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Long-Term Residential Care Policy Guidance for Staff to Support Resident Quality of Life

Mary Jean Hande, PhD,¹ Janice Keefe, PhD,^{1,2,*} and Deanne Taylor, PhD³

¹Nova Scotia Centre on Aging, Mount Saint Vincent University, Halifax, Nova Scotia, Canada. ²Department Family Studies and Gerontology, Mount Saint Vincent University, Halifax, Nova Scotia, Canada. ³Interior Health Authority, Kelowna, British Columbia, Canada.

*Address correspondence to: Janice Keefe, PhD, Nova Scotia Centre on Aging, Mount Saint Vincent University, 201F McCain Centre, 166 Bedford Highway, Halifax, Nova Scotia B3M 2J6, Canada. E-mail: janice.keefe@msvu.ca

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Abstract

Background and Objectives: Amidst a complex policy landscape, long-term residential care (LTRC) staff must navigate directives to provide safe care while also considering resident-preferred quality of life (QoL) supports, which are sometimes at odds with policy expectations. These tensions are often examined using a deficit-based approach to policy analysis, which highlights policy gaps or demonstrates how what is written creates problems in practice.

Research Design and Methods: This study used an asset-based approach by scanning existing LTRC regulations in 4 Canadian jurisdictions for promising staff-related policy guidance for enhancing resident QoL. A modified objective hermeneutics method was used to determine how 63 existing policy documents might be interpreted to support Kane's 11 QoL domains.

Results: Analysis revealed regulations that covered all 11 resident QoL domains, albeit with an overemphasis on safety, security, and order. Texts that mentioned other QoL domains often outlined passive or vague roles for staff. However, policy texts were found in all 4 jurisdictions that provided clear language to support staff discretion and flexibility to navigate regulatory tensions and enhance resident QoL.

Discussion and Implications: The existing policy landscape includes promising staff-related LTRC regulation in every jurisdiction under investigation. Newer policies tend to reflect more interpretive approaches to staff flexibility and broader QoL concepts. If interpreted through a resident QoL lens and with the right structural supports, these promising texts offer important counters to the rigidity of LTRC policy landscape and can be leveraged to broaden and enhance QoL effectively for residents in LTRC.

Keywords: Canada, Caregiving—formal, Flexibility, Health care policy, Nursing homes

Background and Objectives

Long-term residential care (LTRC) facilities in North America are hospital-like and highly regulated. More than two decades of research emphasize LTRC staff's difficulties in abiding by rigid regulations while also trying to respond to resident needs and preferences in order to approximate a balance of safe care and quality of life

(QoL) for residents (Banerjee & Armstrong, 2015; Carr & Biggs, 2018; Daly et al., 2016; Lopez, 2006a, 2006b; Wiersma, 2010). As an increasing number of people will spend their later life in LTRC (Estabrooks et al., 2015), there is a pressing imperative to improve QoL in LTRC. Almost 20 years ago, Rosalie Kane (2001) published a seminal paper that argued LTRC residents' QoL required

advances in 11 domains: relationships, autonomy/choice, dignity, meaningful activities, privacy, physical comfort, individuality, enjoyment, safety/security/order, spiritual well-being, and functional competence. Staff can play an integral role in enhancing these domains, but need to be supported in policy to do so.

In Canada, LTRC staff are regulated through relatively decentralized, inconsistent, and conflicting jurisdictional policies. Staff guidelines focus on the challenges of ensuring the safe provision of resident care (Carr & Biggs, 2018; Kane & Cutler, 2015; Wiersma, 2010). However, residents often find other QoL dimensions meaningful, which can be at odds with policy expectations; this leaves staff with the obligation to prioritize policy over residents' preferences. While there is a growing body of research on the ways that staff might enhance QoL for LTRC residents, it is generally argued that existing LTRC policy inhibits these activities, largely by constraining staff flexibility and discretion (Armstrong et al., 2016; Carr & Biggs, 2018; Garcia et al., 2012). However, there has yet to be conducted a detailed examination of Canada's existing LTRC policy landscape to determine how QoL is currently represented in regulations. Thus, promising LTRC policy texts supporting staff in enhancing QoL may go unnoticed.

This analysis is guided by the question: Does existing Canadian LTRC regulation direct staff to improve resident QoL? We employed a modified objective hermeneutics method to analyze LTRC regulations in four Canadian jurisdictions as they relate to staff, with a particular focus on how these policies might support staff in enhancing QoL. We found that while most policy texts are heavily weighted towards maintaining resident safety/security/order, each jurisdiction in our study offered promising policy texts that support staff flexibility in responding effectively to residents' needs and preferences in order to enhance their QoL. We argue that these regulatory texts are important counterweights to the dominance of the safety/security/order domain and can be leveraged to improve residents' QoL. Rather than specific staff tasks or risk-aversion techniques, resident QoL must be central to the interpretation of policy. In practice, this requires remunerating staff properly and supporting them to exercise flexibility as they navigate highly regulated, hierarchical work environments while meeting residents' needs and desires.

Following a summary of the relevant research literature on staff and LTRC policy, we describe our policy analysis context and research methods. After highlighting key findings from our policy scan, we discuss promising texts and trends in the Canadian LTRC policy landscape and offer guidance on leveraging these texts to support staff to enhance resident QoL in LTRC.

Literature

We focused on three themes in the literature on staff in LTRC policy: the sector's risk-averse and overregulated

characteristics, how staff navigate regulations, and the value for staff and residents in flexible regulations and roles. Most of this research uses a deficit-based approach to policy analysis, where existing policy and its implementation is analyzed for gaps or problems that are then addressed in policy recommendations. We outline the need for a detailed, asset-based approach to understanding the LTRC policy landscape as it relates to staff.

LTRC facilities are considered to be the most regulated of institutions in Canada and the United States. Canadian researchers have noted that many regulations arose in response to scandals and familial litigation (Lloyd et al., 2014), or act as neoliberal mechanisms auditing an increasingly market-driven health care sector (Banerjee & Armstrong, 2015). Regulations are tied not only to managing risk, but also to ensuring safety in notoriously and chronically underfunded large institutions (Armstrong et al., 2009; Wiersma, 2010). This usually requires monitoring staff tasks and mandating documentation and reporting systems that have not made tangible QoL improvements in LTRC (Armstrong et al., 2016; Banerjee & Armstrong, 2015). While Rosalie Kane (2001) lists safety/security/order as a key domain of resident QoL, in later work, Kane and Cutler (2015) reflect that this domain tends to dominate existing rigid U.S. regulatory frameworks. Whittington (2014) describes how current U.S. LTRC regulation breeds extreme risk aversion by punishing staff that take unprescribed yet necessary action. Similarly, Canadian researchers have found that overemphasizing safety and security in Canada negatively impacts residents' overall QoL (Armstrong, 2018), specifically, their autonomy, privacy, and ability to maintain meaningful relations both within and outside the LTRC facility (Tufford et al., 2018). Yet regulation is open to interpretation, and most managers have some latitude for discretion (Cloutier et al., 2016), particularly when it comes to subjective resident QoL domains such as dignity and autonomy (Carr & Biggs, 2018). However, Daly and colleagues (2016) found that Canadian (specifically Ontarian) policy language tends to be prescriptive, thus generally discouraging more flexible, resident-centered policy interpretations. Overall, there is consensus that the complexities, tensions, rigidities, and overall glut of LTRC regulation tends to work against the culture change needed to enhance resident QoL in both the United States and Canada.

LTRC's highly regulated, risk-averse, prescriptive policy context is closely related to its rigid and hierarchical labor division and general organizational constraints on staff activities. Numerous researchers have discussed negative impacts when staff are overly constrained by institutional policies and regulation. For example, residents in Canadian LTRC blamed institutional policies, not staff, for the care they perceived to compromise their sense of dignity and autonomy (Donnelly & MacEntee, 2016). Wiersma (2010) argues that Canada's punitive and overregulated LTRC sector creates a "disjuncture between the system of

long-term care and the ways in which staff want to be able to care for residents [that] is significant” (p. 433). Workers are frustrated and dismayed that they cannot provide the dignified QoL they wish for residents because task-oriented demands tend to trump relational work (Armstrong et al., 2009; see also Lopez, 2006a for U.S. context). Moreover, chronic staffing shortages and organizational factors cause workers to burn out (Chamberlain et al., 2017) and miss tasks (Song et al., 2020). Survey results also show that LTRC direct care staff name decision-making autonomy as key to job satisfaction, but rarely encounter it (Chamberlain et al., 2016). In an American context, Waldrop and Nyquist (2011) found that navigating LTRC policy contradictions and tensions causes stress and difficulties complicating end-of-life care. International research shows that, in comparison to Scandinavian LTRC workers, Canadian LTRC staff may be particularly overworked and lacking in flexibility or job-related discretion (Daly et al., 2016).

Research has confirmed that neither quality of care nor QoL can be ensured by rigorously monitoring and documenting staff activities through narrowly defined checklist tasks (Armstrong et al., 2016). Instead, flexible, responsive, and resident-centered job practices—whether regulated or subversive—have been identified as necessary to counter rigid LTRC regulation and deliver effective person-centered care (Cohen-Mansfield & Bester, 2006; Lopez, 2006a) enhancing resident QoL. In Canada, Müller and colleagues (2018) found that cleaning staff subversively engage in relational care, even contravening their job descriptions, vis-à-vis residents (see also Baines & Daly, 2015; Daly et al., 2016; Lopez, 2006b). In contrast, European countries with more flexible LTRC labor divisions allow cleaning staff to spend more time with residents and to assist with other tasks, effectively improving quality of care. Comparative analyses of Canadian versus Scandinavian LTRC workers have confirmed that interpretive policy approaches, higher staffing levels, less hierarchical work environments, and more flexible scope of duties allow for more relational care (Daly et al., 2016).

In Garcia and colleagues’ (2012) research on optimal LTRC environments for people with dementia, staff flexibility—defined as “performing tasks that are different than those normally completed in accordance with their job description/time schedule” (p. 758)—was considered essential for resident well-being. In an American context, Cohen-Mansfield and Bester (2006) found that staff flexibility was positively correlated with both staff and resident autonomy. Koren (2010) suggests significant culture change and “breaking down departmental hierarchies, creating flexible job descriptions, and giving frontline workers more control over work environments” (p. 2) as important strategies for implementing resident-centered care in LTRC. These strategies might require reinterpreting existing policy rather than significant policy change. Armstrong and colleagues (2009) and Carr and Biggs (2018) both note that LTRC employers interpret policies differently and

have discretion over workers’ flexibility and “voice” within a facility. However, without a detailed understanding of the staff-related LTRC policy landscape, it is difficult to know where there is more scope for interpretation and which rules can be leveraged to maximize flexibility.

Many of the studies reviewed here address particularly problematic policy issues by showing impacts on LTRC staff and residents’ lived realities through a deficit-based policy research approach. Other policy analysis approaches use logic models to examine policy development effectiveness (Goeschel et al., 2012; National Collaborating Centre for Healthy Public Policy, 2013), or conduct comparative analyses on building design or mandated staffing levels (see Armstrong et al., 2009; Armstrong & Lowndes, 2018; Harrington et al., 2012). Yet we find no Canadian literature that examines how QoL is reflected in the existing LTRC policy landscape, and thus there is limited understanding of existing rules to leverage. The asset-based approach we use here locates promising aspects of existing policy that can be used to leverage timely policy implementation and future development that can effectively enhance QoL for LTRC residents.

Research Context

LTRC facilities, also referred to as nursing homes or nursing facilities, are residential settings that provide round-the-clock health services provided by a wide variety of staff, family and volunteers. Canada is widely regarded as boasting a “universal,” publicly funded health care system legislated by the *Canada Health Act*, although LTRC is one of the large segments of health care provision that is not included in the Act. Instead, the federal government allocates health care funding to each province and territory, which can be used to support different funding models. The reliance on jurisdictional public funding means that each province or territory regulates their LTRC sector through standards that must be followed for facilities to be licensed and operational. There are no LTRC facilities in Canada that are not subject to jurisdictional regulation. However, the decentralized, jurisdiction-specific regulations vary widely across Canada, and the sector is characterized by regulatory tensions and inconsistencies both within and across jurisdictions (for more detail on Canadian jurisdictional tensions and complexities, see Berta et al., 2014). Many regulations are developed to buffer institutional liability, optimize resources, and maintain quality of care standards in response to historic problems and scandals (Lloyd et al., 2014). Staff are particularly highly regulated in all jurisdictions. Nevertheless, LTRC has struggled to receive governmental funding priority, and chronic staffing shortages and high staff turnover have intensified due to neoliberal austerity measures (Lowndes & Struthers, 2016). While regulation to improve quality of care is monitored through widely used survey instruments such as the Resident Assessment Instrument-Minimum Data Set

(RAI-MDS) (Armstrong et al., 2016), efforts to measure and improve QoL, largely through nonbiomedical programming and design, have been a relatively recent consideration in the policy landscape.

Canada’s aging population and home care service expansion nationally have modified the demographics of those living in LTRC. While there is significant variation across jurisdictions, women, people over 85, people diagnosed with dementia, and people multiple health challenges are overrepresented in LTRC (Canadian Institutes of Health Information, 2014). The average length of stay also varies by jurisdiction but has generally decreased over the last 15 years to fewer than 2 years for most residents (Hoben et al., 2019).

Research Design and Methods

This study is part of a larger policy analysis associated with a Pan-Canadian multimethod research project, Seniors–Adding Life to Years (SALTY). SALTY uses a team-based integrated knowledge translation approach to investigate QoL for LTRC older residents in Canada. The SALTY research team involved stakeholders, including policy makers, health professionals, and LTRC end users such as frontline staff, family members, and residents. These stakeholders assisted in research design and analysis to ensure that our research addressed priority areas for those most impacted by policy changes (see Keefe et al., 2020, for a more detailed description of the overall project). These stakeholders helped identify staff-related policy as an important focus for the project.

Guided by the overarching question “How does existing policy enable or inhibit the QoL of residents in LTRC facilities?,” the policy analysis team collected data from four of Canada’s 10 provincial and 3 territorial jurisdictions. Alberta, British Columbia, Nova Scotia, and Ontario represent variation in jurisdictional demographics, LTRC funding models, political

systems, and approaches to regulating LTRC. Public and government repositories in each jurisdiction were searched to identify regulatory policy documents related to residential long-term and end-of-life care, which were operational as of July 2017.¹ The initial search resulted in 350 policy documents. After consulting SALTY’s policy stakeholders to ensure our search was comprehensive, this policy library was refined so that each document pertained to LTRC residents at least 65 years of age who currently live in LTRC; was endorsed or authored by government and regulatory or strategic in nature (versus descriptive or background documents); and was specific to facility care or be inclusive of facility care (non-LTRC specific policy). These stakeholders also suggested we anchor our analysis in regulatory policy with mandatory compliance (to ensure their impact on all LTRC facilities) resulting in 98 documents. These regulations were scanned for keywords related to anyone employed by the LTRC facility to provide care and support. We used the keywords “staff,” “employee,” “service provider,” “care aid,” “physician,” “doctor,” “nurse,” and “worker” in our search, further narrowing our data pool to 63 documents. Figure 1 shows how the data pool was refined and organized according to a content analysis (Schreier, 2014) approach where qualitative data are systematically organized and reduced for further analysis. Inclusion/exclusion criteria, data categorization, coding, and interpretation were discussed and refined regularly at research team meetings, which included team leaders, postdoctoral fellows, research assistants, and research coordinators who were involved in various aspects data analysis.

Policy text that included the keywords described above were excerpted and inserted into an Excel spreadsheet to be interpreted and coded according to Rosalie Kane’s (2001) 11 QoL domains.

We used a modified version of Mann and Schweiger’s (2009) objective hermeneutics method to interpret and code policies according to Kane’s (2001) 11 QoL

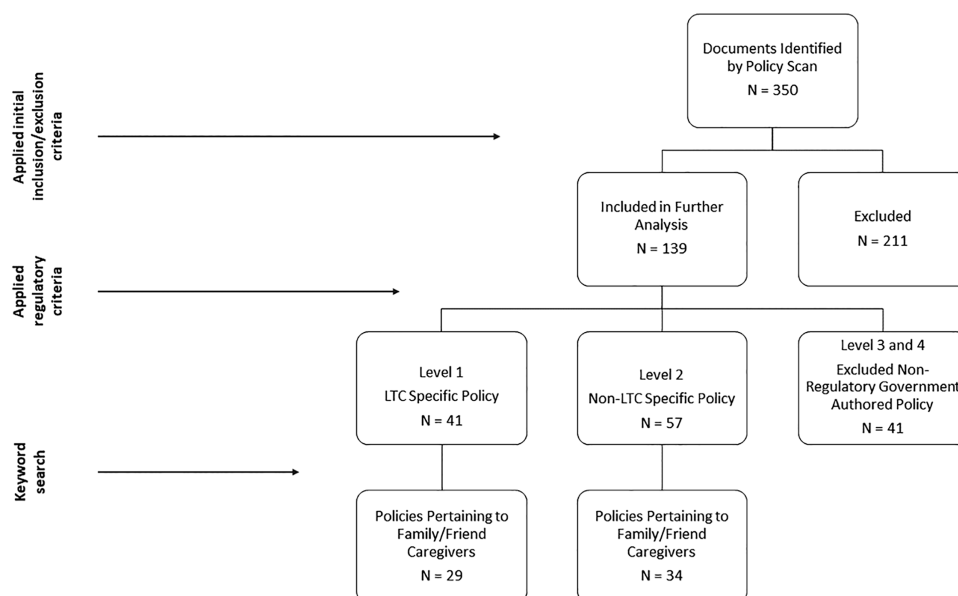


Figure 1. Selection process for long-term residential care staff-related policy documents.

domain definitions (see Table 1). While some hermeneutics approaches to policy analysis involve interpreting the intent and possible outcomes of policy, Mann and Schweiger (2009) explain that the objective hermeneutics method focuses only on what can be interpreted from text itself. Because we wanted to understand how policy might be interpreted across all LTRC facilities, rather than in specific settings, we modified this approach further to determine only which QoL domains are *explicitly* reflected in policy texts. For example, if the policy excerpt did not explicitly refer to resident dignity as defined by Kane (2001) (even if implications could be inferred), it was not coded as relevant to the “Dignity” QoL domain. This method was independently repeated by at least two researchers and then compared to ensure consensus on the direct link (interpretation) between the excerpt and (a) particular QoL domain(s). Table 2 presents examples of these policy text excerpts and how each QoL domain was applied to the text.

Once coding was complete, general themes and patterns, such as how Kane’s 11 domains were represented within and across jurisdictions and how staff roles were framed vis-à-vis QoL domains, were discussed at team meetings. To verify and contextualize our analysis, we conducted five key informant interviews with a total of six senior policy administrators representing health ministries or health authorities in each of the four jurisdictions we investigated. These interviews helped us understand jurisdictional differences and policy makers’ varying understandings of QoL when drafting policy. We also provided key informants with summaries of our early findings to help guide future policy development. For more detail on these policy analysis methods, see Taylor and Keefe (submitted).

Results

Unsurprisingly, considering our literature review, the QoL domain “safety/security/order” significantly dominated the policy landscape in all four jurisdictions under investigation.

The bar graph reflected in Figure 2 depicts the emphasis on safety/security/order compared to the other QoL domains.

Of the 63 documents, about half (30) reflected almost an exclusive emphasis on “safety/security/order” when it came to referencing staff—although “physical comfort,” “functional competence,” and “relationships” were also reflected occasionally in six documents. The majority of these policy texts were preoccupied with providing safe care, often through stipulating adequate staffing levels and appropriate staff training and hiring practices, and in outlining specific staff activity restrictions such as administering medication or treatments without a prescription (Government of Alberta, 1985), assisting with personal items that are not in everyday use, or disease control restrictions (British Columbia Ministry of Health, 2016).

While the QoL domain “safety/security/order” was by far the most commonly coded domain in the staff-related policy texts, we found policy excerpts that reflected all 11 Kane’s (2001) domains in our policy pool. However, not all domains were reflected in each jurisdiction: only “safety/security/order,” “physical comfort,” “meaningful activity,” and “enjoyment” were reflected throughout all four jurisdictions. This suggests that even as staff are integral to enhancing all resident QoL domains, each jurisdiction must improve how it outlines and supports the broad range of roles staff might play.

Figure 2 also shows that the QoL domains reflected in all four jurisdictions are not necessarily the domains with the most regulatory support. Next to “safety/security/order,” the next most coded domains were “relationships,” “physical comfort,” and “functional competence.” This is unsurprising, as many policies emphasizing “safety/security/order” did so by providing guidance on the kinds of relationships staff should have with residents, family, and volunteers in order to maintain safety. For example, many policies require staff to maintain clear communication and collaboration with residents and their families, or that all levels of staff receive training on key safety protocols

Table 1. Kane (2001)’s Quality of Life Domains

Domain	Description
Autonomy/choice	Residents are enabled to have some direction and choice over their respective lives
Dignity	Residents sense that their unique humanity is respected
Food/enjoyment	Residents’ enjoyment is supported through programming and physical settings, including appropriate dining experiences
Functional competence	Residents are as independent as possible, depending on impairments
Individuality	Residents can express identity, receive individualized care, and have a desired continuity with the past
Meaningful activity	Residents’ activities reflect and accord to their personal preferences
Relationships	Residents’ relationships with anyone living, visiting, or working in the LTRC facility reflect a sense of reciprocity
Physical comfort	Residents are free from physical pain and discomfort due to symptoms or environment
Privacy	Residents have some control over when they are alone and what information is shared about themselves
Safety/security/order	Residents’ trust that their living environment is benevolent and organized by ordinary ground rules
Spiritual well-being	Residents have access to spiritual supports and activities which include, but are not limited to, religion

Note: LTRC = long-term residential care.

Table 2. *Examples of Domain-Coded Policy Text Excerpts*

Kane Domain	Text Excerpt	Reference
Autonomy/ Choice	Respects residents' right to independence and to be at risk by: <ul style="list-style-type: none"> - identifying and discussing with families potential and actual risks to the resident; - exploring options for minimizing the risk; - supporting residents' optimum level of functioning; and, - adapting the environment to promote their safety and the safety of staff. 	BC Model Standard for Continuing Care and Extended Care Services 1999
Dignity	The licensee shall ensure: <ol style="list-style-type: none"> 1. A privacy and confidentiality policy and procedures, that reflect the Long Term Care Principles and align with legislation, are developed and implemented. 2. Residents are treated with respect and dignity at all times, including during: <ol style="list-style-type: none"> a) personal care activities; b) consultation with and examination by professional staff; c) intimacy; and d) social contacts with families and friends. 3. Residents' privacy is protected to the extent possible. 4. There is a statement of values posted in common areas and residents are provided with a copy upon admission to the home. 5. Residents receive services that support inclusiveness and respect both diversity and cultural differences. 6. Staff members receive information regarding the home's values, respect, dignity and protection of privacy upon hire and as part of their ongoing professional development. 7. Residents have their own clothing, which are appropriate, correct in size, clean and neat, in good repair and suitable for the climate. 8. Staff members address residents using residents' preferred names. 9. Residents, or their authorized designates, receive mail unopened. 	NS Long Term Care Facility Program Requirements 2016
Food/ Enjoyment	15(1) In respect of meals for residents, an operator shall prepare all meals to meet basic diet requirements in accordance with Canada's Food Guide as approved by the Canadian Council on Nutrition. <ol style="list-style-type: none"> (2) At least 3 meals per day shall be served to each resident with not more than a 15-hour period between the last substantial meal of a day and breakfast on the following day. (3) Nourishment in addition to meals shall be made available to residents at all times. (4) An operator shall prepare a cyclic menu which shall be <ol style="list-style-type: none"> (a) established for meals for each resident day during at least a 3-week period, and (b) approved by a registered dietitian. (5) Menus for meals for each day shall be posted in 1 or more public places in the nursing Home before the first meal of a resident day. (6) Records of menus and changes to menus shall be retained by the operator for at least 3 months after the day of use and shall be available for inspection by the Minister. (7) A resident shall be provided meals in accordance with special dietary requirements. (8) Therapeutic diets for a resident shall be ordered in writing by a physician and be recorded in the resident's resident record. 	AB Nursing Homes Act Operation Regulation 258 1985
Functional Competence	Every licensee of a long-term care Home shall ensure that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion.	ON Long Term Care Homes Act Regulation 410 16

Individuality	Physiotherapy Funding can only be used for physiotherapy provided on a one-on-one basis to any resident: (a) who is assessed as requiring physiotherapy; (b) whose plan of care sets out the physiotherapy services to be provided to the resident; and (c) whose plan of care sets out the therapeutic goals that these physiotherapy services are intended to achieve and includes directions to staff and others relating to these services (s. 6 of the LTCHA), including frequency, intensity and duration of services required to achieve predetermined milestones or goals of care.	ON Long Term Care Home Financial Policy Physiotherapy Funding 2016
Meaningful Activity	(4) Notwithstanding section 12(2), an operator shall designate at least 1 member of the nursing Home staff to provide life enrichment services to residents of the nursing Home in addition to other duties and responsibilities assigned to the member.	AB Nursing Homes Act Operation Regulation 258 1985
Physical Comfort	(b) employees do not smoke or use tobacco, use an e-cigarette or hold an activated e-cigarette while supervising persons in care	BC Community Care and Assisted Living Act Residential Care Regulation 96 2009
Privacy	Residents, staff and families must not travel through one Resident House to access another Resident House	NS Long Term Care Facility Requirements Space and Design 2007
Relationships	During residents' admission and orientation, the interdisciplinary team: 2.1 welcomes residents/caregivers, familiarizes them with their surroundings, and introduces them to residents and staff	BC Model Standard for Continuing Care and Extended Care Services 1999
Safety/ Security/ Order	18(5) An operator shall ensure that all employees and, where appropriate, residents, service providers and volunteers receive adequate training respecting any security, communication or emergency call system in use in the long-term care accommodation. Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers.	AB Accommodation Standards and Licensing Information Guide 2015 ON Long Term Care Homes Act LTCHA 2007
Spiritual Well-Being	1. Providing adequate storage for chairs and table reduces the staff effort needed to rearrange heavy furniture or stack unused chairs. 2. Consider designing and decorating spiritual practice space in a flexible and non-denominational manner. 3. The multi-purpose space can also be utilized by the community which may promote a stronger relationship.	NS Long Term Care Facility Requirements Space and Design 2007

and are clear on the distinct roles and responsibilities of various staff members, family, and residents during emergency situations. “Physical comfort” was often reflected in language mandating regular repositioning, comfortable bathing routines, and home-like design features. “Functional competence” was coded in policy excerpts that prescribed access to suitable mobility devices and technology. While staff might play an active role in assisting with these activities, some policy documents placed restrictions on staff to achieve these QoL domains. For example, in British Columbia’s *Community Care and Assisted Living Act Residential Care Regulation* (2009), staff are instructed not to provide meals through ongoing tray services simply because it is convenient for staff—suggesting that what is convenient for staff might undermine the comfort of residents.

The remaining seven QoL domains are scarcely noted in the regulations we examined. Fewer than half (23) of the policies reflected a recognition that staff play a role in maintaining or enhancing the “individuality,” “privacy,” and “autonomy/choice” of residents, and only two of those

documents (Nova Scotia’s 2007 *Long Term Care Facility Requirements Space and Design* and 2016 *Long Term Care Program Requirements*) reflected all three of these domains. The QoL domains “spiritual well-being” and “dignity” were the least supported domains (reflected in only seven documents). What is written about staff’s respective roles in enhancing these domains reflects efforts to ensure that staff assist residents with activities of daily living (British Columbia Ministry of Health, 2009), like dining experience (Nova Scotia Department of Health, 2007), to maintain resident dignity and ensure that residents have access to places to worship (Ministry of Health and Long-Term Care, 2015) as well as end-of-life spiritual care (Government of Canada, 2012; Nova Scotia Health and Wellness, 2016).

Many coded text excerpts, particularly Ontario’s and Nova Scotia’s design regulations, reflected several QoL domains. For example, detailed resident bedroom requirements in both jurisdictions’ design regulations takes into account detailed features intended not only to meet basic safe care criteria, but also to “meet each resident’s need for comfort and safety, promote resident

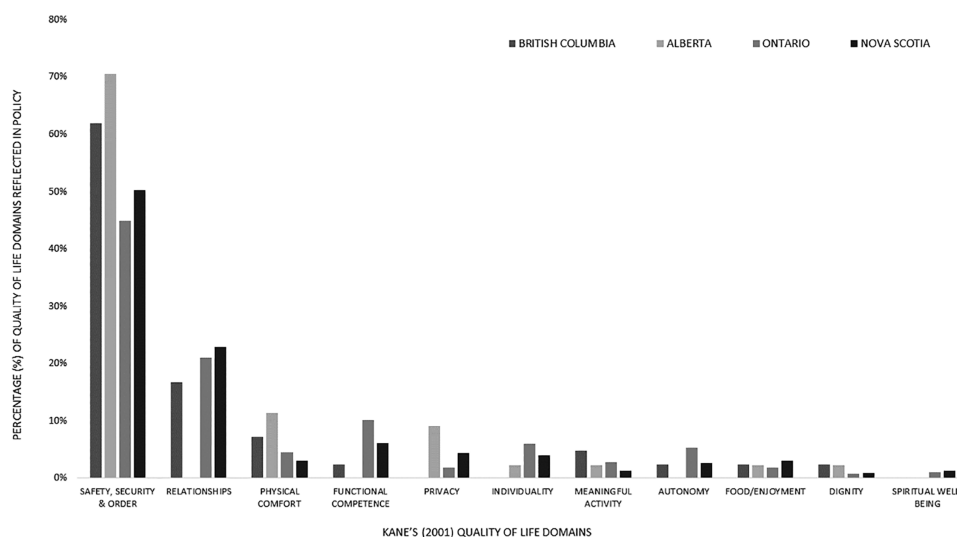


Figure 2. Ranked % of each quality of life domain by jurisdiction.

independence and dignity, and provide for resident privacy” (Ministry of Health and Long-Term Care, 2015, section 2.1; Nova Scotia Department of Health, 2007, n.p.). This particular policy around resident bedroom design seemed to address all QoL domains except “spiritual well-being,” “autonomy/choice,” and “meaningful activity.” Nevertheless, the number of QoL domains coded in each policy text excerpt did not necessarily indicate if they might adequately support staff in enhancing resident QoL. We noted that even in regulations clearly prioritizing a well-rounded resident QoL, staff and their roles were sometimes mentioned only briefly, or were restricted or unclear. For example, in Nova Scotia’s detailed resident bedroom design regulations, the only reference to staff notes that “Each bedroom must be designed to... supports [*sic*] staff in the safe delivery of quality resident care” (Nova Scotia Department of Health, 2007, Spatial Requirements section). In this example, staff are restricted to their usual task of providing safe care, while the other QoL domains are largely reflected in the physical design.

Conversely, we found texts where only one or two codes applied that, nonetheless, provide clear support for staff discretion in actively enhancing resident QoL. For example, both Alberta and British Columbia have policies mandating the designation of at least one LTRC staff member whose responsibilities include planning activities that might enhance QoL for residents through “life enrichment activities” (Government of Alberta, 1985, section 14-4) or “physical, social and recreational activities” (British Columbia Ministry of Health, 2009, p. 45). These policies were coded as directly enhancing “relationships” and “meaningful activity,” although the discretion these policies afford to staff suggests an active role with the potential to enhance other domains.

We found 20 excerpts across nine regulatory policy documents with clear guidance in supporting staff flexibility in order to enhance resident QoL effectively. These

texts prompted staff to use “innovative” or “alternative” care models so that they might take a “resident-centered approach” or employ discretion in prioritizing and appropriately responding to resident preferences and their desires for enjoyment, meaningful activity, or fulfilling relationships. The policy texts in Alberta and British Columbia take a similar approach in designating at least one staff person per facility to plan activities intended to enhance resident QoL. Alberta supports this role by ensuring that staff are adequately trained for this work (Government of Alberta, 2015), while British Columbia focuses on ensuring that staff have sufficient time to complete such tasks (British Columbia Ministry of Health, 2009) and that they “identify [...] communication channels and encourage [...] collaborative relationships between staff, families and volunteers” (British Columbia Ministry of Health, 2016, CH 6-SH-PG1).

The relatively newer Ontario and Nova Scotia documents go further to mandate an active role for all direct care staff—not just one or two designated persons—to use discretion to enhance resident QoL. Nova Scotia’s *Long Term Care Program Requirements* even outlines a “resident-centered” approach to staff activities, such as ensuring that “Staff members work with the residents and/or authorized designates as a team to determine what works best for the residents” and enabling “staff to consistently work with the same residents, when in the residents’ best interests” (Nova Scotia Health and Wellness, 2016, section 6.4). Similarly, Ontario’s *Long Term Care Home Design Manual* provides specific language supporting staff flexibility for services providers:

The Design Manual continues to promote innovative design in long-term care homes in Ontario, by giving service providers flexibility to create environments that make it possible to respond positively and appropriately to the diverse physical, psychological, social and

cultural needs of all long-term care home residents. (Ministry of Health and Long-Term Care, 2015, Background section)

While the documents that support staff flexibility may seem few (13% of our entire policy pool), there are at least two such regulatory documents in each jurisdiction in our data sample, with growing nuance and attention in the most recent policies. This demonstrates promising language in each jurisdiction that can be leveraged to support staff in enhancing resident QoL.

Discussion and Implications

Our academic literature review highlights that LTRC policy context is characterized by risk aversion, safety, and security, which is important in facilities where vulnerable people live. However, policies are often rigidly prescriptive in ways that can be enormously taxing for staff while also undermining overall resident QoL. Moreover, these regulations have largely thwarted the QoL culture change that Kane outlined in 2001; thus, significant change is necessary. However, when we take an asset-based, detailed analysis of the existing policy landscape, it is clear that we do not need to start anew. Promising policy frameworks *are* in place already, characterized by interpretive (rather than prescriptive) language that outlines clear, flexible roles for staff to attend to resident preferences and overall QoL. We argue that when interpreted with a resident-centered QoL lens, these promising policies can be leveraged to counteract the overemphasis on safety/security/order and effectively enhance resident QoL.

For our purposes, interpreting how policy might guide staff in enhancing resident QoL was not limited to tallying the number of QoL domains in each staff-related policy excerpt. Despite finding regulations that addressed each of the 11 QoL domains, our analysis revealed the roles outlined for staff in LTRC policy are often vague, minor, or restricted when it comes to enhancing the domains reflected in the text; thus, much of the policy we analyzed does not necessarily provide clear guidance for staff to improve resident QoL. Policies that can be interpreted to support staff flexibility and discretion have the potential to address shifting QoL preferences depending on tasks and situations and mitigate the rigidity and highly specified focus of the “safety/security/order” policies. This complements Garcia and colleagues’ (2012) finding of tension between physical versus social environment approaches. They found that staff and family prioritized an optimal social environment, characterized by staff flexibility, over an optimal physical environment with promising design features.

Flexibility, as reflected in the policy texts we analyzed, refers to staff being able to use their discretion, pivot their activities around resident preferences, or dedicate part of their time to facilitating specific activities intended to enhance QoL on the resident’s terms, rather than focusing

solely on biomedically oriented care tasks or following strict protocols oriented towards “safety/security/order.” Such policy language outlining flexible roles for staff is typically interpretive (rather than prescriptive) allowing staff to make situation-specific choices about attending to and balancing all QoL domains, including safety/security/order, and not just those explicitly referenced in the policy text.

As our analysis focused almost entirely on written policy, and not its development, interpretation, or implementation, we drew on our key informant interviews with policy makers to help contextualize policy development within a broader policy landscape. Key informants explained that the dominance of safety, security, and order can overshadow the promising texts we highlight above, leaving the rules therein to be ignored, poorly understood, or “unused.” Several policy makers suggested that “safety/security/order” is easier to legislate, rather than QoL domains such as “dignity,” which is much more subjective. Nevertheless, pervasive ageist and ableist assumptions about LTRC residents, which have come to the fore during the coronavirus disease 2019 (COVID-19) pandemic (see Miller, 2020; Vervaecke & Meisner, 2020), are likely important factors influencing the relatively scant attention to domains such as “autonomy/choice” in LTRC policy. We might also consider how prescriptive regulation may not be the most effective tool for enhancing subjective or interpretive domains such as dignity or spiritual well-being. This supports Carr and Biggs’ (2018) study that outlined a continuum of regulation for LTRC activities in Australia. They suggest that flexibility and innovation are supported by shifting gradations of policy interpretation by both frontline workers and managers depending on task, risk level, and the resident domain to which it attends. For example, low-risk daily interactions need less regulation and, in such cases, flexible interpretation of policy should be encouraged.

We also note that staff need cultural and structural support to respond to more subjectively interpreted domains potentially based on individualized preferences and relations with LTRC residents. Increased public education around the importance of these interpretive policies and broader understandings of QoL for improving LTRC are likely necessary for galvanizing staff (particularly managers) to leverage this existing legislation. We recognize that policy interpretation and implementation depend on many factors, including management style, popular opinion, workplace culture, and politico-economic structures. Previous research indicates that LTRC managers, in particular, can play pivotal roles in determining how policies are interpreted and which rules are used and emphasized, varying the degree to which promising policy can be implemented in LTRC (Armstrong et al., 2009; Carr & Biggs, 2018; Cloutier et al., 2016). This suggests that, with the right supports, the promising policies we highlight here can be immediately influential and effective.

We found a tendency for newer documents—particularly the design regulations in Nova Scotia and Ontario—to reflect more QoL domains and stronger,

interpretive language supporting staff flexibility and a “resident-centered approach” to enhancing resident QoL. Our key informant interviews also helped contextualize this trend by explaining that QoL conceptions have become more broad, sophisticated, and influential over the last 20 years. For example, many of Alberta’s older regulations were written and enacted well before Kane published her 2001 seminal paper on QoL domains. In this jurisdiction, staff roles were particularly vague when it came to enhancing QoL domains outside of “safety/security/order,” and several domains (“autonomy/choice,” “dignity,” “functional competence,” and “relationships”) are completely absent. More diverse QoL domains are, however, filtering into the legislation.

Nevertheless, this trend was inconsistent both within and across jurisdictions; for example, even Alberta’s 1985 regulations contain some promising language. Our interview with Alberta policy makers also indicated that other influential, nonregulatory provincial LTRC policy texts in their jurisdiction provide guidance that reflects a broader commitment to resident QoL for staff.² The importance of these promising policies should not be underestimated. However, without regulatory compliance, it is easier for these rules to go unused and the language is harder to leverage in the fiscally constrained, risk-averse LTRC context. Given Canada’s decentralized, jurisdiction-led approach to LTRC regulation, we note that inconsistencies and tensions across jurisdictions are almost inevitable. We suggest that federal regulatory standards reflecting some of the promising policies discussed here would add regulatory clarity and leverage to support staff in enhancing QoL.³

Finally, the literature we reviewed strongly suggests that current Canadian funding levels do not adequately support staff to exercise the flexibility recognized in these promising policies. Thus, staff may remain stuck between a rock and a hard place when deciding which policies to follow and which activities to abandon because of time, funding, and staffing constraints. We suggest that these promising policies be leveraged to underscore the resident benefits of properly remunerated and supported staff, highlight the importance of staff flexibility in enhancing resident QoL, and help expand concepts of QoL that can help de-emphasize safety/security/order in the existing policy landscape.

Limitations

This paper does not present a comprehensive analysis of staff-related LTRC policy in Canada. We have focused only on what is *written* in jurisdiction-specific regulations as they pertain to resident QoL and staff. We do not include regulations that are silent on resident QoL, or nonregulatory LTRC policies at national, regional, or facility levels that may, nevertheless, be influential. Further, by focusing only on what is written, we were not able to explore relationships between policy and practice. Thus, the

complex relationship between LTRC policies, staff activities, and resident QoL in Canada requires further analysis in future research.

Conclusion

Many LTRC policy analyses focus on what policy is missing, or the problems with existing policy. When it comes to LTRC staff, we recognize the policy landscape is saturated with regulations that are often rigid and in tension with other policies. Our asset-based analysis, however, focuses on what *is* there—what is promising that *can be used now* to enhance resident QoL, and what can be leveraged for further policy change. By examining 63 regulatory documents across four Canadian jurisdictions, we were able to develop an expansive view of how staff are reflected in the Canadian LTRC policy landscape. Our use of Kane’s 11 QoL domains for hermeneutically interpreting how resident QoL is supported in existing policy gives us a nuanced analysis of those domains best represented and supported in the existing staff regulation and where more work needs to be done. We found that the policy language that outlines relatively active roles for staff vis-à-vis resident QoL tends to be interpretive and support staff flexibility. Importantly, we found policy language in each jurisdiction that supports staff flexibility to enhance resident QoL, indicating that while the existing LTRC policy landscape often places staff between a rock and a hard place, there are other rules staff can use to support flexibility and counter staff constraints and the overemphasis on safety, security, and order.

Author Notes

¹However, SALT’s policy stakeholders suggested that we add two additional documents, which came into effect after July 2017, because of these documents’ considerable influence in the LTRC sector.

²Alberta is unique in that LTRC facilities must meet national Accreditation Standards to be licensed. Because of this, our Alberta key informants noted, their LTRC legislation was sometimes less comprehensive than other jurisdictions and nonregulatory policy documents (such the [Accreditation Canada’s \(2016\) Residential Homes for Seniors](#)) sometimes carried similar weight in terms of their licensing requirements.

³Indeed, such federal regulatory standards have been proposed recently by the Royal Society of Canada’s Working Group on LTC in response to COVID-19’s devastating impact on Canada’s LTC sector ([Estabrooks et al., 2020](#)).

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Conflict of Interest

None declared.

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