massive impact on recreational programming, essentially halting all community-integrated activities. Homes attempted to work around Covid-19 restrictions with some activities continuing in an altered form, through virtual means or creative adaptations (e.g., students on the outside playing Tic-tac-toe on the windows with residents inside). However, due to continued outbreaks, many of these activities had not been able to return to their original forms or frequency, with some that have not been restarted at all (Quote 12, Table 3). When restarting activities, there was an additional level of planning that was required in advance and after to monitor symptoms.

Many factors affecting community integration existed before Covid-19 and continue to exist. Diversity amongst residents meant that a community-integrated activity could

TABLE 2.
P values of chi-squared tests between community integration and demographic conditions

Community Integration Comparison With:	*Time*	*P value*
Facility type	Before pandemic	.999
	Currently	.993
	Next 2 years	.100
Facility size	Before pandemic	.378
	Currently	.209
	Next 2 years	.558
Facility owner-operator model	Before pandemic	.996
	Currently	.969
	Next 2 years	.100
Facility geography	Before pandemic	.997
	Currently	.978
	Next 2 years	.991

be appropriate for one group, while inappropriate for another. Residents' participation levels were largely dependent on their health. For example, one home did not offer any programs involving children as their resident population largely comprised those with mental health issues that did not allow them to be around children. Physical health limitations were especially prominent in LTC homes, limiting the scope of appropriate activities, with lesser effects in SL facilities (Quotes 13 and 14, Table 3). Additionally, residents had differing faiths, interests, backgrounds, and ages that resulted in varying levels of engagement. One home had admitted younger adults into their SL side and found it difficult to cater programs to different generations (Quote 15, Table 3). For most participants, transportation was a barrier, as homes had to coordinate how residents would get to and from locations, who would go with them, who would receive them, and this often required family involvement. Some activities came with additional regulations or policies that the CCH had to consider, such as regulations surrounding food sale or Covid-19 policies (Quote 16, Table 3). Maintaining the physical, emotional, and mental safety of residents was consistently mentioned.

DISCUSSION

Overall, the type and range of community-integrated activities varied widely across surveyed CCH. Interviews revealed that,

TABLE 3 (part 1 of 2).
Qualitative data from semi-structured interviews

Themes	*Illustrative Quotes*
Resident Quality of Life and Well-Being Participating in community-integrated activities has multiple benefits for residents; removing or limiting these activities may have negative effects on residents' quality of life and well-being.	Q1: "Um, one of our old guys, he's actually passed away since, but he um, he uh he's nonverbal, and they put a uh bunny on his lap, and I've never heard him laugh like that. Like he loved it. The bunny peed all over him. He just thought it was hilarious. He, just. I had never seen him so happy." (Participant 4) Q2: "Oh, I think it's beautiful. It's beautiful. You can see the difference in the client. You know it's versus coming and feeling like they've been moved to worst-case thoughts of moving into a nursing home versus being able to come in and be part of a community instead of just coming to a home. It does wonders for them, and it really does help because a lot of people move in, and they're disorientated, they're frustrated, they're angry, and many of them were forced to be here. You know, in some way, shape or form, with very little choice anyway. It gives them something to focus on, and it helps make, it truly does give them some purpose." (Participant 5) Q3: "I'll be quite honest, we really did push back hard with the Medical Health Officers and what I need to figure out how we could get things going again, because the amount of depression and the functional changes we were seeing in people was far worse than what Covid would do. You know we had two outbreaks, two big Covid outbreaks through the pandemic, and we didn't lose anybody in either outbreak. But the impact, especially that first six months, the number of restrictions was horrible for many of our residents. And not just mentally, not just mentally, they changed (emphasis on they changed)." (Participant 5)
Home's Capacity and Openness The home's ability to offer community-integrated activities is dependent on the home's physical capacity and openness to doing so.	Q4: "[...] I would just do anything I could to improve [community integration], and to facilitate it and let it happen more because I think it's so important. I think sometimes our folks sometimes kind of get forgotten almost, and I think our young people need to see them, and I think we need to develop relationships with them. [...] So I'm up for any community involvement. I'm ready to blow the doors open and let everyone in." (Participant 4) Q5: "We don't have a lot of extra space, so you know, opening up programs that would be, you know, community based, where the community could use our site would be lovely in concept but we don't have the space." (Participant 7) Q6: " We went to the zoo, and we had...I don't know, more residents than staff, and then we had a resident who became ill. And so, me and the other RN were dealing with her. But then, one of the big things we discovered is you have to have one on one right, because, taking two of us out of that sort of area to watch the residents that became a barrier for us...had to have that extra people there and not to take as big a group." (Participant 2) Q7: "It'd be nice, [...] if there was more kind of like a resource page that was more open to places. You know, the types of residents we have. You know, what groups could sign up for, being available you to support that type of resident. It'd be nice if there was something stronger, like as a resource to go to that we may not have thought of. A lot of it is just kind of, either your experience level and knowing how to search for it. And we've had different rec therapists, some have more skills at that than others depending on their experience. We're lucky the one we have is a very strong experienced recreation therapist. She really has explored areas our previous ones did not. I don't know if like every profession, people come with different natural skillsets. Some are great networkers, some not as much" (Participant 5)

TABLE 3 (part 2 of 2).
Qualitative data from semi-structured interviews

Themes	*Illustrative Quotes*
Sources of Support There is a bidirectional relationship between the home and community, with the home receiving support from many sources (family, community, volunteers) and supporting the community through things such as providing information, care, and physical location for activities.	Q8: "We have a great community who our recreational therapist, takes our residents out to different restaurants and stuff, and the restaurants are so great with us, and then we take them shopping at different stores as well, and they let them in and mosey around and stuff like that. So, we're pretty fortunate in that sense where they do allow us um with that kind of stuff." (Participant 6) Q9: "We even used our site as like a community hub so even if it wasn't necessary, programs that would directly impact. So, for an example, we had the warm water therapy committee use our space just so that they could have their meetings, and in turn, that did ultimately end up benefiting the residents because we were able to be participating in the pilot. They, we created a program just to have our seniors go to the newly created warm water therapy pool, and that ended up working out in our favor. So, we really tried pre Covid to have a lot of our site be a hub for places, for anything senior or potentially senior related." (Participant 3) Q10: "[...] most LTCs experience being a community hub so much more than people really initially understand. We get cold calls for every level of care, regardless of us only offering certain levels of care. People kind of just know that there are like nurses, and skilled professionals in the building, and will just call, cold-call for anything. We've had calls like, "My loved one is in another country. How can I help them get here and get health care services?" And so, we've helped people that are never going to be clients of ours, because they are not looking for our level of services, but still are considered like that place and source of information. So, we are very much integrated into our community in that way (laughs), and I think most long-term care would have a similar experience in that way." (Participant 3) Q11: "[...] I think the idea [of community integration] is super awesome and very important. I think implementation into the community is difficult, because we do bring a lot of staff and bad parking, and we're not always a great neighbor, but (laughs) it'd be nice to be able to have somewhere. But at the same time, I think if you can build that relationship with your community, you can get a lot of support from it, too." (Participant 7)
Planning and Programming for Implementation Considerations required for planning and implementation of individual community-integrated activities on the part of the CCH.	Q12: "We're gonna start looking at all of that but you know, (laughs), when everything's still up in the air, and every time you turn around we're back on outbreak, you know how people are. It's difficult to plan large activities when you don't know that at the last minute they could be cancelled because our restrictions are so tight." (Participant 7) Q13: "So we just this year started kind of reintegrating. So, as a faith-based organization, prior to this, we would have attended a lot of off-site stuff. Church offsite as well as onsite and different events held so teas, socials, movie nights specifically for seniors. We would have participated in all of those. We have just started to do that, and mostly with our supportive living residents who are able to make their own decisions. They're all aware of the risk and are already going out to the community for many other things, like doctor's visits and visiting family, whereas our long-term care residents are significantly more compromised, and we haven't quite been ready to take that risk yet." (Participant 3) Q14: "There is not many other things that they can volunteer. We have very few of our residents who can actually potentially volunteer in any of these things anyway. A lot of them are in Gerichairs, and you know, they're very…, the dementia is very severe. They're not capable of walking or taking any kind of commands and stuff like that. So, there's very few of them who can actually volunteer with any of these things." (Participant 6) Q15: "Um, it can be quite challenging to, just in the vein of our only actual example, which is having a younger adult versus a senior over sixty-five, programming for them is hard because you're trying to meet very different generational needs in terms of recreational programming. So that can be quite challenging. And then, just in terms of like behavior, there can be cultural expectations in terms of a generational change in even just how you speak. What would be acceptable for like a forty year old, and how they might speak might not be, as they're sitting and having meals together. They don't always appreciate when people have a different approach to things (laughs)." (Participant 3) Q16: "We have done some restart of programs. Our biggest challenge is the disconnect between health care protocols and community understanding, so when we connect with groups, many of them are quite shocked they still need to wear masks. That has been a barrier, particularly in restarting our intergenerational programming. Schools have a policy now that they can't ask their students to wear masks, which means they can't come into the home, even though it's us asking for their continuous masking, so that prevents a significant number of groups from coming in." (Participant 3)

while community integration had significant benefits for the home and residents, there were various barriers and risks to be considered with each activity.

In the survey, "bringing the outside in" (e.g., community volunteer programs) was more common than "going out" (e.g., residents volunteering in the community). While CCH were open to implementing "going out" activities, staffing limitations posed a significant challenge as outings were difficult to plan with adequate staff numbers or impossible without the presence of volunteers. Understaffing has been a persistent issue within CCH. Care staff are often heavily occupied with numerous essential duties centred around physical care, leaving minimal time to focus on social and cultural needs.[5] The introduction of human service professionals and social workers to CCH to focus on meaningful activities for residents has been suggested.[1,9,29] A multidisciplinary approach engaging other professions to focus on residents' social needs may help alleviate the burden on current health-care staff, and increase the types of activities that may be offered by CCH.

All activities were decreased at the time of the survey due to Covid-19 restrictions that imposed new challenges to their continuation. While Covid-19 was a limitation, the implications remain relevant as infection prevention is a priority in CCH, with protocols and responses that similarly affect community integration.[30] The decline in these activities had major detriments to residents, highlighting the importance of maintaining community connections for older adults in CCH. While restrictions limited the types and amounts of activities that CCH could offer, they also prompted CCH to undertake different approaches to community integration. As CCH prepare to bring activities back, it may be beneficial to incorporate some of these innovative ways to open CCH up to their communities. Existing technology (e.g., Zoom) used to support virtual programming during Covid-19 may be maintained or expanded upon to give residents a way to remain connected to their communities in the event of illness.

The physical design of CCH was identified as a barrier in interviews to implementing activities, as echoed by others.[5,20] CCH struggled with finding additional space to accommodate visitors, impacting the types of community-integrated activities that could be offered. To overcome this barrier, there has been success in repurposing existing space by opening common areas for external usage (e.g., as locations for meetings and events); this may help convert CCH into places where communities grow together, rather than existing as isolated spaces.[6,9,31] In the future, designing new facilities with community integration as a core consideration would be of considerable benefit (e.g., on-site café, placing CCH near other living facilities to allow intermingling between different populations).[5,32]

To counteract the prevailing view that CCH are separate from their communities, existing research has focused on bringing community members into CCH with activities such as intergenerational programs.[19,20,22] However, this study demonstrates that there are many ways that CCH can also support their community. Some homes were acting as hubs to host community meetings and programs, as well as provide information on all levels of care. The concept of bidirectional support has emerged in previous research, although evidence is sparse.[9,31] Recognizing the support that CCH can provide for their communities can be vital in overcoming the enduring perspective of CCH as "total institutions" with an impassable barrier between residents and the outside world.[31,33] When people start to associate CCH with uses that incorporate leisure and result in connections, CCH may be "re-imagined as spaces that are vital for promoting community cohesion and increasing social acceptance."[31[p.31]]

Interviews revealed a knowledge gap; the specific role of the recreation therapist in creating and maintaining community connections remains unknown. The background, personal interests, and age of a recreational therapist may affect the extent, range, and types of community-integrated activities offered in CCH, warranting further investigation. Resources may be created to assist recreation therapists in connecting the home with appropriate community groups and allow sharing of opportunities with each other. A shared space (e.g., online discussion board and resource page) can increase the communication between individual CCH, their communities, and other facilities, making community integration more accessible and achievable.

Limitations

This study was limited to CCH in Alberta, which may affect the generalizability of findings to other locations. The perspectives of residents and community members, which may have differed from the opinions of CCH staff, were not captured. The timing of the project, during the Covid-19 pandemic, led to limitation of activities of interest and may have led to inaccurate reporting.

CONCLUSION

This study addresses a gap in the current literature by demonstrating the importance of community-integrated activities in CCH, and providing insight on the level and types of activities occurring in Alberta's CCH. Findings will prove valuable to researchers, policymakers, and directors of care alike, who aim to make CCH feel more like home.

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CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal*'s policy on disclosing conflicts of interest and declare that we have none.

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APPENDIX A. Physical copy of survey

INVITATION TO PARTICIPATE—A survey of nursing home and supportive living facility-community integration.

Dear Director of Care,

It has often been said that nursing homes and supportive living facilities are "black boxes", somehow separate from the communities in which they are situated. While there are anecdotal reports of nursing homes which undertake activities which do integrate into their communities, we don't really know what kind of activities occur or to what extent they go on in Alberta.

To find out information about what activities do occur, we should be grateful if you would take no more than 10 - 15 minutes of your time to answer this survey. Please feel free to pass this on to a person within your facility whom you feel might be more appropriate to answer on your behalf if you like.

Should you run into any difficulties or questions arise, please feel free to contact M.G.

Thank you so much for your time.

	My facility
Geography	Small population centre, with a population between 1000-29,999 [ ] Medium population centre, with a population between 30,000-99,999 [ ] Large population centre, with a population of 100,000 or more [ ]
Operator model	Private, for profit [ ] Private, not for profit [ ] Voluntary, not for profit [ ] Public [ ]
Size	Small (up to 79 beds) [ ] Medium (80–120 beds) [ ] Large (>120 beds) [ ]
Facility type	Supportive Living Level 3 (SL3) facility [ ] Supportive Living Level 4 (SL4) facility [ ] Supportive Living Level 4 Dementia (SL4D) facility [ ] Nursing home (LTC) [ ] Other [ ] Please specify "Other": _____

If you are responsible for more than one facility type but your responses are **no different** for each type, please fill in **one form**. Please enter the additional facility types for which you are responsible for here: _____

If you think that your responses **will differ** depending on the facility type, we should be grateful if you would consider filling in a **form for each facility type**.

There are three things to bear in mind. We know what a tremendous impact the last two years have had on the long-term care sector, and that many activities may have shut down because of pandemic restrictions. Therefore, we should be grateful if you would cast your mind back to **before the pandemic** when answering the first column, **to now** when answering the second, and **to the next two years**, when answering the final column. We should also like to know of any additional activities which you have undertaken, currently do, or plan to start which we haven't included. Please tick the relevant boxes according to the activities below. You can select YES for each of the columns if you were doing, are currently doing, and plan to continue doing any of the activities.

Activity	*We Did This Before The Pandemic*	*We Are Currently Doing This*	*We Plan To Do This In The Next 2 Years*
Community volunteer program coming into the home	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Residents from the home volunteering in the community	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Community group events in the home; (crafts, gardening, special interest groups etc.) in which residents participate	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Resident group events open to members of the community (craft sales, bakes sales, rummage sales etc.)	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Residents' participation in community groups outside the home (residents leave the facility to take part in community groups)	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Dining facilities in the home open to community members	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Home facilities open for daycare for older adults	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Spiritual activities coming into the home	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Residents' spiritual activities in the community	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Some homes may have services on site, not directly related to long term care of older adults, and open to community members. Residents may be able to interact with such services. Some of these are listed below. Do you have any of these?			
Child daycare	YES [ ] NO [ ] If yes, residents can interact. YES [ ] NO [ ]	YES [ ] NO [ ] If yes, residents can interact. YES [ ] NO [ ]	YES [ ] NO [ ]
Pet daycare (doggy daycare etc.)	YES [ ] NO [ ] If yes, residents can interact. YES [ ] NO [ ]	YES [ ] NO [ ] If yes, residents can interact. YES [ ] NO [ ]	YES [ ] NO [ ]
Local businesses with commercial activities on site open to residents	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]

Some homes have offered residence to those other than their residents. Do you have any of these?			
Students	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Young families	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]
Respite care for older adults	YES [ ] NO [ ]	YES [ ] NO [ ]	YES [ ] NO [ ]

Are there any other activities you feel that would be relevant that are not mentioned above? Please feel free to be as imaginative or creative as you like.

How has having to live with Covid-19 altered your plans? Please describe what changes you've made and to what plans or current activities.

If you'd be willing to talk to one of our researchers in more detail about your views on this subject and the potential benefits, risks, or barriers to implementation of some of these things, please write your email address here so we can get in touch later.

If you'd like your name to go into a prize draw for 1 of 2 $100 gift cards, with around a 1:75 chance of winning, regardless of whether you've completed the survey. Please enter your contact details below. This information will be stored separately from your survey responses.

Name _____

Email address:_____

Address (only if you prefer to have a gift card posted to you) _____

APPENDIX B. Codes, categories, and themes from semi-structured interviews

Codes	*Categories*	*Themes*
New interactions (10) Everybody flocks (62) Just loved it (68) They bring them in (108) Positive for everybody (109) Resident's preference to interact (133)	**New interactions** Residents enjoy interactions with new people, outside of those that they see every day (e.g. community members, pets, kids).	**Resident quality of life and well-being** Participating in community-integrated activities has multiple benefits for residents; removing or limiting these activities may have negative effects on residents' quality of life and well-being.
Get back to normal (38) Amount of depression (91) More disinterest (125) More hesitant (126)	**Effect of Covid-19 pandemic and outbreaks on residents** The lack of community-integrated activities due to Covid-19 had and continues to have negative impacts on residents and staff (e.g. depression, disinterest in altered activities).	
Happy and relaxed (92) A lot of very happy people (93) Own little family (99) Starting to stabilize (100) Really enjoy going off site (130)	**Happiness and well-being** Participating in events involving community (e.g. drives off-site, music from community members) or fellow residents is beneficial to residents' well-being.	
Sense of normality (13) Go to their own churches (20) Home atmosphere where things are normal (55) They continued (127)	**Sense of normalcy** Participating in new community-integrated activities (started during time at the home) or continuing prior engagements allow residents to regain a sense of normalcy of their lives prior to entering the home.	
Openness to doing events (8) If we would accommodate them (32) Great to offer (36) If anybody wants to come in and do anything (51) Somebody to take that responsibility (56) If we had a way of doing it (67) Get our residents out and volunteering (75) Open to all of it (80) Happy to support that (81) Dependent on this teacher (85) That would be great (119) Do anything I could to improve it (121)	**Openness and willingness** The home, community, and/or residents are open and willing to implement community-integrated activities, however, there may be barriers, lack of opportunities or awareness, and/or other factors that prohibit them from doing so.	**Home's capacity and openness** The home's ability to offer community-integrated activities is dependent on the home's physical capacity and openness to doing so.
Unable to accommodate (33) Space is limited (63) If we had the room (65) Had the room or the building (70) We don't have the space (86) Very old (89)	**Space and/or design of the home** The home's current space and/or design limits certain community-integrated activities from occurring, however, if altered, could provide an opportunity to foster activities.	
Own spiritual care (19) Staff support (60) Organizer of recreational programming (6) Need to know ahead of time (64) I don't know what's out there (82) Resource page (112)	**Internal resources** The home's capacity for community-integrated activities is dependent on the number of and ability of staff, including a recreation therapist, as well as availability of resources for programming.	

Codes	*Categories*	*Themes*
Just a lot of uncertainty (1) Gone away from volunteering (41) All kinds of things (72) Most of them are seniors themselves (74) Within our own community (76) We need it (90) Wanted to do some volunteering (97) Currently have one (124)	**Volunteer support** The home can receive support from volunteers, both from the community and within the home itself (residents volunteering).	**Sources of support** There is a bidirectional relationship between the home and community, with the home receiving support from many sources (family, community, volunteers) and supporting the community through things such as providing information, care, and physical location for activities.
Not enough resources (27) Government has cut funding (46) Example of community coming in (47) Donations (48) Example of spiritual care coming into home (49) People who come in (87) Relationship with community (96)	**Community and external support or programs** The home receives or lacks support from external individuals, organizations, and/or programming.	
Family members come in (42) Family permission (57) Sandwich generation (106)	**Involvement of family** Residents' family members offer differing types and levels of support (e.g. taking residents for outings, volunteering).	
Benefits of adult daycare (22) People come in for events (53) Provide the caregiver a good break (95) Palliative care (120) Use our facility for different things (123) Place and source of information (137)	**Support that home offers to community** The home provides a variety of support to the community, such as information, respite or palliative care, and events open to community.	
Lower amount of volunteers (3) Before Covid (18) Going on outbreaks (40) Things have gone by the wayside (43) Changes in mode of delivery (44) It takes a lot (101) Few more activities going on (114)	**Effect of Covid-19 pandemic and outbreaks on programming** Community-integrated activities were and continue to be halted, altered, or limited due to the Covid-19 pandemic and outbreaks.	**Planning and programming for implementation** Considerations required for planning and implementation of individual community-integrated activities on the part of the CCH.
Barriers to interaction (24) We are Level 4 (37) If they're capable (54) Convince them to give it a try (105) Lot of young residents (107) Accommodation on site (136) A little bit different (138)	**Diversity** Residents come from a variety of different backgrounds, ages, faiths, interests, and health that dictate what community-integrated activities they engage in.	
Safe and taken care of (14) We take them (16) Access and transportation (77)	**Logistics** Several factors are taken into consideration when residents leave the home to enter the community.	
Continuous masking (17) Certified pet therapy (28) Event rules (52) Made many changes (71) Barriers are not internal (98) Trained our team (110) Disconnect between health-care protocols and community understanding (128) Visitor to our site (132)	**Policies, regulations, and rules** There are different rules in place for varying purposes (e.g. to protect health, regulations around food).	
Transmission risk (9) Never know how they're going to react (94) Manage the money piece (111) Appropriate compliance (129) Admitted people that are younger (135)	**Safety and risk** Risks and otherwise related factors that can impact residents' safety (physically, mentally, emotionally) must be considered with any programming.	