

Neglecting the Importance of the Decision Making and Care Regimes of Personal Support Workers: A Critique of Standardization of Care Planning Through the RAI/MDS

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Purpose: The Resident Assessment Instrument–Minimum Data Set (RAI/MDS) is an interdisciplinary standardized process that informs care plan development in nursing homes. This standardized process has failed to consistently result in individualized care planning, which may suggest problems with content and planning integrity. We examined the decision making and care practices of personal support workers (PSWs) in relation to the RAI/MDS standardized process. **Design and Methods:** This qualitative study utilized focus groups and semi-structured interviews with PSWs ($n = 26$) and supervisors ($n = 9$) in two nursing homes in central Canada. **Results:** PSWs evidenced unique occupational contributions to assessment via proximal familiarity and biographical information as well as to individualizing care by empathetically linking their own bodily experiences and forging bonds of fictive kinship with residents. These contributions were neither captured by RAI/MDS categories nor relayed to the interdisciplinary team. Causal factors for PSW exclusion included computerized records, low status, and poor interprofessional collaboration. Intraprofessional collaboration by PSWs aimed to compensate for exclusion and to individualize care. **Implications:** Exclusive institutional reliance on the RAI/MDS undermines quality care because it fails to capture residents' preferences and excludes input by PSWs. Recommendations include incorporating PSW knowledge in care planning and

documentation and examining PSWs' nascent occupational identity and their role as interprofessional brokers in long-term care.

Key Words: Care planning, Alzheimer's disease, Nursing homes, Long-term care, Interprofessional collaboration, Personal support workers

Assessment and care planning are the clinical processes on which the goals of individualized care, continuity of care, and team communication are founded (Dellefield, 2006). In nursing homes, the Resident Assessment Instrument–Minimum Data Set (RAI/MDS) provides the core framework for interdisciplinary care planning (Dellefield, 2006; Hawes et al., 1997; Hirdes, 2006; Morris et al., 1997) across North America (Hawes et al., 1997; Morris et al., 1990; Ontario Ministry of Health and Long-Term Care) and abroad (Achterberg et al., 2001; Hawes et al., 1997). Yet discrepancies persist between RAI/MDS-driven activities recorded in the care plan and actual care delivery (Colón-Emeric et al., 2006). Research suggests that care plans do not guide daily care in nursing homes (Dellefield, 2006; Schnelle, Bates-Jensen, Chu, & Simmons, 2004). Instead, features of daily care are greatly dependent on the activities of unlicensed personal support workers (PSWs) (Bowers, Esmond, & Jacobson, 2000; Taunton, Swagerty, Smith, Lasseter, & Lee, 2004), who provide 80%–90% of all direct care in nursing homes (Caspar & O'Rourke, 2008).

This gap between planning and delivery suggests that the growing movement towards standardized care through the RAI/MDS may, in fact, undermine quality care by neglecting the

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importance of the decision making and care practices undertaken by PSWs. Consequently, our purpose was to explore PSWs' core practices within the context of the RAI/MDS standardized process and implementation that may impact on the ability of PSWs to individualize care.

Standardization and the RAI/MDS

Developed in the United States close to 20 years ago, the RAI/MDS has been popularized in Canada, the United Kingdom, Central and Western Europe, Scandinavia, and Japan (Hawes et al., 1997). Although the development team included an interdisciplinary clinical and lay team of physicians, nurses, allied health, nursing home operators, and researchers (Hawes et al., 1997), unlicensed practitioners such as PSWs were excluded.

The RAI/MDS is a standardized assessment system consisting of three components, including Utilization Guidelines, the Minimum Data Set (MDS), and Resident Assessment Protocols (RAPs). The MDS is a 450-item instrument containing common categories designed to provide a comprehensive picture of each resident's functional status (Hawes et al., 1997). MDS responses may trigger the nurse assessor to further assess conditions using RAPs (Dellefield, 2007, 2008). The 18 RAPs summarize common clinical problems and risk factors that aid in the development of an individualized care plan (Dellefield, 2007). Nurses and allied health clinicians complete discipline-specific sections of the RAI/MDS assessment. Although MDS measures adequately capture physical conditions (e.g., vision, hearing, functional status), they do not fare as well at assessing psychosocial well-being (Holtkamp, Kerkstra, Ooms, & Ribbe, 2001) and personal preferences (Carpenter & Challis, 2003). This is despite the importance of such assessment for developing an appropriate individualized plan of care and for improving daily functioning and quality of life (Carpenter & Challis; Carpenter, Van Haitsma, Ruckdeschel, & Lawton, 2000; Whittemore, 2000).

Despite widespread acceptance of the RAI/MDS in nursing homes, it has yet to become an integral element of nursing home documentation and care delivery (Parmelee, Bowen, Ross, Brown, & Huff, 2009). Much of the problem is said to reside in the measurement properties of the instrument itself with inconsistencies in its psychometric performance in everyday practice (Casten, Lawton, Parmelee, & Kleban, 1998). The reliability of MDS-

based assessments of mood and behavioral symptoms has similarly been called into question (Cohen-Mansfield, Libin, & Lipson, 2003) with concerns about its ability to accurately represent the status and care needs of residents (Parmelee et al.). Problems with the reliability of RAI/MDS data have been traced to the lack of standardized definition of terms used within the RAI/MDS (Dellefield, 2007). Other limitations include barriers in its implementation process, specifically poor interprofessional and intraprofessional communication and collaboration (Rantz, Popejoy, Zwygart-Stauffacher, Wipke-Tevis, & Grando, 1999). Although the RAI/MDS was developed to facilitate interprofessional communication and problem solving (Hawes et al., 1997), unregulated staff such as PSWs are most often excluded from the assessment and care planning process (Parmelee et al.; Taunton et al., 2004). Furthermore, care plans are often poorly or inconsistently conveyed to PSWs (Anderson et al., 2005; Caspar & O'Rourke, 2008; Colón-Emeric et al., 2006). In turn, PSWs often reject MDS clinical categories and terminologies as largely irrelevant to individualizing care (Adams-Wendling, Piamjariyakul, Bott, & Taunton, 2008; Colón-Emeric et al., 2006; Dellefield, 2006). Given the nature and persistence of care planning and implementation barriers, the exclusion of PSWs in the RAI/MDS process is a critical area for investigation.

Personal Support Workers

Characterized as unskilled or semi-skilled (Anderson et al., 2005) PSWs provide assistance with delegated nursing tasks, ambulation, and activities of daily living (Health Professions Regulatory Advisory Council, 2006). Training is minimal, ranging from 75–175 hrs across the United States (Department of Health and Human Resources, 2002) to two postsecondary semesters in Canada (Ontario Ministry of Training Colleges and Universities). PSWs lack independent regulatory authority to “initiate any action with respect to a patient” (Health Professions Regulatory Advisory Council, 2006, p. 10) and are expected to fully comply with a care plan developed by a regulated care provider (Health Professions Regulatory Advisory Council, 2006).

PSWs are rarely consulted when care decisions are made or implemented (Caspar & O'Rourke, 2008). This exclusion (Colón-Emeric et al., 2006; Dellefield, 2006; Taunton et al., 2004) has been

Table 1. Demographic Data

	Facility A (<i>n</i> = 13)	Facility B (<i>n</i> = 13)
Gender		
Male	1	0
Female	12	13
Age		
<39	1	1
40–49	7	5
>50	4	7
Missing	1	
Length of time at facility		
<1 year	3	0
1.5–3 years	0	6
>4 years	10	7

attributed to professional stratification as well as low levels of interdisciplinary respect, communication, and collaboration among PSWs and nursing and medical practitioners (Bowers, Esmond, & Jacobson, 2003; Kemper et al., 2008). Yet PSWs are the practitioners most likely to observe, interpret, and respond to resident care situations on a day-to-day basis, often in the absence of direct clinical intervention or guidance (Anderson et al., 2005). Their direct care burden and the absence of bedside supervision by regulated professionals have led, in many instances, to an increase in occupational influence. Studies have noted PSWs' use of occupation-specific tacit knowledge (Kontos & Naglie, 2009) and interpretive abilities (Anderson, Wendler, & Congdon, 1998) to alter or passively decline prescribed care practices (Anderson et al., 2005; Colón-Emeric et al., 2006; Lopez, 2007) and sway licensed professionals (Anderson et al., 2005). Nonetheless, PSWs are often not the primary focus of studies exploring disciplinary barriers to care planning and implementation. The oversight extends to the evaluation of the implications of the RAI/MDS standardized process. We redress these oversights by exploring the decision making and care practices of PSWs in relation to this process.

Methods

Qualitative data were collected during a 2-year (2007–2009) multimethod trial of a 12-week interprofessional arts-informed intervention to improve long-term care. Offered 2 hrs/week, the intervention utilized dialogue, critical reflective exercises, role-play, and research-based drama. Its purpose was to sensitize PSWs, nurses, and allied health personnel to a novel approach to person-centered care (Mitchell, Bourne, & Hollett,

2006), which emphasized embodied self-expressions of persons living with dementia (Kontos, 2004, 2005). For this article, analysis was restricted to data drawn from interviews and focus groups with PSWs and their supervisors.

Setting and Participants

The exploratory in-depth methodological nature of the multimethod trial necessitated that sites be few (2), similarly staffed and sized (Facility A, 32-bed; Facility B, 40-bed), and have strong administrator support. University-based ethics approval was obtained for each study site.

The primary sampling strategy was non-random convenience. All full- and part-time supervisors were eligible to participate in focus groups and interviews. All full- and part-time PSWs were eligible for focus groups. Theoretical sampling (Denzin & Lincoln, 2000), in which the objective of developing an explanation determines the specific criteria by which a sample is selected, was used to secondarily select a subgroup of PSWs for interview. Due to the pre-post protocol of the main study, some PSWs and supervisors participated in a second focus group or interview. Post-intervention data were included because the intrinsic qualities of PSWs that we discuss regarding their approach to care were not outcomes of the intervention.

Following study introductions, informed consent was obtained from 26 PSWs (Facility A, *n* = 13 and Facility B, *n* = 13) and 9 supervisors (Facility A, *n* = 6 and Facility B, *n* = 3). See Table 1 for demographic details of PSW participants. Participant confidentiality was protected by restricting identification to occupational role. Where residents were referred to by name by study participants, pseudonyms have been used to protect their confidentiality.

Focus Groups and Interviews

Of 26 participating PSWs, 19 participated in focus groups and 7 in interviews. Of the nine supervisors, all participated in focus groups and eight participated in interviews. See Table 2 for details of participation. Focus groups for PSWs and supervisors were conducted separately to address possible power imbalances between the groups and provide in-group homogeneity to capitalize on shared experiences (Kitzinger, 1995).

For both PSWs and supervisors, each audio-taped focus group consisted of 3–6 participants and lasted approximately 60 min. An open-ended discussion guide was used by the moderator to

Table 2. Details of Participation

	Focus groups (<i>n</i> = 10)				Interviews (<i>n</i> = 25)			
	PSWs (<i>n</i> = 19)		Supervisors		PSWs (<i>n</i> = 7)		Supervisors	
	One group	Two groups	One group	Two groups	One interview	Two interviews	One interview	Two interviews
Facility A	4	5	3	3	1	3	3	2
Facility B	4	6	0	3	1	2	0	3

Note: PSWs = personal support workers.

explore the care activities and experiences of PSWs in the context of RAI/MDS standardized processes and to probe for factors that constrain and enable PSW care. Audiotaped interviews lasting approximately 60 min were subsequently conducted by two research assistants to probe issues raised by PSWs during the focus groups.

Data Analysis

Verbatim transcripts were produced by research assistants and analyzed using thematic analysis techniques (Denzin & Lincoln, 2000). Descriptive coding was first conducted wherein segments of text were assigned a code reflecting the original statement. Codes were then clustered as categories of emerging themes. Through an inductive iterative process, categories with similar content were investigated for inter-relationships and further refined. Transcripts were again reviewed to clarify the context and meaning of coded text. Finally, analytical categories were examined to illuminate points of intersection and conflict between the care plan and PSW care in order to investigate the influences of the RAI/MDS standardized process on PSW care delivery.

Kontos developed the initial coding scheme. To maximize credibility and trustworthiness, Kontos and the research assistants each independently open-coded 20% of the transcripts, followed by discussion to resolve any differences in code application. Remaining data were divided equally among the research assistants for coding.

Results

Findings organized under the theme “care plan development, content, and access” suggest that the standardized process associated with RAI/MDS assessment and care plan implementation, as well as structural impediments to PSW care plan access, precluded full participation by PSWs. The theme “PSW knowledge and clinical decision making”

illustrates how PSWs relied instead on their own knowledge of residents’ biographical and vocational histories as well as their own capabilities of imagination and empathy to connect with their care recipients and to properly individualize care. Finally, the theme “interprofessional and intraprofessional relations” identifies ways in which PSWs were prevented from making occupation-specific experience-driven contributions to the broader interdisciplinary team either in written form or through interprofessional (PSW-nurse) meetings. To compensate for interprofessional barriers to quality care, PSWs engaged in informal intraprofessional (PSW-PSW) collaboration.

Care Plan Development, Content, and Access

Resident care plans were prepared upon admission and updated quarterly or when there were changes in health status. Notwithstanding supervisors’ accounts of “everyone” being involved in the planning protocol, PSWs were notably absent:

Interviewer: When and how is [the care plan] developed?

Supervisor: It will be done in the first seven days when a resident comes. You gather all your information, you do all your assessments. You assess the resident, you gather your information from the family, you observe the residents, then you make the care plan.

Interviewer: Who’s involved in that?

Supervisor: Everybody . . . you have the nurses, you have the family, you have recreation, dietary, and nursing. [Facility B, Supervisor Interview].

Although information represented in the MDS-driven care plan is intended to be useful to the wider interdisciplinary team, PSWs across both facilities argued it was heavily weighted towards clinical concerns. Consequently, the care plan failed to provide the information PSWs required to individualize care and fully interact with residents. Several PSWs in Facility A nostalgically spoke of a

pre-RAI/MDS intake period when admission documentation provided rich biographical history:

PSW 1: This is my 11th year here, and I remember us opening up their 'documentation book,' and you had a full history on them . . .

PSWs 2, 3, 4 and 5: [affirmative sounds and gestures].

PSW 1: . . . and it was lovely. Yeah. You know, 'cause you could just, you could just like build this person, let me tell you . . . We don't get that beautiful history that we'd get before where you could just put this picture together It was always so nice to know, you know, like the kind of music that they like, their children, what did they do for a living. 'Cause that's stuff you pull for conversation when you're dealing with them. [Facility A, Focus Group].

Supervisors confirmed the clinical content of care plans:

Interviewer: You indicated [the care plan] has their medical history, things about behavioural management. So, does it have information about their life history? . . . Like, what the resident was like? What they did before?

Supervisor: No, no, no. It's just about all your [activities of daily living], your behaviour, your risk, your medical diagnosis. [Facility B, Interview].

In addition to the inadequate content of care plans, PSWs further complained of poor access due to computerized records. This was attributed to gaps in occupational training and competition for computer terminals with multiple professionals, including non-frontline staff:

PSW 1: . . . [Supervisors] said that they were going to teach us how to get onto the computers, and that we could access [electronic care plans] through the computer. But there's only one computer per floor. On an average day, there's like seven [health care providers needing to use the computer].

PSW 2: And we were all gonna be taught how to get in, and have an access code, and so on. But really, never got there. And even now, if you look at it, even if we did know how to get into it, there's just one computer and there's like . . . [many health care provider groups] us[ing] it, yep yep.

PSW 1: Everybody has [computer] access [to the care plan] but the PSW. Even the, what do you call it, the Rehab? The one that teach you to throw the ball.

PSW 2, 3, 4, 5 and 6: [laughter].

Moderator: That would be the 'recreational therapist'.

PSW 1: The one that throw the ball, anyway.

PSW 2: She tosses a lot of balls.

PSW 3, 4, 5, 6: [laughter].

[emphasis in original communication; Facility A, Focus Group].

In both study facilities, supervisors appeared oblivious to structural impediments to PSW care plan access. Instead, PSWs were often described by supervisors as being universally resistant to the care plan, requiring persistent reminders of their importance, "right from [PSW] orientation, during staff meetings, [and] during discipline meetings as well." Such reminders were often believed ineffective. A supervisor in Facility A doubted that PSWs were reading the care plans and further suggested that this was endemic across facilities:

I think, you know, if you went to any long term care home in Ontario, [supervisors] would all tell you, 'yes, [PSWs] read them'. But I'm being honest to you. I don't know if they truly do.

In both facilities, the daily "PSW documentation record" was provided to address the presumed unwillingness of PSWs to access the care plan. Produced by registered nurses, it summarized daily bathing, feeding, and mobility requirements listed in each care plan. PSWs were required to initial the documentation record once tasks were completed and submit the record to the charge nurse who initialed and submitted it for filing. In this way, the PSW documentation record was a normalized part of the organizational information sharing routine. Yet it failed to address provincial regulatory requirements for the review of the care plan by all direct care practitioners. Consequently, despite both PSWs' and supervisors' knowledge of contrary practices, PSWs were instructed to affirmatively respond when questioned by Inspectors about care plan review. A supervisor explained,

I mean, when I have the Ministry of Health coming in here and they ask [PSWs], like, 'how do you know how to care for each person?', the answer should be, 'the care plan.' [Facility A, Interview].

PSW Knowledge and Clinical Decision Making

PSWs suggested that standardized interventions alone were insufficient to inform quality care. In order to understand residents' actions and expressions and thereby reduce agitation and individualize care, PSWs sought information regarding residents' preferences as well as biographical and vocational histories. They also drew heavily on their own personal experiences and capabilities of imagination and empathy to properly tailor the

complex and nuanced interactions implied in tasks of bathing, dressing, and feeding proscribed in the care plan.

Individualizing Care: PSW Knowledge of Residents' Biographies.—PSWs spoke of knowledge of residents' idiosyncrasies gained from close proximity and increased familiarity. A PSW [Facility A, Interview] explained, "you have to be observant, you know? There's always a reason for the behaviour." Similarly, another PSW commented,

PSW: (Yo)u have to know to approach them.

Moderator: How do you know that?

PSW: By constantly working with them. Constantly learning the ins and outs, you know, what they like, what they don't like . . . You have to know what they like. [Facility A, Focus Group].

Knowledge gained through familiarity was highly valued as a means to anticipate and defuse challenging behavior. For example, PSWs often expressed understanding that nonverbal anger outbursts resulted from the frustration of unmet personal preferences:

If you put on the wrong shirt, they'll kick it at you, or throw it away, and things like that. [Facility A, Focus Group].

If they don't like fish, and if you put fish in front of them, it turns out to be a really bad situation. You know, somebody could just knock it off the table. [Facility A, Focus Group].

Knowledge of biographical history further facilitated understanding of residents' behavior and the individualizing of care. The majority of PSWs across both sites recounted instances where knowledge of a resident's trauma, vocation, or marriage enabled the tailoring of care. In one example, a PSW was able to intuit a causal link between a resident's faded tattooed number, the Holocaust, and the terror induced by showering:

I have one resident too, and I am sure because I read lots of books about the [concentration] camp. You know, very very sad, you know what they did to people. And one lady, when we always taking her for shower, she's very scared about when you put the water. When we give her shower, she's screaming. And, this lady has the numbers, you know, on her hand. She remembers this. And we give her nice bath, you know, in the bed . . . And you know what? Believe me, she was quiet. She was quiet and not scared. [Facility A, Interview].

Knowledge of the resident's biography enabled this PSW to correctly reinterpret screaming. She altered the institutional care routine in acknowledgment that the effects of the atrocity of mass killings and gas showers transcend time and evade cognitive impairment.

Many PSWs recounted instances where residents' previous vocation instilled particular bodily dispositions. This knowledge was then used to facilitate the tailoring of care. One PSW explained:

Take Mr. Black, for example. To get him to go, he was in the army, so you have to march like in the army. You say, you know, in the army. [Facility B, Interview].

PSWs often deliberately sought vocational information from residents' families in order to better contextualize behavior. In one example, PSWs approached the wife of a nonverbal resident for insight into what appeared to be repetitive nonsensical dementia-related behavior:

Yeah, he can't really communicate. But like, we ask the wife, 'what he was doing before?' Because everybody was so scared to watch him on the floor on his knees. And everybody try, you know, take him up. But the wife said, you know, 'he was doing some flooring. Floors.' Now we know . . . if he's like doing something on the floor, don't move him. Don't! It's okay, it's normal! Leave him! Of course, you have to be careful with the other residents don't step on him. [Facility A, Interview].

In Facility A, several PSWs independently spoke of a new sensitivity towards a female resident's incessant shadowing of a male resident once family members brought in a photograph of her now-deceased husband:

This resident look just like her husband. I went into the room, and I look at the picture, and they look alike! So now you know why she said, 'this is my husband.' . . . What can you do? They're not hurting each other. You know, as long as they're safe. You just let them sit together. That's all you can do. You're gonna go to tell her, 'it's not your husband'? [Facility A, Interview].

Shared Bodily Experience as a Source of PSW Knowledge.—As part of their occupational care toolkit, PSWs relied on recall to empathetically connect their own embodied experiences with those of care recipients. Recalling embodied

experiences played a critical role in facilitating clinical empathy and individualizing care:

I would say, ‘*why* you can’t go on the bedpan?!’ The patient said, ‘oh, I can’t make it on the bedpan’. I’d say, ‘but you *try*, you have to go!’ Just recently I was in the hospital and they brought me a bedpan and I could not go. So now I just know how difficult it is to be on a bedpan. I did not know! Now I *know* what they mean when they want to go on the toilet. [Now] I try to put them there. Little things happen to you, and so you know what it is for them. [Facility A, Focus group, original emphasis].

[I] put them in their favourite pajamas or their favourite nightdresses . . . It’s better for me when I have my favourite pajamas! So again, they’re less agitated [when] they go to bed feeling very comfortable. [Facility B, Interview].

Imaginary Kin Ties and Their Role in PSW Care.—The reflective gesture of the imagination further served as a significant source of affective care through the establishment of fictive kinship, which involves imaginary kin ties:

I know they are not my mother but I’m here to care for them. They’re not my mom but . . . I still can love them like family. [Facility A, Interview].

They’re like family to us. [Facility A, Focus group].

PSWs believed that feelings of fictive kinship were reciprocal. This reciprocity was variously attributed to the effects of the genuine affection experienced and demonstrated by PSWs, their sense of residents’ dependency, as well as the stark contrast to PSW care suggested by absent blood relatives:

And I think we are, we are family to them. We care about them . . . we’re like their *family*, we take care of them! [Facility B, Focus Group, emphasis in original communication].

We are the ones who are here to give care to them, you know? Some family members, sometimes months you don’t even see one of them. So, we always have it in our mind, we are the ones they depend on. We’re like their family. [Facility A, Focus Group].

Interprofessional and Intraprofessional Relations

Facility-specific implementation and evaluation processes of the RAI/MDS-driven care plan failed to provide structured opportunities for sharing PSW information with interprofessional or intraprofessional colleagues. The source of this failure was

the perceived lack of clinical importance of PSW care by some supervisors relative to that of registered staff. Furthermore, PSWs perceived that nurses questioned the soundness of their clinical assessments leading to disregard for PSW contribution to the care plan. Consequently, PSWs were most often restricted to informal intraprofessional sharing in order to ensure quality care.

Interprofessional Barriers and PSW Care.—At times, supervisors spoke somewhat negatively about the clinical importance of PSW care in contrast to that of nurses—“I mean, if you give [poor] mouth care, and if you give a wrong medication, that is just a different issue” [Focus Group, Facility B]. More frequently, however, they indicated that PSWs’ proximal and intimate relations with residents afforded a unique and specialized knowledge of current functioning as well as first bedside awareness of therapeutic response. The contributions of PSW knowledge to nursing care were explained by a supervisor:

. . . The nurse [should] check with the PSWs. You know, ‘how do you find [the resident]?’ ‘how are things?’ ‘is this working?’ ‘is this not working?’ so then the nurses can update the care plan . . . It’s very important to have input from PSWs to find out ‘how are they in the morning?’ and ‘do you find that they are resistive to care?’ or that kind of stuff. ‘Cause nurses are not there providing this care, so they need to get that information from the PSWs. [Facility B, Supervisor Interview].

Despite this belief, the facilities failed to provide structured opportunities for information sharing. Additionally, PSWs in both study sites consistently explained that nurses often failed to solicit information on residents’ current status or response to treatment. They further indicated that nurses did not respond positively when PSWs initiated the exchange of clinical information.

The following focus group exchange in Facility A is provided at length to demonstrate PSWs’ multiple exposures to negative interprofessional information exchanges. It also demonstrates PSWs’ beliefs in the soundness of their occupational clinical assessments and in occupational discrimination as the source of nurses’ disregard:

PSW 1: About a month ago . . . this guy, we, we put him on the toilet and then he went totally white. So we called code blue [because] something is wrong with him. Because we know him, you know. A nurse from another floor came. When she came, his

colour in his face came back. We put him on the bed. She was so mad . . . ‘Why did you call? There was nothing to call code blue! The man is talking, he’s fine!’ We told her, ‘we know him,’ you know? ‘The way he look he wasn’t well.’ Then I felt bad because I’m the one who call code blue. I think it was that same night. When we went home they sent him out to the hospital, because he wasn’t doing well He died that same night.

PSW 2: Because the [full-time staff] . . . you know we . . .

PSW3: We, we . . . we’re with them 24/7, we *know* them. We know them more than [nurses].

PSW 1: Another time it happened again too where this guy, I told [the nurses], I said, ‘something is wrong with him’. The nurse manager came. She said, ‘you know, [first name of PSW], it’s old age, nothing is wrong.’ They send the guy out [to hospital]; two minutes after, he died from pneumonia. So they’ve gotta listen to us when something is wrong with that person.

PSW4: We notice something wrong.

Moderator: Why do you think they don’t listen?

PSW3: We’re personal support worker . . . not nurse.

PSW4: Because we are this [points to ID badge], ‘personal support worker’. We don’t know anything.

PSW3: Yeah, we don’t know. We don’t know nothing.

PSW4: That’s how some of them treat us.

PSW3: [Nurses] think that we’s just wash [residents], clean them bum, push them to the dining room, nothing more at all. Nothing more going on. That’s how [nurses] feel! They crazy.

Intraprofessional Communication and PSW Care.—Interprofessional barriers to collaboration and communication led PSWs to regularly and deliberately engage in intraprofessional communication. PSWs demonstrated an occupational solidarity that privileged knowledge sharing and mentoring. In several interviews, experienced PSWs spoke of the ways in which familiarity-driven resident information was deliberately passed along to colleagues, especially those who were novice or part-time:

Everyone has their own routine in the morning. You might like getting up first thing and brush your teeth; some people get up and have a cup of coffee So you share that information with the other PSWs saying, ‘you know what, if you give him a cup of coffee first in the morning, you’ll get him dressed better’ . . . [Facility A, Interview].

For lunch we had a problem. If [a new PSW]’s coming, they don’t know [so] we tell them, ‘Mrs. Cohen likes always for lunch fruit, special pineapple’. If she doesn’t have a pineapple—fresh pineapple—she’s, oh boy! She’s angry on the kitchen staff, and everything. But if you know her, you know, always take her a beautiful plate of the pineapple. [Facility A, Interview].

Supervisors acknowledged PSWs’ intraprofessional collaboration:

The PSWs, because of their familiarity with the residents, they get to know the ins and outs. [When] you have part-time PSW or you hire a new PSW you’ll often see that the PSW that has been on the floor for a while say, ‘oh Missus so-and-so likes a cup of tea at 2 o’clock’ or you know, ‘you have to watch Missus so-and-so otherwise she’ll go in there and turn on the tap and leave the water running’. They will give them tips. [Facility B, Interview].

Yet nursing home management did not provide PSWs with scheduled opportunities to discuss resident information among themselves, such as that provided to nurses and allied health professionals. Consequently, PSWs were forced to exclusively rely on informal unscheduled intraprofessional communication:

PSW: . . . As soon as you pick up on something, you share it with somebody So right through the day when something has occurred, you say, ‘so and so’ That’s how we do it. [Facility A, Focus Group].

Discussion

The RAI/MDS movement assumes that standardizing assessment is pivotal to improving care and care outcomes (Rantz et al., 1999; Stosz & Carpenter, 2008). Yet reliance on the RAI/MDS alone, with its medical orientation (Bernabei, Murphy, Frijters, DuPaquier, & Gardent, 1997), and shortcomings in capturing psychosocial well-being (Holtkamp et al., 2001) and personal preferences (Carpenter & Challis, 2003), restricts the care plan to standardized interventions. This has significant implications for dementia care, where knowledge of individual preference, style, and vocational history is critical to accurately deciphering the meaning of behavior (Kontos & Naglie, 2009), individualizing care (Carpenter & Challis; Carpenter et al., 2000), and potentially minimizing the use of physical and pharmacological restraints (Kontos & Naglie, 2007). Our study suggests that PSWs have unique occupational contributions to make in this

regard because they were able to surpass the limitations of the RAI/MDS in order to individualize care.

In our study, individualized care was informed significantly by the imagination of PSWs. Following philosophical insights of Nussbaum (1997, pp. 10–11), imagination makes it possible to “think what it might be like to be in the shoes of a person different from oneself . . . to understand the emotions and wishes and desires that someone so placed might have.” The importance of imagination has been recognized across care settings, including that of long-term care (Kontos & Naglie, 2007, 2009). Consistent with other studies (Anderson et al., 2005; Berdes & Eckert, 2007; Bowers et al., 2000), imagination concerning fictive kinship was a determinant of quality care. Recalled experiences of bodily illness and of comfort (Kontos & Naglie, 2007, 2009) also facilitated small but important empathetic gestures of care, such as the choice of toileting over bedpans and the selection of a favored nightgown. Moving beyond practitioners’ individual experience to understand how practice organizations encourage or inhibit practitioners’ use of imagination and recollection of experiences and the implications this has for individualized care are important directions for future inquiry in these and other long-term care settings.

PSWs’ customized care processes are a central dimension of quality and yet are not reflected in the written care plan (Dellefield, 2006). The inclusion of knowledge held by PSWs of residents’ customary routines, preferences, and concerns would effectively shift care plans from being provider driven and problem based to person-centered and quality enhancing. PSWs’ knowledge of residents and their consequent individualizing of care have been linked to the psychological well-being of residents (Barry, Brannon, & Mor, 2005). Additionally, including PSW knowledge into the care plan would facilitate person-centered care regardless of provider discontinuities associated with staff absenteeism and turnover (Bowers et al., 2000; Dellefield, 2006). Examining the capacity of existing interprofessional processes such as care meetings (at which care plan changes are often determined) to include PSW reporting of information is recommended to more comprehensively relay individualized aspects of care to the broader team (Dellefield, 2006) and improve quality of care.

Strengthening existing collaborative processes to include PSW contributions could lead to the

formalization of an interprofessional “broker role” (Miller et al., 2008) or “go between” (Kvarnström & Cedersund, 2006) that in our study underpinned supervisor encouragement that nurses regularly seek PSW updates on resident status and response to care plan interventions. The interprofessional practice literature has yet to examine the significance of information derived from PSWs’ own specialized knowledge of resident care and care plan implementation for the work of nurses and allied professionals and thus warrants further research.

In terms of intraprofessional collaboration, our study identified occupational self-organization of PSWs, as evidenced by distinct therapeutic care strategies (e.g., seeking biographical and vocational information, using familiarity as a means by which to identify changes in health status), and consistent efforts to relay this information to new or inexperienced PSWs. Thus, another important area for future research is the implementation of structured opportunities, such as regularly scheduled meetings for PSW-PSW information sharing in order to complement the “impromptu care planning” (Colón-Emeric et al., 2006) in which PSWs already engage.

Quality care depends upon complete and accurate information sharing among interprofessional team members (Conn et al., 2009), and the care plan is considered to be the medium of communication for its achievement (Martin, Hinds, & Felix, 1999). Yet here, as elsewhere (Adams-Wendling et al., 2008; Dellefield, 2006; Taunton et al., 2004), the care plan was perceived to mitigate against interprofessional collaboration and communication with PSWs. Inadequate access to computerized records, lack of computer training, and competition for terminals were significant barriers to care plan access. In other clinical settings, access to computers has been strongly associated with professional stratification (Miller et al., 2008). The PSW documentation record was instituted as a care plan “workaround” (Lingard et al., 2007) to these and other access issues. Yet as a workaround, the documentation record failed to address underlying factors of occupational discrimination, access, provincial review requirements, and content issues. Our analysis suggests the importance of addressing these underlying factors in future research on interventions designed to improve care plan implementation.

Our study strongly demonstrated poor interprofessional regard for PSWs. However, the evidence here is persuasive that PSWs actively repudiated the

opinions of other professions. Moreover, in the case of their group dismissal of the activities of the recreational therapist, it would appear that PSWs have established an esprit de corps (Miller et al., 2008) based on their own occupational knowledge, the articulation of group humor, and a strengthening of group solidarity based on negative perceptions of other professions. Similar sources of intraprofessional solidarity have been identified among registered nurses (Miller et al., 2008) and may signal the development of a nascent occupational identity among PSWs that warrants further investigation.

Care planning, operationalized within the RAI/MDS framework, is expected to improve quality of care in long-term care homes (Hawes et al., 1997). However, our examination demonstrates that exclusive institutional reliance on the RAI/MDS undermines quality care because it fails to capture residents' preferences and excludes input by PSWs. These findings provide new insight regarding barriers to the interdisciplinary development and implementation of individualized care plans and signpost future investigation of the integral role of PSWs in the provision of individualized care.

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