ORIGINAL ARTICLE

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

# Leadership for quality in long-term care

Ivy L. Bourgeault[1]; Tamara Daly[2]; Catherine Aubrecht[3]; Pat Armstrong[2]; Hugh Armstrong[4]; and Susan Braedley[4]

Healthcare Management Forum
2022, Vol. 35(1) 5–10


Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/08404704211040747
journals.sagepub.com/home/hmf
SAGE

**Abstract**

Leadership in long-term care is a burgeoning field of research, particularly that which is focused on enabling point of care staff to provide high-quality and responsive healthcare. In this article, we focus on the relatively important role that leadership plays in enabling the conditions for high-quality long-term care. Our methodological approach involved a rapid in-depth ethnography undertaken by an interdisciplinary team across eight public and non-profit long-term care homes in Canada, where we conducted over 1,000 hours of observations and 275 formal and informal interviews with managers, staff, residents, family members and volunteers. Guiding our analysis post hoc is the LEADS in a Caring Environment framework. We mapped key promising leadership practices identified by our analysis and discuss how these can inform the development of leadership standards across staff and management in long-term care.

## Introduction

Leadership in Long-Term Care (LTC) organizations is a burgeoning field of research and intervention. Effective leadership is associated with improved staff outcomes, job satisfaction and reduced turnover enabling greater continuity, high quality and responsive care.[1] Behavioural interventions have been conducted with LTC leaders to improve a variety of resident- and provider-based outcome measures.[2,3] What requires additional attention are promising leadership approaches in LTC that focus on leadership across organizations and bring attention to the organization of the overarching system.

### *Purpose*

This article is part of a larger project of how care relationships can enhance quality of care, work, life, and death in LTC. A principle underpinning this work is the intricate connection between the conditions of work and the conditions of care.[4] We strove to identify promising practices, such as enabling policies and approaches at point of care that foster quality of care and quality of work. Leadership is an important facilitator of quality that emerged from our study – both through LTC management teams as well as through leadership distributed to all the members of care teams who were supported (or not supported) to contribute to enhancing of quality of care, life and death in LTC. In this article, we focus on the important role leadership practices play in enabling the conditions for high-quality LTC.

## Leadership styles and practices

Recent studies encourage a shift from traditional command and control or 'transactional' leadership approaches, which emphasize a top-down hierarchical form of leadership.[5] Servant leadership – where leaders lead in a less hierarchical 'side-by-side' approach inspiring others and enabling integrity and professionalism – is another approach, but more closely aligned with interdisciplinary collaboration because it focuses on the strengths, contributions and development of trust within the team, and on serving the needs of residents.[5] More recently, there has been a push for a distributed leadership approach, which involves sharing leadership roles and practices by different team members, or leadership plurality.[6,7] This approach, it is argued, better acknowledges the different experiences and skill sets various members of a healthcare team bring to informed decision-making.

In each of these traditional and newer forms, the focus is still on the overarching approach of 'a' person in the role of positional authority (eg, the leader or manager/supervisor) rather than on how 'leadership' practices could be distributed. This focus often deconstructs leadership into specific observable and measurable practices to make the conceptual more concrete. For instance, responsive leadership is an approach rooted in self-determination theory that breaks down a leader's behaviours into key components: (1) acknowledging staff perspectives, (2) providing them with relevant information in a non-controlling way, (3) offering choices and (4) encouraging self-initiation.[2] Similarly, Backman et al.[8] identify that 'handling conflicts in a constructive way, coaching and giving direct feedback, experimenting with new ideas, and controlling work closely' are all highly effective leadership characteristics in LTC.

In sum, most leadership literature in LTC focuses on a leader, their personal style and training (or lack thereof), leaving the examination of broader approaches associated with distributed

[1] University of Ottawa, Ottawa, Ontario, Canada.
[2] York University, Toronto, Ontario, Canada.
[3] St. Francis Xavier University, Antigonish, Nova Scotia, Canada.
[4] Carleton University, Ottawa, Ontario, Canada.

**Corresponding author:**
Ivy Lynn Bourgeault, University of Ottawa, Ottawa, Ontario, Canada.
E-mail: ibourgea@uottawa.ca

leadership as a critical knowledge gap (with a few exceptions). Indeed, there remain several inconsistencies in discerning leadership from supervision or management; these, in turn, are related to the lack of empirical data on effective leadership in LTC.[1]

## Methods

Our methodological approach involved in-depth, rapid ethnographic fieldwork undertaken by our interdisciplinary team. Eight non-profit or public homes were purposively selected, two in each of four provinces – Nova Scotia, Ontario, Alberta and British Columbia.[1] Once chosen, extensive background preparation was undertaken on the home.

The team ethnography involved our six to eight team members together undertaking interviews as well as extensive observation for three or more 12-hour revolving shifts in each home, sampling across early morning, late evenings and weekends to observe a range of staffing roles and resident activities. We typically started with a focus group with the management team, a tour of the facility with introductions to other staff, followed by direct observations of different activities and spaces (including tasting food) and interviews with a broad range of staff, family, managers, residents and volunteers. In total, we gathered over 1,000 hours of observations and 252 interviews with managers, staff, residents, family members and volunteers (see Table 1). The interview guide outlined sentinel dimensions of quality of care, life and work in long-term care and was revised and augmented as the fieldwork ensued. Interviews were often conducted in teams of two, recorded, verbatim transcribed, and coded thematically based on an a priori and emergent coding scheme. Observations were captured in fieldnotes. We concluded our 'visit' with wrap-up conversations with managers when we provided high-level feedback.

**Table 1.** Interview participants by site and type.

| | Alberta | British Columbia | Nova Scotia | Ontario | Total |
|---|---|---|---|---|---|
| Residents | 1 | 0 | 4 | 3 | 8 |
| Family/Friends | 10 | 12 | 5 | 6 | 33 |
| Students/Volunteers/ Coordinator | 5 | 2 | 1 | 5 | 13 |
| Nurses | 8 | 4 | 4 | 9 | 25 |
| Care aides/Personal support workers | 6 | 12 | 16 | 11 | 45 |
| Allied health | 3 | 3 | 0 | 1 | 7 |
| Recreation therapy | 4 | 4 | 2 | 4 | 14 |
| Paid companion | 1 | 1 | 0 | 0 | 2 |
| Housekeeping/ Maintenance/ Laundry | 3 | 2 | 2 | 4 | 11 |
| Food services | 6 | 4 | 5 | 5 | 20 |
| Admin/HR | 4 | 2 | 10 | 4 | 20 |
| Senior management | 7 | 2 | 15 | 13 | 37 |
| Government/Research | 1 | 0 | 10 | 1 | 12 |
| Advocacy/Union | 0 | 0 | 4 | 1 | 5 |
| Site totals | 59 | 48 | 78 | 67 | 252 |

The research team met on several occasions before, during and after the fieldwork and interviews to reflect analytically on the data being gathered and to triangulate the emerging analyses. These team debriefings were also recorded and transcribed for thematic analysis.

All of this fieldwork was undertaken prior to the pandemic, between the months of April 2018 and August 2019. The protocol was approved first by York University then by the University of Ottawa, St. Francis Xavier University, Mount Saint Vincent and Carleton University, as well as by the ethics boards governing each individual organization in each province. Interview participants provided written informed consent.

### *Conceptual framework*

Guiding our examination of leadership in LTC post hoc is the LEADS in a Caring Environment framework.[9] Briefly, this framework outlines five domains: Lead self, Engage others, Achieve results, Develop coalitions, and System transformation – each containing four observable capabilities required to lead across sectors and types of organizations (see Table 2). This framework did not guide the interview questions or observations directly, but our analysis of the data provided confirmation for such an approach. Key excerpts from the interviews with staff and management are captured in Table 3 by these five domains.

## Findings

### *Leading self*

We observed those in leadership positions modelling behaviour they wanted staff to exhibit, in other words, leading by example. Several staff noted the importance of management being present and being prepared to take up any aspect of the work. This could range from simply being on the units, sitting and talking to residents or eating with them in the dining lounge. Leading by example also involves holding oneself accountable to high-quality care being expected of staff. When discussing how they develop themselves as leaders to improve the quality in their facility, some identified LEADS explicitly. It was in this way they began to implement a more distributed leadership model, which links to the next capability of engaging others.

### *Engaging others*

Engaging others started with explicit attention paid to staff engagement, especially during times of change management. It went beyond simply including staff to considering how they were included. Engagement also went beyond staff to include communities and families. A number saw leadership as needing to be distributed to be most effective. This was contrasted with more traditional command and control approaches. Challenging situations arouse when more traditional approaches to team communication and collaborative decision-making were most prevalent. In some cases, engaging others involved explicit attention to education and training as opposed to just doing

**Table 2.** LEADS framework mapped to leadership for quality in long-term care.

| | Lead self | Engage others | Achieve results | Develop coalitions | System transformation |
|---|---|---|---|---|---|
| Capabilities | • Are self-aware<br>• Manage themselves<br>• Develop themselves<br>• Demonstrate character | • Foster the development of others<br>• Contribute to the creation of healthy organizations<br>• Communicate effectively<br>• Build teams | • Set direction<br>• Strategically align decisions with vision, values and evidence<br>• Take action to implement decisions<br>• Access and evaluate | • Purposively build partnerships and networks to create results<br>• Demonstrate a commitment to service<br>• Mobilize knowledge<br>• Navigate socio-political environments | • Demonstrate systems/ critical thinking<br>• Encourage and support innovation<br>• Orient themselves strategically to the future<br>• Champion and orchestrate change |
| Exemplars | • Lead by example | • Developing distributed leadership through staff and family engagement | • The challenge with measuring quality | • Community engagement, including developing volunteer capacity | • Right-touch, resident-centred regulations as tools to foster positive systemic change |

or saying. This not only applied to staff but also with family. Engaging others is not an end in and of itself but typically oriented to achieving shared results.

### *Achieve results*

Achieving results builds on typical approaches to change management, whereby one creates a conducive climate for change, implements and sustains it. Setting a direction for change may start with management but needs to involve staff in the spirit of distributed leadership. Evaluation is key when trying to achieve results, which raises the challenge of appropriately measuring outcomes that make the biggest difference to caring and working conditions. It goes beyond measurement for measurement's sake and includes assessing what needs to be measured, how and why. Both managers and staff voiced concerns that a focus on the measures without attention to the goal of what the measures are supposed to be measuring could lead to negative outcomes. In the case of those provinces that have adopted a standardized resident assessment tool (like the RAI-MDS), staff noted its potential to draw a significant amount of time away from point of care to the task of paperwork. Others commented on the need for staff to see changes resulting from data collection efforts. Achieving results also needs to be visible to staff who bring concerns to the attention of management.

### *Develop coalitions*

Developing coalitions to improve quality of care within LTC often requires community engagement taking various forms and involve different actors. These are tied closely to achieving results because results are often achieved through additional resources that community engagement can provide. A number spoke of creative ways to develop programs which enabled budget envelopes to be supplemented. For example, one organization supplemented the limited publicly funded food budget with a breakfast program bringing family and other community members together for a shared activity.

Another form of community engagement was through concerted efforts to solicit volunteer support. Through the community connections of both staff and residents, some organizations supplemented constrained staffing budgets with a significant amount of volunteer labour. This does raise the issue of *sustainability*, with many volunteers being of advanced age themselves, and *continuity* when volunteer student labour was encouraged. Some did manage to use volunteer channels to recruit students into the system, develop them and create a career path/ladder. One organization partnered with the local training program to gather more resources to get at better measures of whether they were achieving results. Engagement was seen as necessary to creating the conditions in which good care could flourish, but without changes at the system level, LTC organizations were notably constrained.

### *System transformation*

Part of our interview involved asking participants what changes they would make to improve quality of care at their organization. For some, the changes they proposed were quite local, often calling for more staff, or some seemingly small things that would improve the lives of residents for whom they were providing care. Others expressed a desire for a very different system of care for older adults, particularly those with dementia. Dementia villages were noted as a promising system transformation; others spoke to the system transformation possibilities of different models, such as the Eden Alternative. They talked about how such models were presently adopted and adapted piecemeal because of the associated costs. Few offered ideas about how to get from their present state to a future transformed system. It often remained aspirational. One participant noted that regulations needed to be changed to effect broader system change. This type of change, they felt, would require Ministry support and a different inspection system focussed on different types of outcomes than the current (limited) ones.

## Discussion

Leadership for quality LTC clearly matters – both directly and indirectly – in the way it can (or cannot) foster the conditions of

**Table 3.** Key quotes by managers and staff in long-term care mapped to the LEADS framework.

| | Lead self | Engage others | Achieve results | Develop coalitions | System transformation |
|---|---|---|---|---|---|
| Management | "I can't ask somebody else to pour their heart and soul into care and not be willing to do the same. So I think the only way to like walk the walk, right?" AB<br>"I also like to assist in feeding when I can. … if I walk down and I see someone sitting and their whole plate of food is there … and the staff are busy running around … It's not in my scope but it gives me a chance to assess someone. … and staff will sometimes come up and give me some information." AB<br>"Staff eating with [residents] makes them feel like it's a home." ON | "Last year was really focused on staff engagement … for us I think honestly just talking to them all the time, connecting with them. I've tried to be as transparent as possible with our staff and accessible to them." AB<br>"I think we all need to lead and be a mentor … just to support people in their autonomy within their job and to recognize that they have an opportunity to bring forward an idea that will be supported by the people in the seats who can say, yes, we have the money or no, we don't." ON<br>"It can't always be management-led. So that's why we're really trying to build our leaders in the community, empower them, give them the tools that they need, support them, but they are taking the lead." NS<br>"… the toughest times are when we do our most learning. They need someone. They need consistent leadership… they needed that leadership to pull them through and that's become very evident." AB | "I think that culture has to come from management and foster downwards. … so for example, by having meetings and saying, 'You guys have a voice' but I've also said …'if you have a problem, you come with a solution or you come willing to look at a solution.' … so they start feeling empowered that they're part of it too." BC<br>"Surveys are fine, but if they're just shoved in a drawer, you're just dashing people's hopes, and actually, instead of encouraging somebody, it's just having the opposite effect." BC<br>"We talk about this in our site quality team meetings too is how do we capture … those moments of happiness and satisfaction and sense of well-being, and we don't have that answer yet." AB | "Each year when we set out goals … they're almost always relationship focused … we started with community engagement." AB<br>"I helped put a satisfaction survey protocol in place with sampling and training … to make things a little bit more valid and reliable … but what we're finding is that it really doesn't get at what people want – they're wanting to know the experience. … so what I've done this past year … we got a community innovation grant and I approached … [local faculty of nursing] students to … gather narratives … and that's our process of actually coming up at this lived experience." AB<br>"Students are great – they bring in new ideas." NS | |
| Staff | "From my perspective, a leader is somebody who comes to see you and works with you, right? … they come into the unit and see what their staff is dealing with right from the PSWs to housekeeping." ON<br>"management encourages you to spend as much time with people." BC | | "I noticed that the level of needs at [wing X] during the three years that I was there deteriorated considerably, so the staff was getting busier and busier, but the levels did not. So what they did is pulled a half a staff member from here and put it there … the manager was very happy to let me know that this is what was done and she was pleased with that." BC<br>"I think when they feel like they're being supported they feel heard, because people are here, they want to be here. They've chosen healthcare for the most part because they really do want to look after people." BC | | They say resident-centred, I say stop [just] saying the words and let's truly be resident centred. The resident bill of rights is really the only regs you need because it covers everything" ON |

work and thus the conditions of care. LEADS is a way to more fully understand the various layers that leadership entails. The LEADS framework also encompasses a broader purview of leadership beyond positional authority to embrace all members of healthcare teams leading from where they are presently situated. To be sure, the context must enable this kind of distributed leadership[10]; managers play a critical role, but they too can be limited by conditions such as funding for staff and hierarchical structures of power.

On this point, Cloutier et al.[5] found managers working from a servant leadership perspective engaged entire teams to develop solutions enabling quality care improvements. Our findings confirm that "If quality of care rests on a foundation of solid, supportive, empowering relationships, then efforts to improve quality of care must at some level be based on improving all relationships as well, be they between leadership and direct care staff, between staff and staff, or between staff and residents and family members." Indeed, support for relationship-building and a strong sense of community are critical to effective leadership in long-term care, although on its own it is not a sufficient condition for quality working and living conditions in LTC.

Employing the LEADS framework enables us to move beyond leadership types and practices towards a system focused on shared and specific capabilities. Leadership is not only a capability that rests among those in managerial positions; it can be encouraged amongst all LTC staff and in partnership with families, volunteers and communities. Perhaps the most important measure we should consider of those in managerial leadership positions is their ability to enable distributed leadership, so as to draw out the keen insights of those at the various points of care positions in the provision of long-term residential care.

## Conclusion

### *Limitations, future research, policy and practice*

First, our findings pre-dated the enormous disruption to LTC caused by the COVID-19 pandemic, but as many have stated, the pandemic has not only created significant negative impacts, it has also revealed long-standing fissures in the system. It is instructive that the report of the LTC Commission in Ontario noted that in the context of COVID, "Strong leadership proved critical in the face of unprecedented challenges in long-term care homes".[11] We anticipate that our findings about leadership in LTC, through a LEADS lens, will be instructive to the ongoing dialogue of new principles and standards in LTC that enable higher quality care. In particular, given the current and future projected shortages of staff in LTC, our LEADS-framed analysis of leadership capabilities can help improve both recruitment and retention of much needed staff.

Second, it is important to acknowledge that the LTC workforce and its leaders are mostly women and, as such, the gender dimensions of leadership in LTC are important but to consider. This is particularly relevant in the pandemic and post-pandemic context which we know has had disproportionate impacts on women and women of colour in particular. We encourage future research to take into consideration the uniquely gendered nature of these contexts.


## Acknowledgements

We would like to thank Negeen Park for her assistance in the coding of the interviews, the preparation of the participant table and the formatting of the references. The authors acknowledge the *Seniors–Adding Life to Years* (SALTY) team for its contributions to this study.

## Funding

This research is funded through a Late Life Issues grant from the Canadian Institutes of Health Research (#145401) in partnership with the Michael Smith Foundation for Health Research, Nova Scotia Health Research Foundation and the Alzheimer Society of Canada.



## ORCID iDs

Ivy Lynn Bourgeault https://orcid.org/0000-0002-5113-9243
Pat Armstrong https://orcid.org/0000-0001-5742-9375


## Note

1. Each home was chosen using existing measures of quality. For ON, AB and BC, we used the Canadian Institute of Health Information's 'Your Health System' to determine 'high-quality' and 'low-quality' homes based on these measures. In NS an environmental scan involving interviews with decision makers from the LTC sector to determine definitions of quality and LTC homes with promising approaches.

## References


1. Edvardsson D. Systems research in long-term care special interest group session: Leadership in long-term care and its association to care worker outcomes in four countries. *Gerontol*. 2016;56:283.
2. Caspar S, Le A, McGilton KS. The responsive leadership intervention: improving leadership and individualized care in long-term care. *Geriatr Nurs*. 2017;38(6):559-566.
3. Bender D, Lui KYG, Holyoke P. Five opportunities for healthcare leaders to better support person- and family-centred care in long-term care settings. *Healthc Manag Forum*. 2017;30:20-25.
4. Armstrong P, Daly T. There are not enough hands': conditions in ontario's long-term care facilities. Results of an independent survey commissioned by the National Research Department of the Canadian Union of Public Employees, 36; 2004. http://archive.cupe.ca/updir/CUPELTC-ReportEng1.pdf.
5. Cloutier D, Cox A, Kampen R, et al. A tale of two sites: lessons on leadership from the implementation of a long-term care delivery model (CDM) in Western Canada. *Healthcare*. 2016; 4(1):3.
6. Chreim S, MacNaughton K. Distributed leadership in health care teams: Constellation role distribution and leadership practices. *Health Care Manag Rev*. 2016;41(3):200-212.

7. Denis J-L, Langley A, Sergi V. Leadership in the plural. *Acad Manag Ann*. 2012;6(1):211-283.
8. Backman A, Lövheim H, Sjögren K, Lindkvist M, Edvardsson D. Characteristics of highly rated leadership in Swedish nursing homes. *Gerontol*. 2016;56:283.
9. Dickson G, Tholl B. *Bringing Leadership to Life in Health: LEADS in a Caring Environment*. London: Springer; 2014.
10. Osborn R.N, Hunt J.G, Jauch L.R. Toward a contextual theory of leadership. *The Leadership Quarterly*, 13 (2002). pp. 797-837.
11. Marrocco F., Coke A., & Kitts J (2021) *Ontario's Long-Term Care COVID-19 Commission Final Report*. Queen's Printer for Ontario, http://www.ltccommission-commissionsld.ca/report/pdf/20210623_LTCC_AODA_EN.pdf.