Dementia Care at the Intersection of Regulation and Reflexivity: A Critical Realist Perspective

Pia C. Kontos, PhD,
Research Scientist, Toronto Rehabilitation Institute, Assistant Professor, Dalla Lana School of Public Health, University of Toronto

Karen-Lee Miller, MA, MSW,
PhD Candidate, Public Health Agency of Canada

Gail J. Mitchell, PhD, and
Associate Professor, School of Nursing, York University

Cheryl A. Cott, PhD
Professor, Department of Physical Therapy, University of Toronto, Toronto Rehabilitation Institute

Abstract

Objectives—To understand point-of-care decisions, and in particular rule-breaking, by personal support workers (PSWs) regarding institutionalized elders with dementia within a context of legislative and organizational care mandates.

Methods—Qualitative baseline data including focus groups and semi-structured interviews with PSWs (n=26) and supervisors (n=9) were collected during a 2-year, multi-method trial of a 12-week interprofessional arts-informed educational intervention in two Alzheimer support units, and were analyzed using a critical realist approach.

Results—PSW care decisions were the outcome of a discordant interrelationship between PSWs' reflective deliberations, and legislative and organizational care mandates. PSWs responded to discordance through rule-breaking in order to provide individualized care. Unbeknownst to PSWs, rule-breaking was contingent upon supervisors' case-by-case complicity as they strove to balance fears of regulatory citations with private assessment of the soundness of PSW logic.

Discussion—Quality care emerges at the intersection of policies governing long-term care, PSW rule-breaking, and the supportive but undisclosed role supervisors play in these violations. Understanding this complexity has important implications for initiatives to improve care practices, and to challenge legislation and policies that impede dementia care.

Introduction

Patient care is a complex social phenomenon influenced by macro-level factors such as legislative and organizational care mandates and micro-level interactions between professional care providers and patients. Yet studies of dementia care have, for the most part,

Correspondence to: Pia C. Kontos.

focused on micro level issues including: the experience of living with dementia (Beard, 2004; Clare, Rowlands, Bruce, Surr, & Downs, 2008; Reed-Danahay, 2001); discourses on selfhood (Golander & Raz, 1996; Kitwood, 1997; Ryvicker, 2009; Small, Geldart, Gutman, & Scott, 1998; Surr, 2006); care providers (Anderson et al., 2005; Berdes & Eckert, 2007; Parke, 1998; Wright, Varholak, & Costello, 2003); communication techniques (Byrne & Orange, 2005; Killick & Allan, 2001; Small, Gutman, Makela, & Hillhouse, 2003); and those characteristics of practice settings and caregiving relationships that may foster infantilization, stigmatization, and depersonalization (Kitwood, 1997; Marshall, 2001), or person-centredness and quality care (Kitwood, 1997; Kontos & Naglie, 2009; Vittoria, 1998). While there are some studies that explore the experience of care providers within the political economy of long-term care (Armstrong & Daly, 2004; Diamond, 1992; McLean, 2007) they do not address the interrelationship between practitioners and social structures. Consequently, *how* agency and structure are intertwined, *why* the relationship between the two assumes the form it does, and in *what ways* the relationship between them serves to enable and/or constrain dementia care is poorly theorized and understood.

With an interest in redressing the inattention to the structure/agency interplay in long-term care we explored the experiences of PSWs, who provide the majority of direct care in nursing homes (Ontario Ministry of Health and Long-Term Care, 2001), and supervisors on Alzheimer support units in two long-term care facilities located in central Ontario, Canada. Our purpose was to better understand point-of-care decisions, and in particular the factors that enable and constrain quality care. The paper is organized as follows: we begin with a brief review of pertinent literature on PSWs; an overview of the regulatory environment of long-term care; and the foundational precepts of critical realism. Next, we organize findings around the key critical realist concepts of *emergent properties* and *internal conversation* (Archer, 1995, 2000, 2003). Our findings underscore how quality care emerges at the intersection of policies governing long-term care, PSW rule-breaking, and the supportive but undisclosed role supervisors play in these violations. Understanding this complexity has important implications for initiatives to improve care practices, and to challenge the legislation and policies that impede dementia care.

Background

Personal support workers (PSWs)

PSW is the umbrella designation for unlicensed personnel variously known as health care aides, personal attendants, certified nursing assistants, and health care assistants (Health Professions Regulatory Advisory Council, 2006; National Health Service). Characterized as un- 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 limited, ranging from 75–175 hours across the US (Department of Health and Human Resources, 2002) to two post-secondary semesters in Ontario (Ontario Ministry of Training Colleges and Universities), the largest province of Canada. PSWs lack independent clinical authority to "initiate any action with respect to a patient" (Health Professions Regulatory Advisory Council, 2006, p. 10), and are restricted to supporting the treatment decisions of regulated health professionals.

Despite their low status in the healthcare hierarchy (Anderson et al., 2005; Beck, Doan, & Cody, 2002), PSWs provide 75–80% of all direct care in nursing homes (Ontario Ministry of Health and Long-Term Care, 2001). They are the staff most likely to observe, interpret, and respond to care situations on a day-to-day basis, often in the absence of direct medical, nursing, or social work intervention or guidance (Anderson et al., 2005). This direct care burden and the absence of bedside supervision by regulated professions have led, in many instances, to an increase in occupational influence. Several studies have noted PSWs may alter or fail to follow prescribed care practices (Anderson et al., 2005; Janes, Sidani, Cott, & Rappolt, 2008; Lopez, 2007), exceed organizational mandates (Angus, Kontos, Dyck, McKeever, & Poland, 2005; Aronson & Neysmith, 1996a, 1996b; de la Cuesta, 1993) or sway the care practices of licensed professionals through informal corridor consultations (Anderson et al., 2005). These practices underscore how the reflexive and clinical deliberations of PSWs influence patient care (Berdes & Eckert, 2007; Black & Rubinstein, 2004; Kontos & Naglie, 2009; Parke, 1998; Wright et al., 2003).

The regulatory landscape of care: Standardization and regulation

All long-term-care providers in the US are governed by their respective state regulations (Miller & Mor, 2008). In Canada, long-term care homes are governed by provincial legislation which standardizes care and accountability, and requires they operationalize codes of conduct through institution-specific policies and practices. For example, in Ontario, long-term care homes are expected to satisfy as many as 400 rules ranging from hygiene practice to the preservation of individualism (Ontario Ministry of Health and Long-Term Care, 2006). Inspectors conduct on-site reviews to examine the physical environment, care policies, and interactions between residents and staff (Ontario Ministry of Health and Long-Term Care, 2007). Where provincial legislation provides unequivocal directives (e.g. denture labeling), determining institutional compliance is straightforward. However, where the legislation bespeaks more of fundamental principles such as the recognition of dignity (Ontario Ministry of Health and Long-Term Care, 2006, p. 2), compliance becomes highly subjective. As Miller and Mor (2008) have argued, the federal guidelines used by long-term care inspectors in the US are open to wide interpretation and often lead to inconsistent enforcement. As in the US, in Ontario consequences of citation may be severe, ranging from temporary suspension of patient admissions to the revocation of the license to operate (Ontario Ministry of Health and Long-Term Care, 2002).

Theoretical framework: Critical realism

Understanding the relationship between human agency (the capacity of an individual to act independently and to exercise choice) and structure (patterned arrangements in society such as norms and institutions) is a central debate of social theory (Archer, 2003) characterized by dichotomies - human agency versus social structure; voluntarism versus determinism; meaning versus structure; micro versus macro. Critical realism, associated most closely with the foundational work of Roy Bhaskar (1975), offers a promising way to redress the polarizing perspectives that the debate has generated. Critical realism views structure and agency as "distinct strata of reality, as the bearers of quite different properties and powers" (Archer, 2003, p. 2) with causal mechanisms linking the two. The concern is with how

structural powers impinge upon agents, and how agents use their personal powers to reinforce, challenge, or transform structural impingements (Archer, 2003).

A key issue in critical realism is understanding causality which is conceptualized in terms of emergent properties that may be structural or agential. They are emergent in that properties may or may not result in particular outcomes, as this is dependent upon the right conditions (Pawson & Tilley, 1997). For example, structural emergent properties do not possess an intrinsic capacity for constraint or enablement. A structural emergent property is dependent on material resources that exert only conditional influence upon agency; it cannot determine agency because "agency itself is the bearer of emergent powers" (Archer, 1995, p. 184) including the power to transform social structure (Archer, 2003). Agential power is exercised through individual reflexive interior dialogue or *internal conversation* through which agents clarify beliefs, deliberate concerns, and construct schemes for future action (Archer, 2003). Internal conversations constitute the mediatory process between structure and agency; the tactics devised by individuals to deal with structural emergent properties are as significant as the structures that exist.

Critical realism, with its commitment to elucidating both the structures which constrain and enable activities, and how individual actions reinforce, challenge or transform structural impingements, offers a promising way to remedy the tendency in dementia studies to either strip agency of structure, or structure of agency. Decoupling structure and agency facilitates understanding of the impingements of structural properties upon human activity (i.e. "constraints" and "enablements") but also how the effects produced through human agency may alternatively serve to transform or perpetuate social structures (Archer, 2003).

Critical realism has been effectively applied to the study of treatment delays in breast cancer (Angus, Miller, Pulfer, & McKeever, 2006), racism between nurses and doctors (Porter, 1993), evidence-based medicine (Clegg, 2005) and implementation science (Clegg, 2005; Kontos & Poland, 2009; Pawson & Tilley, 1997). This study is the first to use a critical realist framework to examine long-term dementia care.

Methods

Qualitative methodology is particularly suited to critical realism given its ability to elicit rich explanation of complex phenomena (Given, 2008). Qualitative data (focus groups and in-depth interviews) were collected during a 2-year (2007–2009), multi-method trial of a 12-week interprofessional arts-informed educational intervention. The intervention, offered 2 hours per week, was designed to improve long-term care by sensitizing PSWs, nurses, and allied health practitioners to a new philosophy of person-centred care (Mitchell & Bournes, 1998) that emphasizes the importance of recognizing and supporting embodied self-expressions by persons living with dementia (Kontos, 2004, 2005, 2006). The arts-based components of the intervention included a DVD presentation of professional actors portraying interactions between practitioners and residents in dementia care, and pre-scripted role plays that were enacted by the practitioners. All arts-based components were based on practitioner-resident interactions observed in qualitative studies (Kontos, 2004, 2006). For the purpose of this paper, our analysis was restricted to qualitative baseline data

drawn from the interviews and focus groups with PSWs and the supervisors who oversee PSW care.

The setting

Focus groups and semi-structured interviews were conducted in similarly-sized Alzheimer support units of two facilities in southern Ontario (Facility A, 32-bed; Facility B, 40-bed). Both facilities are for-profit, with significant similarities in therapeutic and recreational programs, and the interprofessional mix of health care practitioners.

Participants

University-based ethics approval was obtained for each study site. The primary sampling strategy was non-random convenience. Informed consent was obtained following study introductions from PSWs (Facility A, n=13; Facility B, n=13) and supervisors (Facility A, n=6; Facility B, n=3). See Table 1 for demographic details of PSW participants. All full- and part-time supervisors of each facility were eligible to participate in focus groups and interviews. All full- and part-time PSWs of each facility were eligible for focus groups. Theoretical sampling (Denzin & Lincoln, 2000) was used to secondarily select a subgroup of PSWs of each facility for interview.

Focus groups and interviews

Focus groups for PSWs (n=4) and supervisors (n=2) 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 of the audiotaped focus groups consisted of 3–6 participants and lasted approximately 60 minutes. An open-ended focus group discussion guide was used by the moderator to explore the factors that constrain and enable PSW care. In each focus group with PSWs, participants were invited to reflect on a recent situation when things went well during a caregiving interaction and also when things did not go as well as they would have liked, and in both instances to describe what and/or who influenced their actions. Supervisors were asked about their perceptions of PSW care; the barriers and facilitators to achieving quality care; and their role in helping PSWs to achieve it. In each site, the PI moderated 2 focus groups with PSWs (Facility A, n=6, n=3; Facility B, n=5, n=5), and 1 with supervisors (Facility A, n=6; Facility B, n=3).

Subsequently, audiotaped semi-structured interviews lasting approximately 60 minutes were conducted to probe in further depth issues raised by the focus groups. In each interview PSWs were asked to provide examples from their practice to illustrate what helps them to achieve quality care, and what constrains their ability to do so. Supervisors were asked about their understanding of quality care, their perception of how consistent or inconsistent the care provided on the study units is with what they understand to be quality care, and the factors that influence the nature of care provided on the units. Two research assistants (RAs) conducted these interviews with PSWs (Facility A, n=4; Facility B, n=3) and supervisors (Facility A=4; Facility B=3).

Analysis

Verbatim transcripts were produced by the RAs for all focus groups and interviews, and analyzed by the team using thematic analysis techniques (Denzin & Lincoln, 1998). Descriptive coding was first conducted wherein segments of text were assigned a code reflecting the original statement; this then served as the basis for category formation. Through an inductive, iterative process, categories with similar content were investigated for inter-relationships, and further refined into fewer analytical categories. During this process, researchers continually returned to the transcripts to clarify the context and meaning of coded text. Finally, analytical categories were examined to determine linkages between care practices and the key critical realist concepts of *structural emergent properties,* and *internal conversation*. The purpose was to illuminate the generative relationships that serve to constrain and enable PSW care. Themes identified were consistent across focus groups and interviews.

Findings

Findings are organized thematically. "Supervisory surveillance and the interpretation/ enforcement of legislation" identifies the structural emergent properties faced by PSWs including provincial policies and administrative regulations which enforce standardized practice. "The internal conversation and violation of rules" captures the ways in which PSWs experienced and processed discordance between care practices driven by personal versus structural emergent properties and their thoughtful deliberations over possible courses of practice and intended patient outcomes. Resistance, rule-breaking, and the individualizing of care resulted from PSWs' internal conversations. "Complicity of supervisors" highlights how rule-breaking involved the complicity of supervisors as they struggled to mediate between provincial regulations and best practice for dementia care. This highlights the contingent nature of structural impingements on the convergence of agential powers of PSWs and supervisors. The selection and placement of participants' statements is organized by the themes that are presented rather than by category of participant.

Supervisory surveillance and the interpretation/enforcement of legislation

Structural emergent properties include Ministry standards of care and practice guidelines that structure day-to-day organizational care delivery. These guidelines are enforced by supervisors through monitoring or surveillance to ensure compliance. Interviews and focus groups evidenced links between government regulations and institutional policies, supervisors' fear of citations, and surveillance of PSW care activities. In one example, a supervisor's fears of citations arising from food handling violations disallowed staff from personalizing care through flexible morning wake times:

> (W)hy can't the residents sleep until ten o'clock in the morning and then get up and have something to eat? Why do they have to all be up and in the dining room at 8 o'clock for breakfast?…(I)t's based on the fact that…an inspector might be walking through the door, and if they find leftovers in the fridge, they're going to, you know, leave you a violation!…So there's a lot of ways where we can't

personalize it as much as we want to because we're so regulated. [Facility B, Focus Group]

Another supervisor elaborates further why leftovers could be treated as a food handling violation:

The Ministry standard is that the food has to be a certain temperature when it's served to a resident. So if you keep the food, then you have to warm it up and everything has to be covered for infection control reasons…But the dietary staff have their own schedule…they're like on the rush rush rush. So if the resident wants the food at 9 o'clock, what the staff have to do is…warm it up before they serve it. It's just the system we're in. Certain things we cannot always initiate. [Facility B, Focus Group]

Supervisors' strategies to pre-empt violations included the use of unannounced unit visits and care observations to ensure PSW compliance with institutional policies:

(T)here are times that I will spend, sort of in the background, just observing someone give care… I try to do it at least once a month… I take my stuff and I'm up there and I'm sort of going, 'okay!'....I think [PSWs] need to know that you can pop in any time. [Facility A, Interview]

PSWs were aware of the purpose of unit surveillance. In the same facility, a focus group discussed the shared belief that supervisors only appeared on the unit "to see if you do something wrong, to chastise you".

Supervisors' efforts to pre-empt Ministry citations often required subjective interpretation of regulations since clear legislative directives were not always provided. For example, while the use of terms of endearment (a word or phrase used to address a person for which the speaker feels affection) for residents were not explicitly prohibited by provincial regulations, corporate policy of both facilities appeared to suggest that terms of endearment were infantilizing and thus contravened the "courtesy", "respect" and "abuse" clauses in the Resident's Bill of Rights legislation (Ontario Ministry of Health and Long-Term Care, 1998). Yet PSWs rejected this interpretation, arguing that practice should be in keeping with the preferences of residents:

PSW 1: [F]or terms of endearment we're not allowed to use them. [Supervisors] said it's a big no-no.

Moderator: Terms of endearment?

PSW 1: Like, um, 'honey', 'sweetie', 'sugar sugar'.

Moderator: [Supervisors] *don't* want you using those?

PSW 2, 3, 4, 5 and 6: [Chorus of no's]

PSW 1: Yeah. [Supervisors want] 'Mister' this and 'Mister'… [Residents] don't want to hear 'Mister' this and 'Mister' that! They wanna hear…

PSW 2: 'Darling'!

PSW 1: And 'sugar sugar'. It perks them up, as if somebody care for them.

PSW 2: It's like they're close family.

PSW 3: Yeah! They want to feel human!

PSW 4: You're not allowed to, you are not allowed to.

PSW 5: We are not allowed but they like it!

[Facility A, Focus Group, original emphasis]

Subjective interpretation was also evident in supervisors' deliberations as to whether the use of such terms constituted a violation:

Like calling a resident 'darling' or 'sweetheart'…according to policy, you're not supposed to. You know, but the staff still do. And myself and [names another supervisor] we see this on a daily basis…if somebody wanted to go just by policy they could say this is abuse. You know, it's a grey area…very fine line. And you kinda have to sometimes use your own judgment to see is this actually abuse?…you have to look at the *tone*, you have to look at the *body language*, right? Is this person making fun of the resident?… Yes, if I do see that absolutely I would stop it… [Facility B, Interview, original emphasis]

PSWs also spoke of the disjuncture between policy and resident preferences in the matter of personal care. Institutional policy dictated that personal care such as the shaving of facial hair, and the cutting of finger and toe nails be performed only in residents' individual rooms. In contrast, PSWs often found that residents preferred to remain in public or communal spaces, and would resist or refuse being moved for such care.

PSW 1: …these residents for instance, if they're sitting watching TV or whatever, you have to shave them or things like that…it's so hard to get them to go to the room to give them a shave or cut their nails. You can't cut the nails there, you have to take them to the room…And it's so hard, you know? They don't wanna move! They let you do it if you do it right there, they prefer that, but to get them up to go to the room to do it?

PSW 2: Yep, yep. That's a big issue, especially on [our unit].

PSW 3: You just have to catch them at the moment.

Moderator: But you can't - 'cause you have to physically move them.

PSW 4: Because of the privacy clause.

PSW 1: And sometimes things you wanna do you, you, you know, you feel bad leaving yourself, because this person need a shave, you leave…and he didn't get a shave. Because he don't want to get up, you cannot get him up, and you know, and you cannot give him [a shave in a public area]… you know.

[Facility A, Focus Group]

As the above reference to the "privacy clause" indicates, PSWs were aware of the Resident's Bill of Rights (Ontario Ministry of Health and Long-Term Care, 1998) which stipulates that residents are to be afforded privacy in treatment and in care for their personal needs. Yet PSWs spoke of residents "who let you do it right there" (that is, provide grooming care in

public areas) as well as leaving grooming tasks undone rather than move residents against their wishes. In both instances, residents' preferences superseded institutional and government policy. Indeed, supervisors commented that they had witnessed PSWs shaving residents in the public lounge and reprimanded them for doing so.

Another structural impingement to individualizing care was the institutional rule that disallowed PSWs from eating with residents because Ministry funding for meals was specifically calculated per resident. Yet several PSWs argued the inability to share meals often prevented them from carrying out the intended task of nourishment:

> PSW 1: If you don't eat with them, they will not eat.
>
> PSW 2: …They want to share it. They want to give you 'cause they want to share. We can't do that.
>
> PSW 1: We can't even have a cup of coffee with them!
>
> Moderator: Why?
>
> PSW 1 [repeats question]: Why? -
>
> PSW 3 [interrupts]: It's policy.
>
> Moderator: You can't eat with them. So what do you do in those situations?
>
> PSW 1: You have to leave them -
>
> PSW 2 [agrees]: You have to leave them.
>
> PSW 4: They will go hungry.
>
> PSW 1: You feel terrible.
>
> [Facility A, Focus Group]

PSWs repeatedly commented they felt "terrible" for participating in organizationally-approved practices that they knew went against what residents desired and that had negative consequences for care.

The internal conversation and the violation of rules

To understand the components of PSW care, we must account for PSWs' internal conversations which comprise their deliberations about how to respond to those policies they believed contradicted residents' best interests. For example, PSWs used terms of endearments despite awareness of employment risks:

> PSW1: We use it but we can't use it in front of [supervisors].
>
> PSW 2: You know, so you have to be very careful.
>
> PSW 3: You have to be very careful. You get in trouble.
>
> [Facility A, Focus Group]

Challenging institutional routines such as the timing of showers was also identified as risky but necessary to accommodate the preference of residents. A PSW boldly commented:

> (T)hey can do what they wanna do with me, but what is important to me is not what my manager tell me to do or what the facility tell me to do. The resident is my priority. And whatever works with them, what they like, I will do it. They can fire me if they want to…I don't care. So they can bring their policy, or their procedures, or whatever it is, if my residents need to get a shower before supper, I'll be giving them a shower before supper. And if they need to get it after, later…I have to do what is best for them. Their comfort comes first. [Facility B, Interview]

Another violation involved two-carer mobility assistance. In addition to protecting the resident, this rule relates to the Ministry of Labour's objective to reduce workplace injuries in long-term care (Ontario Government, 2008). Yet PSWs often cooperated to only marginally comply with the "two-assist" rule. A PSW explained:

> (D)oing care when they said you have to be two [PSWs] in the room to give care, I find sometimes [residents] get more agitated when there's a lot of people around them because it's like you're ganging up on them, you know. That's my impression of why they behave and act the way when there's more than one [PSW]. So when I go in there, I ask [a second PSW] to help me to transfer them, and then I secure them in the chair and I say [to the second PSW], 'Okay, I'll call you when I'm ready.' And I give my shower…and we are one-on-one now so they don't feel like threatened. [Facility B, Interview]

In this example, the employment risk also extends to the second PSW who agreed to leave for the duration of the shower.

Complicity of supervisors

Supervisors of both facilities expressed their belief that the regulatory structure of long-term care often restricted quality care:

> I think my next biggest complaint would be the fact that we're so legislated. And you're trying to balance the rule book, which is all these regulations we have to follow, with resident care. You've got certain requirements you have to meet but where does that come in when it comes to humanizing the resident? [Facility B, Focus Group]

> I find that the Ministry talks out of both sides of the mouth because you've got all these rules that you have to follow and you have to meet on one hand, and on the other hand they want you to be resident focused. But sometimes in order to meet the needs of the resident or to make it more resident focused you need to bend the rules a little bit. And there isn't a whole lot of grey in the Ministry's eyes. It's very black and white. So that piece is always a challenge, balancing Ministry rules against what you think is best for the residents. [Facility A, Interview]

This belief led many supervisors to reflect both on resident outcomes and their own priorities when deliberating how best to respond to staff violations:

> So sometimes it's kinda like breaking the rules that you put out, but, they're done with good intentions. There's not a negative impact in the end of it, a negative outcome. [Facility A, Interview]

And sometime you just hope that [the inspectors won't] come and check on this, right?.. Sometimes you just need to decide, right? Need to decide, okay, which side [PSW or Ministry] I'm going? [Facility B, Focus Group]

The outcome of their deliberations was in many cases their condoning of rule-breaking when PSW reasoning was perceived consistent with the needs or preferences of the residents. For example, a supervisor described condoning PSW violations of a Ministry standard regarding how meals are to be served:

Ministry of Health has a standard that residents get served course by course to be like a restaurant setting. That's exactly how it has to be served. But the residents are so behavioural, a lot of them like it all at once, so you can do it all at once as long as you make sure…this is how this person likes it. So, you know, if it means giving dessert [alongside the main course] you know, it happens. So they will do it for the residents. [Facility A, Interview]

Supervisors also noted their awareness that PSWs use terms of endearment. For example in Facility B, a supervisor referred to a particular resident who liked staff to call him by an affectionate diminutive of 'grandfather' in his mother tongue, and staff would often comply despite that "the policy states that we should be calling him with the first name or the last name".

Yet regardless of the belief in the veracity of PSWs' clinical logic, supervisors did not allow rule-breaking to become routinized. Supervisors explained that this was largely because of the importance of respecting the temporal order of institutional practices for the smooth operation of the facility:

If breakfast is late and dietary starts late, then the clean up doesn't happen on time. The laundry doesn't get done on time to get back up for the next meal, you know? I mean, it's a domino effect there…Bibs, same thing. If they aren't down by a certain time into laundry, laundry can't get them laundered you know for the supper meal…You know, it's just throws everybody off. And I know it sounds so silly but when you're looking at the time factor and the shifts, it's what you have to work with so we could never have PSWs bringing residents in whenever they want. [Facility B, Interview]

The contextualized nature of rule-breaking was further explained by supervisors in the context of their fear of Ministry violations. Supervisors noted violations needed to be kept hidden from inspectors so that the facilities will pass muster at the time of inspection:

First of all, the business we're in, it's very human, and you want what's best for the resident. And despite all the rules and regulations that we have to follow, sometimes I turn a blind eye to things that I know I shouldn't. When it comes to resident care, because I know that, I know [PSW's] logic behind it. …I'm usually aware of these types of things, and you know we're really not supposed to do that but you know, as long as the Ministry's not walking in the door right now…

[Facility B, Focus Group]

> I don't think [rule-breaking] is something you're gonna carve in stone, simply because it can hang ya in the end…we being the managers. I think the managers try to follow the rules the best they can simply because this is the role we're supposed to take. Where the flexibility comes in is when [the rules] don't really work for a person and then we kind of become a little more flexible. But to say it outright or put it in writing…not gonna happen [laughter]… I think we do a lot of making sure that we're doing things right. Maybe we're bending rules a little bit more than we should be according to the Ministry….[so] on the day the Ministry's here, you wanna make sure you're not bending the rules. [Facility B, Interview]

Discussion

Structural properties impinge on agents in the form of constraints and enablements (Archer, 2003). They shape the situations in which agents find themselves such that some courses of action are impeded, and others are facilitated (Archer, 2003). For PSWs, structural emergent properties arose in the form of Ministry standards of care and institutional policies that structured day-to-day organizational care delivery. Bureaucratic rules have been noted to discourage the initiative and spontaneity of PSWs (Foner, 1994), and to devalue the supportive emotional labour PSWs provide (Diamond, 1992). Yet our findings suggest that the internal conversations undertaken by PSWs exerted causal powers as evidenced by their abilities to perceive, negotiate, reluctantly comply with, or selectively resist provincial and institutional regulations, and to thereby shape point-of-care decisions in accordance with their own deliberations concerning quality care. Thus contrary to the presumption that PSWs simply comply with care and treatment plans developed by regulated health professionals (Health Professions Regulatory Advisory Council, 2006, p. 10), our findings suggest that dementia care is significantly influenced by what PSWs do and how they do it. This underscores the importance of PSW caregiving work, the nature of their clinical decision-making, and the implications for resident outcomes (Anderson et al., 2005; Diamond, 1992; Henderson & Vesperi, 1995; Janes et al., 2008; Kontos & Naglie, 2009). Extending an exploration of PSW caregiving work to include other factors that might influence decision-making, such as cultural origins, is an important direction for future inquiry as this would broaden our understanding of the complexity of care dynamics.

The slippage between official rules and actual practice in US long-term care has been explored by Lopez (2006, 2007) and Foner (1994). Lopez identified rule-breaking as necessary since "no level of staffing supported by the current federal reimbursement system would allow nurse aides to actually live up to official care standards" (2007, p. 241). Lopez found rule-breaking to often compromise quality of care, with managers colluding with unsafe care to avoid citations. For example, supervisors recognized that PSW compliance with the rule that residents be monitored on the toilet would increase the amount of time residents waited for call lights to be answered – and these records were subject to review by state inspectors. Foner (1994) viewed rule-breaking by PSWs as defiance against nursing home management. Like Lopez, she argued rule breaking had negative consequences for resident care.

In contrast to these studies, our findings suggest that rule-breaking was pursued by PSWs as a *strategy to individualize care* since full compliance with rules constrained their ability to do so. In addition, in contrast to overt routinization of "unofficial rules" (Lopez, 2007, p. 227), we found that rule-breaking was contextualized rather than routinized. The agential powers of PSWs were themselves contingent upon covert, reflective evaluation vis-à-vis the internal conversation of supervisors who responded by disciplining some violations of PSWs and ignoring others. Supervisors' decision to discipline violations or ignore them was the outcome of their own internal deliberations concerning resident interests, their own priorities, and the disparity between provincial and institutional regulations and quality care. Where supervisors shared PSW reasoning that rules compromised quality care, PSWs were not disciplined. The choice to collude with the violation of rules was further contingent upon how supervisors interpreted the intentions of PSWs. For example, tone and body language were considered when determining whether terms of endearment constituted "abuse". Where policies and regulations were enforced and violations disciplined, supervisors acted in the interests of maintaining order with regards to the scheduling of care activities in the facilities, and to preempt sanctions by the Ministry. Supervisors were keenly aware that institutional violations are reported publicly and thus can adversely affect future admissions (Foner, 1994). Findings of violations lead to orders for correction and re-inspections to verify compliance, and pose the threat of temporary suspension of patient admissions, or even the suspension or revocation of the facility's license to operate (Ontario Ministry of Health and Long-Term Care, 2002).

At no point during interviews or focus groups with supervisors was it suggested that they believed PSWs were aware of supervisors' complicity regarding rule breaking. Similarly at no point during PSW interviews or focus group discussions was it suggested that they were aware of supervisors' complicity; this perpetuated PSWs' erroneous belief that violations went undisciplined because they were not detected - and likely fueled further rule-breaking. This suggests that successful rejection of structural impingements (i.e. rules and regulations) were contingent on often unseen and asynchronous decision-making of PSWs *and* supervisors. Ultimately, despite congruence between the care logic of PSW rule-breaking and the complicity of supervisors, the covert nature of their respective efforts failed to effect change at either the institutional or provincial levels. This is because PSW rule violation and supervisor complicity remained non-dialogic, thus undermining the potential for their combined reflexive capabilities to transform the legislative landscape of long-term care.

This study is the first to demonstrate the contingent nature of decision-making in long-term care. It reveals not only the strong contribution that PSW rule-breaking makes to the delivery of quality care, but also the supportive role that supervisors play in the continuance of these provincial and institutional violations. With each reflexive deliberation, PSWs and supervisors could choose to act otherwise, and by so doing, influence the nature and quality of care activities. This illuminates a new dynamic in long-term care that significantly shapes the way that care is delivered. Further research is necessary to evaluate the applicability of our findings to other long-term care settings.

Long-term care is fundamentally a multidimensional construct (Mor, Zin, Angelelli, & Miller, 2004). A critical realist lens addresses this multidimensionality by highlighting the

irreducibility of care either to the regulatory regimes that influence the content and delivery of care, or to the experience, knowledge and reflective deliberations of PSWs or supervisors that oversee PSW care. Critical realism is a perspective that invokes the complexity of the "messy" interrelationship between agential and structural factors capturing both causal mechanisms and their contingency in dementia care. This, in turn, has implications for knowledge translation research that seeks to embed interventions in long-term care settings for the purpose of improving quality of care. As Kontos and Poland argue (2009), using critical realism to elucidate the complexity of the conditions of practice would help to successfully embed interventions in settings, thereby ensuring greater impact and sustainability. It would also inform evaluation efforts in terms of analysis of how the interconnection of structural, agential, and intervention elements facilitate and/or impede action or inaction related to research uptake (Clegg, 2005; Kontos & Poland, 2009).

At a time when evidence-based decision-making is reshaping clinical and policy reasoning and practice, it is imperative that research contribute to the generation of theoretical explanation that can inform decisions by health care managers and policy makers (Mykhalovskiy et al., 2008). By illuminating the causal generative mechanisms of care practices, including inspector subjectivity, and supervisory complicity with PSW rule breaking, critical realism has the potential to generate knowledge that will challenge ill-fitting policies that constrain humanistic care. Critical realism, taken up in future research in long term care, can significantly inform the cumulative and systematic development of knowledge informing the areas of public policy applications and program interventions.

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Table 1

Demographic Data for PSWs

	Facility A (n=13)	Facility B (n=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