Dementia Care for Residents in Rural Nursing Homes:

A Process Evaluation of the Enhancing Care Program

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DEDICATION

To Mackenzie and Alexa
The greatest daughters a mom could wish for.

To Cameron
My soul mate. My rock. Thank you.

ABSTRACT

Persons with dementia experience impairments in cognitive, behavioral, and functional ability, often leading to long-term care placement. The Enhancing Care Program was developed by the Alzheimer Society of Canada to assist organizations in improving care for this population. Although this program has been implemented in many facilities, the majority have been located in urban settings and there has been limited formal evaluation. Little is known about dementia care in rural facilities, or about how programs are implemented in rural settings.

The Enhancing Care Program is based on eleven guidelines that outline best practices for caring for individuals with dementia. With the assistance of a facilitator from the Alzheimer Society, a multi-disciplinary team from the facility assesses their current ability to meet each guideline. In subsequent meetings, the team establishes specific, measurable goals to improve care in targeted areas. The two purposes of this study were to conduct a process evaluation of the Enhancing Care Program and to develop theory relating to the implementation of a program in two rural long-term care facilities.

Observations were made over the course of seven months as teams worked through the guidelines and set goals. Focus group interviews consisting of team members took place at the end of the observation period. In addition, individual interviews were conducted with general staff, the facility managers, and the facilitator from the Alzheimer Society. Grounded theory methodology informed the research and analysis process. The theory that emerged, *The Process of Building Effective Teams***,** explains the transition of the participants from collections of individuals to cohesive units that functioned as teams. Five key categories were developed in the theory: trust, respectful and open communication,

transformational leadership, creating change collectively, and enhanced team culture. As part of the process evaluation of the Enhancing Care Program, 24 recommendations were made for program improvements.

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CHAPTER ONE
INTRODUCTION

1.1 Statement of the Problem

In our Canadian culture there is a mystique about the aging process. Many strive to avoid it at all costs. This is illustrated by advertisements on the television promising reductions in wrinkles for those who use certain creams or a wonderful life after retirement at the ripe age of 55. The dream for many is to grow old gracefully, looking younger than their chronological age and in perfect health. Unfortunately, this is a dream that is not realized by the majority of Canadians. The reality is that there are changes that occur as part of the natural aging process. These changes often include the graying of hair, an increase in the number of wrinkles, and the onset of certain medical conditions, such as osteoporosis, arthritis, and diabetes. For some aging Canadians, changes may also include deterioration in mental abilities due to dementia. Dementia is defined as acquired degenerative brain diseases that affect cognition, behaviour, and functional ability. (1) It is estimated that 60,000 new cases of dementia are diagnosed each year in Canada. (2) Of these cases, Alzheimer Disease (AD) accounts for 64%. (3) It affects approximately 8.0% of Canadians over the age of 65, ranging from 2.4% in those aged 65 - 75 years, to 34.5% in those aged 85 years and older. (3) The 2006 census indicated that Canada has never before had so many persons over the age of 80. Their number reached 1.2 million for the first time in that year. (4) The prevalence of dementia continues to rise beyond the age of 85; by the age of 105, the prevalence of dementia reaches almost 85%. (5)

Those suffering from dementia are not afforded the luxury of “aging gracefully” as defined by our culture. Instead, those with moderate to severe cognitive impairment may find they need to move to a long-term care facility because of their increased care requirements. With an increasing number of people facing this necessity, nursing home staff are beginning to think

more about providing a holistic environment for those with dementia and about creating a culture of care that is respectful and nurturing for all their residents. The trend in long-term care is to move towards a more social, person-centered model for care and away from the traditional medical model. (6) The challenge becomes one of process. Many facilities are aware that change is needed but are uncertain how to attain their goals. (7)

Nowhere is this challenge more acute than in rural Saskatchewan. Those who live in rural areas and who are facing dementia frequently require nursing home care and many choose to move to long-term care facilities in their rural communities. These facilities are usually small in size, and may lack the resources afforded larger urban institutions. (8) Facilities wanting to shift away from the traditional medical model are forced to consider programs that have been developed in urban agencies with urban facilities as the intended users of the programs. Little is known about how urban-based programs are implemented in small rural facilities, nor about the factors that influence organizational change within small rural facilities as they implement programs intended to enhance the care of residents with dementia.

1.2 Purpose of the Study

The Enhancing Care (EC) Program was developed by the Alzheimer Society of Canada to provide strategies for long-term care facilities as they care for an ever-growing population with dementia. (9) The purpose of this study was to conduct a process evaluation of the EC Program as it was implemented in two facilities in rural Saskatchewan in order to inform ongoing program improvement that is sensitive to the specific needs of rural facilities. A second purpose of this research was to develop grounded theory regarding the management of organizational change within the facilities as they implemented a new program. The mere fact that a new program is being initiated suggests that changes are likely to occur in several areas,

including communication and interactions between staff members, interactions between staff and the residents, and communication between administration and staff. By implementing a new program the social fabric of the facility as well as the organizational structure will be forced to adapt to change. The purpose of this study was not only to document how these social and organizational structures adapted throughout the program implementation but how staff responded to the successes and challenges that emerged through the process itself. Through the observations and documentation of this process, grounded theory was developed to explain how small rural organizations manage change within their facilities.

1.3 Research Partners

This study was conducted as part of a New Emerging Team (NET) project entitled "Strategies to Improve the Care of Persons with Dementia in Rural and Remote Areas." The NET project was awarded funding by the Canadian Institutes of Health Research (CIHR) and other partners in 2003. This five-year project has three core initiatives. The first core project is the development and evaluation of a one-stop multidisciplinary rural and remote memory clinic which is currently in its third year of operation. The second core project is a study of the prevalence and utilization of health care services by individuals with Alzheimer Disease living in rural or remote areas. Initially, the third core project was to be an evaluation of dementia care education for nursing aides employed in rural and northern nursing homes and home care agencies, an initiative of the Alzheimer Society of Canada. After further consideration this educational program was seen as somewhat outdated and the project changed its focus to the evaluation of the EC Program, which was also developed by the Alzheimer Society of Canada.

The Principal Investigator for the NET project is Dr. Debra Morgan of the Canadian Centre for Health and Safety in Agriculture at the University of Saskatchewan. She also acted as

my co-supervisor for this thesis. As there is potential for continuing the EC Program evaluation within the NET project beyond the scope of this thesis, Dr. Morgan and the NET project coordinator, Sandy Normand, observed several of the EC meetings in the two facilities and provided technical support during the two focus group interviews.

1.4 Literature Review

Before the method and design for this research are outlined, it is important to first consider the literature that already exists on this topic. This literature review begins by describing dementia and the care that is required for those affected by this condition. Statistics and demographics are provided to outline the extent to which dementia permeates our society. Since this study is located in a rural setting, the term "rural" will be defined and operationalized. Dementia care within the province of Saskatchewan is then described, with attention paid to rural long-term care facilities. Finally, a discussion of organizational culture is presented, outlining some unique facets of rural life in general.

1.4.1 Dementia Care

The Canadian population is aging. According to the 2006 census, the number of Canadians aged 65 and over increased by 11.5% over the previous five years. (4) Those in the Canadian population aged 65 and over constituted a record 13.7% of the total population. (4) Dementia is a health problem that is associated with aging. It is estimated that 450,000 Canadians will have Alzheimer Disease or a related dementia in 2007. (10) By 2031, over 750,000 Canadians will have Alzheimer Disease or a related dementia. (10) Dementia is a strong predictor of nursing home placement. (11) The Canadian Study of Health and Aging Working Group conducted a national study and found that the prevalence of dementia in long-term care facilities was approximately 57%. (3) This figure will only rise as the population ages.

The prevalence of dementia in those 85 and over has been reported at 34.5%. (3) It is estimated that between 70% and 90% of residents in facilities have some form of cognitive impairment. (12)

With more than half of their residents experiencing dementia, long-term care facilities are faced with the challenge of providing holistic care that addresses the unique physical, social and spiritual needs of this population. What does that mean? What are the needs of residents with dementia? Those with dementia experience changes on several levels. Their cognitive functions become altered. Their ability to understand, think, remember, and communicate is reduced. Decision-making becomes difficult. Confusion and memory loss gradually increase, accompanied by difficulty in finding the right words when following a conversation. (13) In addition to the cognitive decline is a change in behaviour including repetitious verbalizations or physical actions, wandering, self-abuse, resisting care, hoarding, throwing objects, general agitation, and aggression. (14) This last category, aggression, can be very disturbing for both residents and staff. Aggressive behaviour among persons with dementia in nursing homes has been reported at an alarming rate of 86.3%. (15) When comparing the behaviour of residents with dementia with those who are cognitively intact, studies have consistently shown a higher prevalence of disruptive behaviours among residents with dementia. (16) The cognitive and behavioural changes common with dementia are progressive and irreversible. (13) The environment in which these individuals live must provide compensation for these losses. Without such supports, excessive disability may occur beyond that which is attributable to the disease process. (8)

One important consideration in the care of individuals with dementia is the staff who work in long-term care facilities. Working with residents with dementia can be physically,

emotionally, and mentally exhausting. (17-19) Aronson et al. state that caring for residents with dementia requires more staff effort than does caring for residents who are cognitively intact. (20) This contributes to work load strain as staff increasingly need to respond to residents who may be exhibiting difficult behavioural symptoms. (14) The front line staff of rural long-term care facilities in Saskatchewan have raised concerns over inadequate staffing levels, insufficient training in caring for residents with dementia, and the increased burden of having to care for residents with dementia in an integrated setting compared to a special unit. (21) The issues around providing holistic care for residents with dementia are complex.

1.4.2 Definition of Rural

The process evaluation of the EC Program took place in two small rural facilities. At this point, it is important to define the term "rural", as it can be used in a variety of ways. There is little consensus when it comes to defining the term. One common way is posed in the negative, that being "not urban". (22) Anyone living outside a city would be categorized as being rural. Others categorize rural by population or population density. For instance, Pampalon defines rural areas as those municipalities which lie outside census metropolitan areas, and have a population under 2500 residents or a population density below 400 residents per square kilometer. (23) Rural has also been defined by some not by population but by occupational and sociocultural factors. This definition relies on ideology and values, which include conservative politics, support for the nuclear family, and self-reliance teamed with commitment to the community. (24) One simple but somewhat misplaced definition is to equate rural with farm residences. (25) In the past, rural has also been defined simply by using postal codes that have "0" in the first three digits. (22) Although this designation may have been useful at one time, it has become a less reliable method of defining rural due to changing practices by the postal

service in Canada. (26) Statistics Canada and the Rural Secretariat define "rural" using six categories that fall along a continuum. (27) These categories take into account an area's proximity to a large city and therefore access to services.

Which definition is ultimately chosen has several implications. Firstly, depending on the definition, different *numbers* of people will be generated. Secondly, different *subgroups* of people would be classified as rural. Finally, different *characteristics* of those living in rural areas would be identified. (22) These differences have implications for researchers who endeavor to compare their studies with research conducted by others. For the purposes of this study, rural and small town were defined as those living in towns and municipalities outside the commuting zone of centers with a population of 10,000 or more. (27) This is the working definition for other members of the NET project.

1.4.3 Dementia Care in Saskatchewan

Demographically, Saskatchewan has a number of unique challenges when considering its aging population. In 2006, 15.4% of those living in Saskatchewan were aged 65 years and over, the largest percentage of all the provinces and territories. (4) When this is further broken down to compare urban and rural dwellers, the statistics are noteworthy. Nationally, 24% of seniors live in rural areas. (22) In Saskatchewan, 33% of those living in communities with a population less than 4,000 are aged 55 and older, compared to only 24% of communities with populations greater than 4,000. (28) Seniors in this province are choosing to remain in rural communities in their retirement years. As the population in this province ages, the prevalence of dementia will only increase. In 2005, it is estimated that 18,080 residents of Saskatchewan had Alzheimer Disease or a related dementia. (10) Rural nursing homes will increasingly be relied upon to provide safe and nurturing environments for residents with dementia to reside. However, rural

facilities face challenges that are less prevalent than in urban facilities. For example, most health care providers are clustered in urban regions. In 2000, only 17% of family physicians, 4% of specialists, and 18% of registered nurses practiced outside of urban centers, yet 30% of the population lived in rural communities. (29)

Lack of access to health care professionals has implications for rural long-term care in two ways. The first is that many strategies that are suggested to improve care for residents with dementia include participation by a multi-disciplinary team that would consist of such disciplines as social work, physiotherapy, gerontology, and neurology. Rural institutions simply do not have access to these kinds of professionals to the same degree as their urban counterparts. (29) The second implication stems from the fact that many strategies are formulated with urban facilities in mind, with the expectation that rural facilities can "down-size" the ideas to fit their institutions. This does not always work. (6) Strategies that are urban-centric often fail to consider the uniqueness of their rural counterparts.

One trend in long-term care over the past few decades has been to create segregated Special Care Units (SCUs) for residents with dementia. (14) These units provide environments that allow residents with dementia to live with dignity and to maintain their independence as long as possible. In Saskatchewan, however, these units are not equally distributed between urban and rural facilities. Presently in Saskatchewan, approximately 10% of the rural nursing homes have a SCU, the majority of which are located in the larger facilities. (8) There are several reasons for this. One consideration is the size of the institution. Morgan et al. state that 47% of rural nursing homes in Saskatchewan have fewer than 30 beds, with a further 37 % having 30 to 60 beds. (8) In contrast, only 3% of urban nursing homes have fewer than 30 beds, with 27% having between 30 and 60 beds. The size of the institution has been viewed as a proxy

for availability of resources. (30) Larger facilities have access to greater funds and therefore have the potential to provide high-quality care for residents with dementia. (31) In addition, large facilities more often have the space and the staff resources to create SCUs.

In many cases, SCUs may not be a viable option for small rural facilities. This does not mean, however, that these smaller facilities are not committed to providing holistic care for their residents with dementia. The challenge for these facilities is to acknowledge the unique needs of this population and to provide this care within an integrated setting with the general nursing home population. Administrators and directors of care are increasingly seeking viable alternatives to SCUs that are appropriate for their facilities. Programs such as EC are being considered as possible strategies for initiating change in how care is delivered.

1.4.4 Organizational Culture

Any organization that is implementing a comprehensive program such as EC must be willing to undergo change. The goal of this program is to encourage staff to shift their way of thinking and working so that every action is resident-centered. This is not always easy. This shift will affect the very nature of the institution. It will have an effect on the culture of the facility. As anyone who has worked in a long-term care facility can attest, there is a distinct culture present within these institutions. Residents call the facilities “home”, for this is where they eat, sleep, and interact with friends and staff. Relationships are important, and as in any family, some relationships are stronger than others. Staff members become attached to the residents through the care they provide. The philosophy of care that defines the facility is evident in these interactions.

The term “organizational culture” refers to “the glue that holds an organization together through a sharing of patterns of meaning. The culture focuses on the values, beliefs, and

expectations that members come to share". (32, p.227) Gibson and Barsade describe organizational culture as having three distinct layers. (7) The first layer is represented by the visible artifacts that are apparent throughout the institution. These would include such things as staff dress, the presence of personal objects in public spaces, and how common rooms are decorated. At the second layer are the norms for behavior within the institution. These are the unspoken "rules" of conduct for staff regarding how residents are treated and how staff members deal with interpersonal conflict. At the third layer are the deepest held beliefs and values about how the world works. These values would include such things as teamwork over individuality, respect for personal differences, innovation and flexibility, or stability and tradition. (7)

Closely related to the term "organizational culture" is the concept of "organizational change". This term has been used to describe the process that facilities undergo as they attempt to shift from the traditional medical model of care to a holistic, resident-centered model. (7) In some instances, organizational change requires a shift in the power structure within facilities whereby those in management positions allow front line staff to make decisions regarding the care of residents that traditionally were only made by managers. This can be a difficult transition for those involved and involves changes for both management and front line staff. (33) Institutions may feel external and internal pressures to shift their paradigm of care but are uncertain what the goal should be or how to get there. (34)

Many models that explain organizational change are based on the work of social scientist Kurt Lewin. (35) Lewin's model, developed in the 1950s, proposes that within organizations there are two opposing forces, the driving forces which support organizational changes, and the restraining forces that attempt to keep the status quo. (36) Organizations remain static when the two opposing forces remain equal. In order for change to occur, either the driving forces within

the organization must increase or the restraining forces must be decreased. Lewin used the concept of an ice-cube to illustrate this process of change. The Government of Ontario states it in this way.

> The ice cube in its original shape represents the current state of the organization. In order to change, the ice cube must be unfrozen, moulded to its new shape, and then, refrozen. Similarly the organization, in order to change positively, must melt any forces which resist change and create a climate of acceptance and trust that will reinforce or refreeze the new state of the organization. (37, p.3)

While this theory is important as a basis for understanding other models, the idea of likening an organization to an ice cube has its limitations. Firstly, it assumes that an organization's natural state is static or unchanging. Even after the organization has undergone change (the ice cube has thawed), it returns to a static state. The organization becomes an ice cube again. Viewing an organization as unchanging and static is simplistic. (38) Secondly, Lewin's theory assumes that an organization can neatly be divided into two groups, those who drive change and those who resist change. Again, this view of organizations has its limitations. (38)

Many theories have been developed since Lewin's to describe and explain organizational change. However, few of these theories have arisen from research in rural settings or from small long-term care facilities. Authors from the Ontario Prevention Clearinghouse, an on-line resource available to organizations, offer some insight into the conditions needed for long-term success for healthy change within organizations. (39) They state:

> Organizations typically base their approach to bring about change on two basic human emotions: fear and hope. A fear-based approach tends to start the change process more quickly, appears to generate more energy and work activity, and may even increase productivity, especially in the short run. However, this early momentum is almost never sustained, and fades as quickly as it began. By contrast, a hope-based approach provides the people who make up the organization with the tools and support they need to create their own change. While it is true that this kind of approach takes longer and requires more 'up front' investment by the organization, experience shows that it greatly enhances

> a sense of ownership by staff in the process. As a result, the overall change is more easily sustained. (39, Article 4)

Based on their research, authors from the Ontario Prevention Clearinghouse indicate that healthy change can occur when four criteria are met regarding support for staff. The first criterion, healthy communication, includes adequate information about issues and process, information that is available often and on demand, information that is provided in a variety of forms, clear guidelines for influencing decisions, and the opportunity for ongoing dialogue. The second criterion, support for staff, entails equipping staff for the challenges of the future, both personally and within the organization. The third criterion, structural support, refers to the reduction in bureaucracy within the organization while sharing authority as well as resources. The final criterion, creating the future, entails clearly defining the planning process, focusing on both a vision for the organization as well as its current reality and providing clear guidelines for innovation. (39)

1.4.5 The Rural Context

The participating facilities for this study were located in rural Saskatchewan. There are cultural differences between rural and urban residents in general that have implications for this study. In order to evaluate this program within a rural setting, it is important to be aware of these differences. It should be noted that there were few sources available in the literature within the past seven years that focused specifically on rural values in Saskatchewan or even in North America. There remains a perception of cultural difference between rural and urban residents based on past research that has yet to be disproved.

1.4.5.1 The Role of Family. Rural values are at the root of rural culture. Central is the role of family. Bigbee states that “rural families occupy a central place in the social system, value structure, and economic dynamics in rural culture”. (40, p.137) One study investigating

gender bias in the intergenerational transfer of farmland on the Canadian prairies indicated that many farm residents have life-long ties with their family. (41) In order to maintain the viability of farms, the labor of several members of the family is often required. This study illustrates the importance of family in the farming context, one example of a rural lifestyle. Within long-term care, commitment to family manifests itself by residents requesting placement in facilities that are located in close proximity to other family members.

1.4.5.2 The Role of Community. Closely related to family values is the strength of the community spirit in rural locales. Even with the distance that often separates rural residents from one another, community spirit remains strong. (25) Long-term care facilities are often viewed as an extension of the community. There is often a connection between staff and residents that precedes admittance to the institution. They may have been neighbours, friends, or attended the same church. A common link can often be found. The strong relationship between rural residents and those who provide care was demonstrated in a study on geriatric mental health care in a rural community in Ontario. The study concluded that there is a significant relationship between physicians and patients in rural areas, even beyond the clinic setting (42). The authors attributed this relationship to the informality of rural culture, which was thought to contribute to a sense of trust between the two parties. (42) Relationships are significant in the rural setting.

1.4.5.3 Self-Reliance. Other rural values include self-reliance and a strong work ethic. These permeate all interactions between members of the society. These values make some rural members wary of initiatives that originate outside of their community. These initiatives can be viewed as an unwelcome intrusion into their lives or a criticism of their ability to accomplish the task at hand. (40) This self-reliance was found in a study completed in a rural American high school. The research was a case study of students' perceptions of factors that shape aspirations

in one rural school. The researchers found that the rural participants placed a great deal of value on hard work, independence and responsibility. (43) Any program that is initiated in a rural facility must take these issues into account. Understanding the rural context is vital to a program's success.

1.4.6 Implications for the Current Study

As Canada's population ages there will be an ever-increasing need for long-term care for those affected by dementia. Caring for these individuals can be challenging. Long-term care facilities are struggling to create environments for their residents that meet their physical, social, and spiritual needs. Facilities in rural Saskatchewan face challenges that are reflective of their location. Lack of access to health care professionals, size of facilities, and rural values all influence what is possible in these institutions. Many of the programs that have been developed to help facilities adapt to person-centered care are designed for urban institutions. Little is known about dementia care in rural facilities or about how programs such as the EC Program are implemented in rural long-term care settings.

CHAPTER TWO
METHODOLOGY

Many rural facilities have begun to seek out alternative models of care for residents with dementia. In recent years increasing attention has been paid to the quality of life that residents should expect within long-term care. Some nursing homes have become committed to changing in ways that both enhance quality of life for their residents as well as create positive working conditions for their staff. One program that can assist facilities to create change is the EC Program. In 2006, this program was implemented in two rural Saskatchewan long-term care facilities. This chapter first discusses the nature of the EC Program and then outlines the methodology used to evaluate the implementation of the program in the two study sites.

2.1 The Enhancing Care Program

The Alzheimer Society of Canada recognized a need for a program that would guide long-term care facilities through the issues regarding care for residents with dementia. The EC Program was developed in 1992 by the Alzheimer Society of Canada. (9) The program is based on 11 'Guidelines for Care' that are meant to apply to all individuals living with dementia, as well as guidelines for those who care for these individuals (see Appendix A, Guidelines for Care). The program assists long-term care facilities in identifying their strengths and weaknesses with respect to each of the Guidelines for Care. With the aid of a staff member from the Alzheimer Society the facility then identifies priorities for change and addresses the identified target issues.

2.1.1 The Players

At the outset, it is important that the long-term care facility be committed to the process. Organizational change can be difficult and administrative support is vital from the very

beginning. It is often someone from the management team of the facility who identifies the need for change and initiates program implementation. Once the commitment to the EC Program has been made, the first step in the implementation process is the selection of participants.

2.1.1.1 On-site Coordinator. The person initiating the program implementation may decide to act as the on-site coordinator or may seek another individual to fill the position. The on-site coordinator is responsible for the overall coordination of the project. This includes organizing the meetings, liaising with administration, and communicating with the Alzheimer Society. It is helpful if this person works on the unit that is implementing the program. The first duty of the on-site coordinator is to enlist staff to participate in program meetings.

2.1.1.2 Multi-disciplinary Team. The largest group of participants in the EC Program is the multi-disciplinary team. These members may volunteer to participate or be asked specifically by the on-site coordinator. Alternately, staff may nominate a fellow staff member, who then is asked by the on-site coordinator to participate. This team should include *all* disciplines and departments within the facility, including nursing (both supervisory and front-line staff), dietary, house-keeping, laundry, recreation, occupational therapy, physiotherapy, social work, family, administration and board members. Obviously, in a small rural setting, all of these disciplines (especially occupational therapy, physiotherapy, and social work) may not be part of the care team in the facility. However, it is important that each department, regardless of the size or number, be represented. These representatives are responsible for attending meetings and offering personal as well as professional perspectives. They are also responsible to communicate the outcomes to other members of their department.

2.1.1.3 Alzheimer Society Facilitator. Whenever a facility decides to implement the EC Program the Alzheimer Society of Canada commits one staff person to act as a facilitator. This

person is usually located in the regional Alzheimer Society closest to the facility. This individual is responsible for assisting the facility in carrying out the assessment, setting goals, and supporting the team as they implement their action plans. This person facilitates two meetings and continues to act as a resource to the group on an on-going basis.

2.1.2 The Program

Once the team has been confirmed, EC meetings can commence. The Alzheimer Society facilitator is present at the initial meeting to introduce the program to the team members. At this meeting each team member receives a binder that outlines the program. The goal of the first meeting is to assess the facility guided by the 11 Guidelines for Care. Each guideline has several questions and participants are asked to rate how well their facility is doing in that area. Successes are documented as well as areas for improvement. If the team is unable to complete the entire assessment on this first day they are expected to meet on their own to complete this task.

After several weeks, a second meeting with the Alzheimer Society facilitator is arranged. In this meeting team members develop short and long-term goals for each guideline that are specific, measurable, actionable, relevant, and timely. Next steps are discussed, such as who is responsible for each strategy. Finally, communication strategies are discussed so that those who did not attend the meetings remain informed. Ultimately, the aim of the program is to include as many staff members as possible in the goal setting. After this second meeting the facility is on its own, and is expected to continue to meet on an ongoing basis to determine subsequent goals. The EC Program will be further explained in following sections.

2.1.3 The Pilot Project

The Alzheimer Society of Canada conducted a pilot project of this program in 1998 in four institutions across four provinces. Subsequently, the EC Program has been initiated in over 150 long-term care facilities across Canada. To date there has only been one program evaluation, which examined the initial 1998 pilot study. The report discussed how the project was implemented at the pilot sites and identified ways to improve the project for future use. (44) All four pilot sites were urban, and three of these implemented the program in only one unit of the larger facility. One key recommendation from the evaluation of the pilot project was that "the Alzheimer Society of Canada should launch a more extensive project to allow for a long-term study of this Enhancing Care Project in order to refine materials, further develop protocols and begin the process of measuring success". (44, p.16) This study begins to address this recommendation.

2.2 Design

This study used a naturalistic approach. Evaluations using this method seek to understand the program in a holistic way. Naturalistic inquiry "involves observing ongoing programs as they unfold without attempting to control or manipulate the setting, situation, people, or data". (45, p.278) This approach has merit when the program is in the process of developing, innovating, or changing in an attempt to improve or adapt to different circumstances. (45) Since the EC Program had yet to be evaluated in a rural setting, this naturalistic approach seemed applicable. The second purpose of the study was to develop theory regarding organizational change as it unfolded during the program implementation. A naturalistic approach allowed for the development of theory as the program unfolded, without any manipulation by the researcher of the process of program implementation.

2.2.1 Process Evaluation

The purpose of this study was to conduct a process evaluation of the EC Program as it was implemented in two rural facilities in an attempt to inform ongoing program improvement that is sensitive to the specific needs of rural facilities. Toward this end a process evaluation was conducted. Process evaluation looks at the internal dynamics of a program, including the day-to-day operations, in order to understand its strengths and weaknesses. (46) The focus is on determining whether a program has all its parts, if the parts are functional, and if the program is operating as it was designed to operate. (45) Although it is important to know whether a program "worked" or not, this knowledge is not useful unless program planners know *what* worked, and why and how. As King et al. state, "Few evaluation reports pay enough attention to describing the processes of a program that helped participants achieve its outcomes". (47, p.9) Unless a program is operating as intended, there is little reason to expect it to achieve its goals. As Patton states,

> Process evaluations ask: What's happening and why? How do the parts of the program fit together? How do participants experience and perceive the program? … Process evaluations search for explanations of the successes, failures, and changes in a program. Under field conditions in the real world, people and unforeseen circumstances shape programs and modify initial plans in ways that are rarely trivial. (45, p.206)

To this point, the EC Program had been implemented primarily in specific units in large urban facilities where most often residents with dementia are clustered together. However, most rural Saskatchewan facilities do not have specialized units for residents with dementia. Rather, all residents are integrated in the facility. In the introduction of the EC Program manual, it states that "The Enhancing Care Project endeavors to provide implementation strategies for long-term care facilities.... The Guidelines for Care are general concepts that apply to all settings". (9, p.3) If this program is to fulfill its mandate and be successful in small rural nursing homes, it is vital

to understand how the program is implemented, and to document the successes and failures so that changes can be made to the program to address any shortcomings.

The results of program evaluations can be used in three distinct ways: to render a judgment, to facilitate program improvements, and/or to generate knowledge. (45) Judgment evaluations are used to explore accountability, improvement evaluations are helpful for ongoing development of programs, and knowledge-based evaluations attempt to answer questions of interest to the academic community. (48) These purposes are not mutually exclusive, but as Patton warns, one is likely to predominate, and it is important to acknowledge this. (45)

The current research was intended primarily to produce results that could be used by the Alzheimer Society of Canada to develop the EC Program further. Through the process evaluation recommendations were made that could impact future EC Program development. Thus, the predominant purpose of this study was to facilitate program improvements. At the conclusion of the evaluation, a detailed report will be sent to the Alzheimer Society of Canada. The program recommendations can be found in Appendix M. Through the evaluation, theory regarding the management of change in rural organizations was also developed.

2.2.2 Grounded Theory

The methodology that informed this study was grounded theory. Originally developed by Barney Glaser and Anselm Strauss, grounded theory "is based on the systematic generating of theory from data, that itself is systematically obtained from social research." (49, p.2) Researchers immerse themselves in the social environment that is to be studied and gather data through in-depth interviews and personal observations. Theory is developed as the data is continually analyzed and compared, with themes and sub-themes constantly being identified. As such, the researcher does not begin with a hypothesis to be tested but allows the data to influence

theory development. (49) Grounded theory is an inductive form of inquiry that seeks theoretical explanations for processes that are grounded in social context.

This study utilized the methodology outlined by grounded theorist Kathy Charmaz. Charmaz espouses a constructivist approach whereby the researcher is acknowledged as actively shaping the research and influencing the analysis of the data. (50) As Charmaz states,

> I treat grounded theory methods as constituting a craft that researchers practice. Like any craft, practitioners vary in their emphasis on one or another aspect but taken together share commonalities… (50, p.10)

In choosing the constructivist approach the researcher openly acknowledges her role in authoring a story of the experiences shared with the participants, and in creating meaning out of those shared experiences. (51) The constructivist grounded theorist strives to find meaning in the data that goes beyond the surface, searching for significance in the realms of values, beliefs and ideologies. (51)

2.2.3 The Role of the Researcher

The qualitative evaluator must acknowledge that in order to understand the people and the situation being studied, she must become somewhat immersed in the social context. (52) This is necessary to understand the depth and details of what is going on. Part of the research data includes direct quotations from people as well as descriptions of people, activities, and interactions. This requires interaction between those being interviewed and the one doing the interviewing. As Charmaz states,

> Grounded theory serves as a way to learn about the worlds we study and a method for developing theories to understand them. In the classic grounded theory works, Glaser and Strauss talk about discovering theory as emerging from the data separate from the scientific observer. Unlike their position, I assume that neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We *construct* our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices. (50, p.10)

As such, my background must be acknowledged, for it will influence how I perceive situations and the meanings I might unwittingly attribute to comments made to me. By profession, I am a nurse. I graduated in 1992 from the University of Manitoba. I worked in Winnipeg for seven years on a medical oncology ward. After that time, I moved to a small town in Saskatchewan where I have worked in a long-term care facility for the past eight years. As such, I have personal insight into the operations of a nursing home. However, I have no personal connections with staff or residents at either of the facilities participating in the study. Having lived for some time in both urban and rural settings, I appreciate the strengths of each location. My father-in-law was also diagnosed with Alzheimer Disease in 2005, and died in a long-term care facility in Saskatoon in 2007. Thus, I also have experience as a family member with a loved one who resided in a nursing home.

Using a naturalistic approach to this project, the aim was to allow the program to proceed as it would normally, with no attempt to influence the site, participants, or the process. I observed the EC teams numerous times over the course of seven months. During breaks and lunch hours, conversations were held and I got to know the team members personally. Although I tried to make it clear during the team meetings that I was only an observer, on several occasions I was asked for my perspective on some issue. I answered that I was not in a position to respond, but these instances made it clear to me that my presence was felt, regardless of how quiet or unobtrusive I might try to be. It is also my opinion that these groups may have taken this program more seriously than others might have because someone from the University was conducting a study. This is only speculation and the amount of influence my presence had on the process would be difficult to quantify.

2.2.4 Setting

The research was conducted in two rural long-term care facilities in Saskatchewan that have residents with dementia integrated within their total population. This is reflective of the majority of long-term care facilities in this province. An evaluation of the EC Program had not previously been done in this context. Two facilities were chosen in order to add depth to the understanding of how the program might be implemented in two different locations. They were both located in the same regional health authority in Saskatchewan. The facilities had comparable demographics, as Table 2.1 shows.

Table 2.1

Facility Demographics

Facility #1	Facility #2
Town population < 1000	Town population < 1000
Integrated healthcare facility:	Integrated healthcare facility:
Health clinic attached to facility	Health clinic attached to facility
35 residents	32 residents
21 full-time staff	12 full-time staff
24 part-time staff	26 part-time staff
Facility does not have a Special Care Unit	Facility does not have a Special Care Unit

These sites were chosen for two reasons. The first is that they met the criteria for the original NET research proposal. The sites had to be located in rural Saskatchewan, and have the residents with dementia integrated into the general population of the facility, which is reflective of the majority of rural nursing homes. Secondly, the facility manager, who originally had

responsibility for both of the research facilities, had participated in a grant application to the Health Quality Council that included several facilities wishing to implement a number of programs, including the EC Program. Dr. Morgan was made aware of this by one of the managers involved in writing the Health Quality Council grant application. Although the project was not funded, those involved were still interested in implementing the program.

Funding from the NET grant made it possible to cover some of the costs to the facilities when they implemented this program. The facilities were reimbursed for money spent on the program binders (which cost $30.00 each) and the facilitator's travel expenses. The facilities were not compensated for staff time to attend the meetings. The rationale for this was that the institution must take ownership for the program from the very beginning if it is to succeed, and a financial commitment assists towards this end.

2.2.5 Approval and Consent Process

This study was conducted in two facilities situated within the same health region in Saskatchewan. At the outset of the project, one facility manager had responsibilities for both institutions. After discussing the project via telephone with the facility manager, she wrote a letter of intent, outlining a commitment to the EC Program for both facilities. This letter of intent was forwarded to the manager of corporate research in the district where the facilities were located. Ethical approval for the project was granted by the University of Saskatchewan's Office of Research Services, Behavioural Research Ethics Committee (Appendix B). The letter indicating ethical approval from the University of Saskatchewan was forwarded to the manager of corporate research, at which time the district gave approval for the research to be conducted in the two facilities.

Written informed consent was obtained prior to conducting all interviews with study

participants. Different consent forms were used for the focus group interviews and the individual interviews. Copies of the consent forms can be found in Appendixes C and D. Study participants were asked to refrain from using the names of residents living in the facilities to respect resident confidentiality.

2.2.6 Participants

There are several principles that are clearly articulated in the EC Program. The program advocates a person-centered approach to caregiving that focuses on the individual with Alzheimer Disease and addresses his or her physical, emotional, social, and spiritual needs. It is important that everyone working within the institution work together to help the person with Alzheimer Disease remain as independent as possible, and feel connected to others. (9) It is clear that this program affects every discipline; thus an evaluation must attempt to gather information from as many of these sources as possible.

Participants for this study included several groups of people. Several members from the Alzheimer Societies of Canada and Saskatchewan were asked to participate. This took place early on in the process in order to obtain some background material to the EC Program. Toward this end, I interviewed a facility manager who had previously implemented the program in two rural long-term care facilities in Saskatchewan. Other participants included the facilitator from the Alzheimer Society of Saskatchewan, the facility managers from each facility (who also acted as on-site coordinators), members of the multi-disciplinary teams, and general staff from both facilities who were not part of the multi-disciplinary teams.

Grounded theory is based on theoretical sampling; participants are chosen intentionally as directed by evolving theoretical concepts. (49) New participants are selected until there is data saturation. This means that data are collected until no new information is obtained from the

participants. Toward this end, participants were chosen for this study from a variety of sources. When questions arose throughout the study, I actively sought participants to interview who could provide me with the information I required. At the outset, members from the Alzheimer Society of Canada were interviewed in order to provide background information regarding the EC Program. A facility manager was included in the study who had prior experience implementing the program in two rural Saskatchewan facilities. All individuals involved in the teams within the two study sites were included in the focus group interviews. General staff were included at the end of the study period. Both of the facility managers included in the study were interviewed individually to provide insights into their perceptions of the program as it was being implemented. Finally, the facilitator from the Alzheimer Society of Saskatchewan was interviewed.

At the conclusion of the observational period, I made the decision to conduct a focus group interview with each of the EC teams. Although it may have offered added insights to the research to interview each of the team members individually, it was not feasible to conduct lengthy interviews with each participant. The alternative became a focus group interview with each team that would allow all the voices to be heard and for the teams to be able to reflect the group process that had taken place because of the program.

Similarly, this program had implications for the general staff. However, it became clear early on that their knowledge of the program was quite limited. A focus group interview for this set of participants was not feasible due to scheduling challenges within the facilities. In small rural facilities, it is difficult to replace a large number of staff at one time due to lack of replacement workers. As an alternative I spent one day in each facility, where I interviewed the majority of staff on duty. Although these interviews only lasted 10 to 15 minutes each, I felt that

there was ample opportunity for these participants to share their thoughts of the EC Program. By the end of the day, I was not receiving any new information from this group of individuals, so did reach saturation with this population.

It is important to note that one participant in particular joined the program once it was already underway. Originally there was only one facility manager who divided her time between the two facilities. She was the primary contact early on in the project and had agreed to implement the program in both facilities. However, in the spring of 2006, the district hired another full-time manager for Facility #2. Therefore, as of May 2006, each facility had a full-time manager. The new manager agreed to continue on with the EC Program although she had not been present at the first team meeting with the Alzheimer Society facilitator. The implications of a change in management during the implementation of the program will be discussed in the findings. A list of those who participated in the individual interviews and in the focus group interviews can be viewed in Table 2.2.

Table 2.2

Interviewed Participants

Participants	Number
Alzheimer Society Staff	4
Facility Managers	3
Facility #1	
Focus Group	9
General Staff	11
Facility #2	
Focus Group	10
General Staff	10
Total Number Interviewed	47

2.2.7 Data Collection Techniques

In this study, data were collected utilizing several techniques over a period of seven months. An overview of the collection techniques and time-line can be seen in Appendix E.

2.2.7.1 Preliminary Telephone Conversations. At the outset of the project, it was important to include the Alzheimer Society of Saskatchewan because support from their staff was required to implement the EC Program. I contacted the Executive Director of the Alzheimer Society of Saskatchewan by telephone on September 16, 2005. She provided some background to the program from her perspective and offered the Society's support for the project.

The director indicated that the EC Program had been implemented in two rural facilities in central Saskatchewan. I contacted the facility manager who had responsibility for both

facilities and discussed the program with her via telephone. She offered insights into the program as well, from the perspective of someone who had been through the process on two occasions.

In order to better understand the background and history of the program, a conference call was arranged that included several staff members from the Alzheimer Societies of Canada and Saskatchewan. The EC Program is an initiative of the Alzheimer Society of Canada, and it was vital to include these stakeholders from the outset, in hopes that they might incorporate the research findings into future program development.

2.2.7.2 Observations. I observed the EC team meetings over a seven-month period, from April until October, 2006. I attended every team meeting in both facilities, and took extensive field notes at each meeting. Observations were made primarily of interactions that occurred between team members during the meetings, including informal exchanges and nonverbal communication that might not have been recorded during the meeting. Body language of the team members was noted, such as crossing of arms, or lack of eye contact while speaking. I also paid attention to the mood in the room, noting whether the team members seemed nervous or at ease during the meetings and how the mood changed through the course of the day. Within the process of implementing the EC Program, team members from both facilities arranged to have a general staff meeting to inform others about the program. I attended one of the general staff meetings, at which time notes were made of the conversation that occurred as well as of the general atmosphere of the meeting.

2.2.7.3 Focus Group Interviews. These occurred at the end of the observation period, once the teams were meeting on their own to set goals. The interviews were not conducted earlier in order to allow the implementation process to unfold naturally. One focus group

interview was conducted in each facility with members of the multi-disciplinary teams. These interviews were one hour in duration and were conducted using the general interview guide approach as outlined by Patton. (53) Issues were outlined prior to each interview, and were shaped by the observations made of the program while it was being implemented. The guide ensured that relevant topics were covered during the interview. However, as the discussion progressed, spontaneous questions were asked that related to the subject at hand. As Patton states, "A guide is essential in conducting focus group interviews for it keeps the interactions *focused* while allowing individual perspectives and experiences to emerge". (53, p. 344, Italics in the original). After written consent was obtained from team members, these focus group interviews were taped and later transcribed. Dr. Debra Morgan and Sandy Normand observed each of the focus group interviews.

2.2.7.4 Interviews. Two types of interviews took place. The first approach was to conduct one-hour interviews with several key players in the program. After the observation period was complete, the facility managers from both facilities were interviewed as well as the facilitator from the Alzheimer Society who had been a part of both teams. These interviews were conducted using the general interview guide approach, which provided some structure to keep the discussion focused on important issues while allowing the flexibility to follow up on questions of interest. Two of these interviews were conducted over the telephone and one in person. Extensive notes were taken during all of these interviews, which were not taped.

The second set of interviews took place with the general staff of both facilities. Focus group interviews were considered but logistically it was too difficult due to the challenges of finding replacement staff in a small facility for so many staff at one time. With the permission of the facility managers, a day was spent in each facility interviewing individual staff for

approximately 10 to 15 minutes, whenever they could fit it into their schedules. This approach ensured that virtually every staff member on duty that day was interviewed. A brief interview guide was used to ensure consistency across interviews. The guide included questions about their knowledge of the EC Program, how they had obtained that information, and their perceptions of the program as a whole. Written consent was obtained before each interview.

In November 2006, additional information was gathered through an informal meeting with a staff member from the Alzheimer Society of Manitoba who had facilitated the EC Program in several facilities in that province. This meeting occurred while attending the Alzheimer Society of Canada annual conference in Toronto, Ontario. Through this discussion knowledge was obtained of how the EC Program was being facilitated in other provinces. This discussion was not recorded but notes were made following the meeting.

2.2.8 Data Analysis

In this project the data analysis was conducted using a grounded theory approach. As its name implies, grounded theory is the discovery of theory from data. (54) The grounded theory method offers a rigorous, orderly guide to theory development. (49) The theory generated must meet several criteria: it must fit and have relevance, it must work, and it must be readily modifiable. *Fit* means that the categories of the theory must fit the data. They must be *relevant* to the action of the area, by allowing core problems and processes to emerge. *Work* means that a theory should be able to explain what happened, predict what will happen, and interpret what is happening. (49) *Modifiable* means that quick modifications to the theory can be made to help explain surprising or new variations in the data.

Towards these ends, theoretical sampling is done. As Glaser states, “Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly

collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges". (49, p.36) Codes are elicited from the raw data from the very beginning and are constantly compared with the new data as it is collected. These codes then determine the sources of further data collection. Codes are then continually developed with respect to their various properties and their connections with other codes until saturated. (49)

The EC Program was observed over the course of seven months. During that time, my duty was to allow the program to proceed as naturally as possible. Because of this, I had no control over how the program was conducted, what topics were chosen, or who was involved. I chose not to conduct interviews during this observational period for fear of influencing the program. As such, theoretical sampling, as described above, was modified to allow for the program to proceed as it was intended. To compensate, field notes were written after each meeting, documenting what areas I would like to cover when it came time to conduct interviews and focus group discussions. These interview questions were developed and revised as the program continued. The questions asked at these interviews stemmed directly from the notes taken after each meeting. Although no coding per se was done during the observational period, analysis occurred in the form of memo writing and interview question formation.

Once interviews were conducted and transcribed, open coding was performed. Every line of the transcripts was coded in at least one way. Theoretical coding allows the analyst to conceptualize the underlying patterns of a set of empirical indicators within the data. (49) Coding was conducted first line by line. After this was completed, coding was conducted meeting by meeting. For instance, the meeting where the facility assessment was conducted with the Alzheimer Society facilitator in Facility #1 was compared to the parallel meeting in Facility

#2. The EC team focus group interview from Facility #1 was compared with the parallel interview from Facility #2. Finally, coding was conducted facility by facility. That is, codes derived from field notes and interviews from Facility #1 were compared with the codes from Facility #2. At the conclusion of the open coding, a list of codes had emerged that described an element of every line in the transcripts. As Charmaz states,

> Initial codes help you to separate data into categories and to see processes. Line-by-line coding frees you from becoming so immersed in your respondents' worldviews that you accept them without question. Then you fail to look at your data critically and analytically. Being critical about your data does not necessarily mean being critical of your research participants. Instead, being critical forces asking yourself questions about your data. These questions help you to see actions and to identify significant processes. (50, p.51)

Once the open coding was completed, focused coding was conducted. Categories were developed that grouped the open codes together. Conceptual relationships between the categories were explored. Through this process, core categories began to develop in the data. Focused coding entailed deciding on which earlier codes categorized the data incisively and completely. Core categories account for the basic social process or problem that is central to the grounded theory. All other codes are considered only as they relate to the core categories. As such, initial codes were delimited to only those variables that related to the core variables in sufficiently significant ways to be used in a parsimonious theory. (49)

Once the core categories were determined, theoretical coding began. As Glaser states,

> …theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory. They, like substantive codes, are emergent; they weave the fractured story back together again. (49, p.72)

Thus, the theoretical codes specified relationships between the categories that were determined during the focused coding. By determining the conditions for and the consequences of the categories, the theory of the process of team building was constructed from the data. The

grounded theory that was created was evaluated by its context, its relationship to the data as a whole, and its ability to explain the social process that was at the heart of the study.

Throughout the data collection and analysis process, memo writing took place. Memo writing entails documenting the ideas that occur to the analyst regarding the relationships between the different codes. (49) Memo writing allowed me to capture new ideas and ways of relating the codes. Memos were written on paper, and later sorted as a way of formulating the theory. In this way, divergent data was put together in a structured way. By this sorting of ideas, a generalized, integrated model was developed which guided the writing of the theory.

In this project, I found the task of coding and developing theory very difficult. The project took place over the course of seven months. During that time I attended numerous day-long meetings in two facilities. This resulted in several hundred pages of transcripts which required coding. The initial open coding was quite straightforward, but required many hours to complete. Focused coding proved more complicated. It was difficult to group the codes into categories that encapsulated all the data. Numerous attempts were required to determine the core category or process that was central to the theory, and to relate all the subsequent categories to that process. Much of the difficulty was due to my lack of experience with coding, and the sheer amount of data that I needed to sort.

2.2.9 Trustworthiness

There are a number of activities that can be done by those engaging in qualitative research to increase the probability that credible findings will be produced. These are prolonged engagement, persistent observation, and triangulation. (55) *Prolonged engagement* means that sufficient time has been spent in the area of study to build trust and to understand the culture being studied. This study took place over the course of seven months. This allowed for time for

me to become acquainted with the staff, and to begin establishing rapport. *Persistent observations* were made over the course of this research. The facilities were visited on numerous occasions throughout the project, telephone conversations with the facility manager were on-going, and the interviews were conducted at several stages of the program implementation. Finally, *triangulation* was utilized incorporating multiple sources. Data were gathered through observations, individual interviews, and focus group interviews. Although I was the primary investigator throughout this project, at selected sessions two colleagues (Dr. Debra Morgan and Sandy Normand) accompanied me and assisted with the debriefing after the meetings. These debriefing sessions offered fresh insights into various aspects of the study. In addition, information was gathered from various groups of individuals, including management, program planners, the facilitator from the Alzheimer Society, and front line staff from the facilities.

The goal of this evaluation was that it be a useful tool. As such, it was written in such a way that extrapolation was possible. Extrapolations are modest speculations on how the findings of the evaluation could be applied to situations that are similar to those under study, but not identical. (45) The results, then, may have potential application for other rural long-term care facilities.

As explained earlier, this study had two main purposes. The first was to conduct a process evaluation of the EC Program as it was implemented in two facilities in rural Saskatchewan. The second purpose was to develop grounded theory regarding the management of organizational change within the facilities as they implemented a new program. In keeping with these two purposes, the findings from this study will be presented in the following two chapters. Chapter Three will outline the process evaluation of the EC Program while Chapter Four will describe the theory that developed throughout the project.

CHAPTER THREE
PROCESS EVALUATION

The two purposes of this study were to conduct a process evaluation of the EC Program and to develop theory relating to the implementation of a program in two rural long-term care facilities. A process evaluation looks at the internal dynamics of a program, focusing on whether a program has all its parts and if all the parts are functioning as they were intended. This chapter describes the evaluation process that occurred during this study. Each component of the program is reviewed, including the choosing of participants and the program materials. Recommendations are made at the end of each section in an attempt to inform program improvements that are sensitive to the unique needs of rural facilities. After the program evaluation is outlined, it is followed in Chapter Four by a description of the theory that I developed as a result of the evaluation. The first step in a process evaluation, then, is to identify the parts of the program that were observed and to evaluate whether they are indeed fulfilling their function.

3.1 EC Program Participants

The EC Program involves many participants from the facility as well as a facilitator from the Alzheimer Society. The goal of the program is to have a representative from each department present at the team meetings, as well as an on-site coordinator who acts as liaison between the facility and the Alzheimer Society. Part of the program entails finding individuals who are willing to participate in the program. Each group or individual involved will be discussed.

3.1.1 Alzheimer Society Facilitator

At the outset of this program, it is imperative that someone from the Alzheimer Society

agrees to act as the facilitator. In the case of this project, the provincial Alzheimer Society office in Regina was contacted in October, 2005. Support for the project was immediate, and a worker assigned from a regional office. From this time, it was a matter of coordinating the facilitator's schedule with the time frame desired by the facilities for implementing the program. This seemed to work well. In discussion with the facilitator after the project was completed, a few areas of concern became apparent. The primary concern voiced was the nature of the facilitator training she had received from the national organization, stating that it didn't adequately prepare facilitators for the challenges that arise during the actual implementation of the program. In her words, "I'm flying by the seat of my pants."

During an informal discussion with a facilitator from the Alzheimer Society of Manitoba it became evident that there are significant differences in how the EC Program is being implemented across the country. During this conversation, the Manitoba facilitator commented that she relies to a great extent on the training she has received previously to assist her when facilitating the EC Program. This sentiment was echoed by the facilitator from the current project. During the implementation of the EC Program, the primary role of the facilitator is to guide the team members through the process. In this project, this guidance was done well. Every team member voiced an appreciation for the skills of the facilitator, particularly in navigating through the program.

> I thought [the facilitator] did an amazing job and was keeping everybody on track, and keeping everything going. I think she was really interesting.

The facilitator herself felt that the EC Program could succeed only if the facilitation was done well. She stated, "Success [of the program] is in the facilitator and how the first day goes. It's a big responsibility." However, the facilitator commented that the facilitator training for the program had been inadequate to prepare her for the responsibility of leading the team members

through the process. Those facilitating the EC Program need to have knowledge of group process, facilitation techniques, goal setting strategies, the background to the EC Program, and dementia care within long-term care facilities. This makes the facilitator role complex, incorporating many skills. Although observing the facilitator training was not part of this project, the conversations with the facilitator in the project suggest that the facilitator training as it now stands needs to be revisited. (See Appendix M for a complete list of recommendations.)

<u>Recommendation</u>. That the Facilitator Training sessions be reviewed by the EC Program Coordinator at the Alzheimer Society of Canada to ensure facilitators are trained in group process, facilitation techniques, goal setting strategies, and dementia care in long-term care facilities.

3.1.2 On-site Coordinator

The EC Program binder states the on-site coordinator does not necessarily need to be the manager from the facility, although both facility managers in this project functioned as the on-site coordinator. In small rural facilities, this is not surprising, given the small number of overall staff. The role of the on-site coordinator is to coordinate the meetings within the facility as well as act as liaison with the Alzheimer Society facilitator from the regional office. With the facility managers both acting as the on-site coordinators, the scheduling of meetings was done effectively and efficiently with the assistance of the administrative assistants in charge of scheduling. However, the role of liaison was not as effective. Communication between the Alzheimer Society facilitator and the on-site coordinators was lacking. Although it was clearly outlined that the facilities could contact the facilitator at any time, this was not done at any point in the program.

The communication deficit was especially made apparent in Facility #2 where the facility

manager was hired after the EC Program had begun.

> If I want to be very honest about this, I felt totally abandoned. This was dumped on my plate. I took the book home. I read the book. I studied the book. I'm supposed to take over this role and I've got absolutely no help. It was always there that we could phone or call them, but phone or call them for what? Because you don't know what the expectation is. I did not know what the end result is or the goal. So you kind of think, we'll take this piece by piece and we'll all work through this together. And I think that has worked, but not with the assistance of the Alzheimer Association.

Had there been a clearly articulated process for communication between the facilitator and the on-site coordinators, this feeling of abandonment might have been avoided. Particularly in Facility #2, the on-site coordinator was unsure of her role, and did not understand what was expected of her in relation to the facilitation of the program. The process of assessment and goal setting was unclear to her, and thus she was unable to determine whether the group was proceeding through the program as it was intended. The way it was stated in the program material, the onus was on the facility to contact the Alzheimer Society when issues arose. In both facilities, this communication was not initiated by the on-site coordinators other than to arrange dates for meetings. Since the program cannot succeed without the support of the management, it is important to outline clear communication strategies up front.

<u>Recommendation</u>. That the Alzheimer Society facilitators initiate communication with on-site coordinators at regular intervals before and during the implementation of the EC Program.

3.1.3 Multi-disciplinary Team

The goal of the EC Program is to have representation from every department. In both facilities, the recruitment was done by the facility manager, who asked for volunteers and/or asked specific individuals personally. Although there was some disappointment by a few staff members for not being asked to be on the team, in general these methods were accepted by the

team and general staff members. Most felt that they had been informed of the opportunity and could have chosen to participate if they had wanted. If this wasn't the case, staff members understood the rationale for having a certain person participate (usually the head of the department or a full-time staff member). Because these rural facilities are so small, it is vital that the on-site coordinator communicate to all staff members the methods for choosing team participants. This was done successfully in these facilities.

3.2 EC Program Materials

At the first team meeting, each member is given a binder that was developed by the Alzheimer Society of Canada that outlines the Guidelines for Care as well as the process for evaluating the facility and setting goals. This binder provides the roadmap for the program, and as such, is a vital communication tool. The purpose of the binder is to assist team members in navigating the EC Program during the meetings, and to provide the information necessary for the continuation of the program after the Alzheimer Society facilitator is no longer there to guide the group. The binder is the only source of information about the program given to participants, other than what may be offered by the Alzheimer Society facilitator during meetings.

During the interviews, the team members did not have anything negative to say regarding the binder. The Alzheimer Society facilitator, on the other hand, found elements of the binder frustrating. Some of the frustrations felt by the team members at various points throughout the process may have been averted had the binder provided more guidance to them. In this section, some suggestions will be made that might make the binder more user-friendly for rural facilities.

3.2.1 Wording

For any communication tool to be effective, it must use wording that is clear to the reader. There were numerous times throughout the program where team members debated the

meaning of the wording present in the binder. Although at points this led to productive conversations, the debates did take time away from the process. These debates could have been shortened or even eliminated had the language been clearer. Many team members would not have had previous experience to draw from other than the facility where they currently work. Please see Appendix I for a complete list of terms that were unclear to the team members.

One example is in the section where Specialized Human Resources are assessed. In the introduction to the section, there is one short paragraph that explains alternate models of care that best meet the needs of residents with Alzheimer Disease. In this paragraph, *generic staffing* is mentioned, as well as *cross-training staff*, both in the course of two sentences. Both facilities in this study had questions as to what these terms meant. Most of the team members had never heard of these terms, nor had they ever experienced other models for care other than the one in their facility.

Further on the page, it states that one of the objectives for facilities is that "Cross-training or generic staffing should be implemented" (9, p 58). When misconceptions are present around the meaning of both concepts, the objective to implement them becomes impossible. In addition, the conversion from the present model of care in these facilities to either generic or cross-trained staffing is a huge undertaking for both management and staff. In order to implement generic staffing for instance, all present staff members would need to be trained in areas such as housekeeping, activities, and care so that every worker could do a combination of tasks throughout the day. It would include retraining for all staff as well as the remaking of staff schedules. Although the benefits to this conversion might be substantial, two sentences are insufficient to do justice to the concepts or explain their potential rewards.

In many other cases where wording causes confusion, it is a matter of defining terms.

One example is the word *clutter*, a word that was easily understood, but could be applied in a variety of ways. This word was found in the section on Supportive Physical Design. What one team member might view as clutter, another might see as vital equipment. However, the EC binder is meant to be a useful tool for all team members and must be understood by all. Changes to the wording that would reduce the chances of misunderstanding could have benefits to the efficiency of the process. In one instance the wording caused confusion not because of the words, but because the words were put under one category. In the Assessing Supportive Physical Design section, the team members are required to rate whether "Equipment and hazardous materials are locked away". (9, p 68) Team members were clear as to the meaning of the words, but felt that *equipment* and *hazardous materials* were two different subjects, and should be rated individually, and not as one. Again, this wording caused some confusion as to how it should then be assessed.

Recommendation. That the wording throughout the binder be revised to make all terms clear and unambiguous.

3.2.2 Assessment Process

The first task for team members in the EC Program is to assess their facility using the 11 Guidelines for Care. These guidelines are listed in Appendix A. This entails reading a short introduction to each guideline, then answering numerous questions using a rating system. In both facilities, the Alzheimer Society facilitator took on the role of deciding the order in which the guidelines were assessed. Although she did ask for suggestions from team members at times, they usually accepted whatever suggestion the facilitator made. The facilitator chose guidelines in no particular order, randomly moving from guideline to guideline. Once the guideline was chosen, team members took turns reading the introduction, and then they rated their facility by

answering the questions provided.

3.2.2.1 Rating System. After each question was read team members rated the item on a scale from 1 to 5, 1 being "Almost Never" to 5 being "Almost Always". Each team member was required to first write their rating in their binder and then share this with the group. All the numbers were tallied. If this number was above the pre-determined average for the group, it indicated that the facility was faring well in this area, and no action was required. If, however, the tallied score was below the pre-determined average, the item required further discussion, and was put on the "needs" pile.

One area of uncertainty arose when certain team members were unaware that a particular action occurred at the facility. This was very apparent when it came time to assess the categories of Individualized Assessment and Individualized Care Planning. In both facilities, only those involved in direct care (nursing and special care aides) were aware that residents were individually assessed and that individual care plans were derived from these assessments. Other auxiliary departments, such as laundry and housekeeping, were uncertain what other departments did in these areas. When it came time to rate how well the facility did in these areas, the auxiliary departments were at a disadvantage. Since there was no "I don't know" category, team members were instructed to rate these items as a 1, "Almost Never". However, this did not reflect accurately on whether the activity was being done, only on whether the team member was aware of it or not. These are two different issues. In addition, some of the team members rating "1" due to lack of knowledge felt badly that they knew so little in the area.

> *Interviewer:* How did you feel about that when you had to write the '1' down?
> *Participant:* Like you know nothing!! (Laughter). Like you aren't part of the team.

Some team members also felt that when they rated an item '1' due to lack of knowledge, this had implications for whether it required further action or not.

> We found it hard to answer some of them because we didn't know, and that's why we ended up, you know, putting '1', and it sort of gave it a false indication.

<u>Recommendation</u>. That the rating system be modified to include an "I don't know" category.

3.2.2.2 Number of Questions. As part of the assessment process, team members were required to rate their facility in 11 areas, each having numerous questions. In total, team members responded to a total of 151 questions. That is, they were required to provide a rating 151 times in the course of the assessment process. The Alzheimer Society facilitator chose to go around the circle each time to elicit a number from each team member. Although this ensured that everyone had a voice in the process, it was time consuming. Neither of the participating facilities was able to complete the assessment in one day. Each required a second day on their own to assess the remaining guidelines.

At the first meeting Facility #1 was able to assess five of the Guidelines for Care, answering a total of 92 questions. This was with the assistance of the Alzheimer Society facilitator. Since they were unable to assess all 11 guidelines, the team members met a month later without the facilitator, where they assessed six of the Guidelines for Care, and answered the remaining 59 questions. Facility #2 had a comparable experience. On the first day, six Guidelines for Care were assessed, and 104 questions answered with the assistance of the facilitator. A month later at the second meeting the remaining five Guidelines for Care were assessed without the facilitator and 47 questions answered. In both facilities, when it came time to continue with the facility assessment without the facilitator present, there was confusion as to which guidelines had already been covered, and how to proceed independently.

In both cases, facilities spent eight to nine hours of paid staff time to complete the facility assessment. This is a long time to produce ratings. The Alzheimer Society facilitator mentioned

that after a few hours of doing the assessment, some of the team members would "just throw answers out because they were getting tired." Although the team members did not state in the focus group interview anything negative about the number of questions in the assessment, the facilitator observed that the team members became less focused as the day progressed.

In discussion with the Alzheimer Society facilitator from Manitoba, she stated that the facilities where she had been, they were able to complete the assessment in four hours, half the time it took the teams I studied. She stated that rather than having every team member write down individual answers for each question, she verbalized each rating number after reading the question and asked members to raise their hands when they agreed with a rating. If there was general agreement, the rating was recorded. If there was a great discrepancy, then discussion was encouraged to find the source of the discrepancy. Discussion either resulted in general consensus, or the item was placed on the "needs" pile for future consideration. In many cases, the team members were in general agreement of the rating and no discussion was required. In this way, the team members were able to move quickly through the questions. The facilitator also mentioned that she made every attempt to group questions into categories so that more than one question could be rated at the same time. By doing this the assessment process was most often completed in the allotted three to four hours that is stated in the EC binder. (9) This speaks again to the need for consistent facilitator training across the country.

<u>Recommendation</u>. That the Facilitator Training be modified to make it possible that the assessment component be completed in one session.

<u>Recommendation</u>. That the assessment questions requiring a rating be reduced in number.

3.2.2.3 Binder Tabs. In total, there are 11 Guidelines for Care. In the binder, almost all of the guidelines have a tab at the side indicating where that section begins. It is an easy way of

accessing these sections. However, the final two Guidelines for Care, Transportation and Prevention of and Response to Abuse are put together under the tab of *Other Considerations*. This was the source of confusion for both facilities, and one of the guidelines was almost missed both times. Fortunately there was a team member in each group who noticed this and both guidelines were assessed. In one instance, post-it notes were circulated so that team members could make another tab.

Recommendation. That each of the 11 Guidelines for Care has its own separate tab in the binder.

3.2.2.4 Recorder. In the binder it states that "A recorder will be needed to document the final decisions of the assessment and record successes and needs". (9, p.8). Although this was alluded to at both assessment meetings with the facilitator, it was not done formally, and was left to individual team members to make their own notes. As a result, an accurate record of the day was not made, and caused some challenges when it came time to go to the next stage of goal setting.

Recommendation. That a person be explicitly named as the recorder for the meetings by the on-site coordinator or the facilitator. This will ensure that detailed notes are taken at each meeting and minutes distributed to each team member after the meeting.

3.2.3 Goal Setting

Once the assessment was completed, team members looked at the items in the "needs" pile, and determined goals that would address those needs. The facility was expected to set goals on an ongoing basis, even after the Alzheimer Society facilitator had completed the second meeting. Whereas the assessment process was relatively straightforward, the setting of goals proved more complicated, and several concerns were voiced by team members.

3.2.3.1 Setting Priorities. The facilitator from the Alzheimer Society was present for the first assessment meeting in each facility. The teams met independently for the second assessment meetings. After several weeks the facilitator then returned for the first goal setting meeting in each location. Since there had been no official recorder for the assessment meetings, the goal setting meetings in both facilities began with some confusion on the part of the facilitator and the team members. This confusion was compounded in Facility #1 by the fact that the person whose notes the facilitator had borrowed wasn't present at the meeting and the handwriting was difficult to decipher. In addition, seven weeks had transpired between the two meetings where the facilitator was present, and thus the facilitator had difficulty recalling what had been discussed at the first meeting. The team members had also met once in between without the facilitator to complete the assessment, and naturally the facilitator had no knowledge of what occurred at that meeting.

At the first goal setting meeting, considerable time was spent trying to find a "place to start". The facilitator made it clear that the first goal should be straightforward and be guaranteed to succeed so that the group would have an early success. However, since no one had a comprehensive list of the "needs" that had arisen from the assessment, and no one had prioritized those needs, setting the first goal proved a daunting task. Had there been an official recorder of the assessment meetings, much of this confusion could have been eliminated.

Distributing the minutes from the assessment meetings to all team members could be the first step in prioritizing the needs of the facility. It might have been helpful had those needs been listed in the order of importance to the facility. This would have allowed the facilitator to step into the process with a game plan in place, and time would not have been sacrificed trying to determine where to begin. It should be noted that after the initial goal setting meeting with the

facilitator, the facility manager from Facility #1 did collate the list of successes and needs for each of the guidelines and distributed them to all team members. This list was used as a starting point for the group when they met on their own to set goals.

<u>Recommendation</u>. That the recorder take minutes of the assessment meetings, including successes and needs, and distribute them to all team members and the facilitator prior to the goal setting meeting.

<u>Recommendation</u>. That at the end of the assessment meeting, a small committee be struck that would review the needs of the facility, and give them the authority to prioritize them.

3.2.3.2 SMART Principles. The EC Program recommends using the 'SMART' principles to evaluate goals (See Appendix K for more information). Once a potential goal was identified, team members were to assess whether the goal met these criteria: Was the goal **S**pecific, **M**easurable, **A**ctionable, **R**elevant, and **T**imely? The Alzheimer Society facilitator referred to these principles throughout the goal setting day that she spent at each facility. When the facilities were working on their own, they did not consistently refer to the principles when discussing new goals. It could be argued that since they were referred to repeatedly in the program, team members began to internalize the principles and did not need to refer to them each time. When asked about the SMART principles, this is what the team members said.

> The basics are in this tool [of the SMART principles]. The basics are very good.
>
> Because if you don't set a realistic goal, you can't work your way through it. Kind of, that's why you get caught up, then you think, we have to change our goal. So we can get the right steps [with the SMART principles].
>
> I think for most of us [the SMART principles] were back here [pointing to her head] because we knew it had to have action, it had to have measure, it had to have a goal, a timeframe. It was good.

One of the facility managers felt that the SMART principles were useful, but she might not have

chosen to use them had she been the facilitator for the meetings. She was also someone who had considerable experience in group facilitation and likely had other tools that she preferred.

3.2.3.3 Wording. During the goal setting meetings, wording came up as an issue. Once the list of needs has been compiled, team members were required to choose a need to be worked on, determine a goal that would address that need, and then identify specific steps or tasks that would ensure that the goal was met. During the goal setting meeting with the facilitator, it was made very clear that one need might require several goals. This chain of events was difficult for some team members to understand. Thrown into the mix was the use of the words "issue" and "objective" in the introduction to each guideline. This caused confusion several times throughout the process. While the facilitator was present, she was able to assist the group to differentiate between all the wording and stay on track, but when working on their own, both teams struggled to keep the wording clear. Team members experienced frustration with the process, as these quotes attest.

> You didn't know whether you were upside down, turned around, if you were doing [the goal setting] right. You could second guess it, you could go back over it and change it again, and still you didn't know if that was right… it was really difficult. We needed more than one goal [setting meeting] with her on sorting out the goals and how to achieve it. It took us a long time.
>
> I think, once we established what our goals were, what you know, we struggled with the whole "what's a goal" but I mean once we got on track as to what we were aiming towards, I think we did a lot better. I think it took us a while to sort of feel our way through what we were trying to do.
>
> I think it took us a while to struggle through what we'd looked at and perceived as a goal vs. an objective. You know like, it was kind of grey.

<u>Recommendation</u>. That a sheet be provided that clearly and simply outlines the process of goal setting, providing definitions and examples of each stage in goal setting (issue, guidelines, objective, need, goal, task).

3.2.3.4 Group Process. When the groups were struggling, it was the facility managers who usually took a leadership role in guiding them through the issues. Both facility managers later stated that they had to draw on previous experience in group work to make the EC process work. One element that is lacking in the EC Program is the development of group process skills. It cannot be assumed that everyone at the table is experienced with group process or problem solving. It would have been beneficial for more time to be spent articulating group process at the outset. Although it could be argued that team building will occur as a result of the EC Program, some preparation during the introduction could have been beneficial.

<u>Recommendation</u>. That some group work exercises be added to the introductory section of the assessment meeting that include an overview of group process as well as problem solving strategies.

3.2.3.5 Time. The result of the confusion with the wording was that it took considerable time for the groups to determine actual goals that addressed the needs. Even with the facilitator present, determining goals was a challenge. At the end of a five-hour day, Facility #1 had only addressed one need, for which they had identified two goals. In Facility #2, one need was addressed with three accompanying goals. Given the scope of the assessment, there were potentially 151 needs that might have been identified, and these groups addressed only one throughout the day. This rate of goal setting may not be adequate incentive for these groups to stay involved in the process over the long term.

> I didn't realize [the goal setting] was going to take *this* much time because when we first sat down, it took us forever and a day to figure out how we're going to have the first staff meeting.
>
> *Four hours* to fix one little problem. And we've got many.
>
> Why did it have to be so hard? [Those who developed the binder] didn't *have* to make it that hard. That wasn't the test, for the endurance, as to whether your mind could take four

hours of this …

The rate for setting goals was duplicated when the groups met independently. Facility #1 continued on with the first need that was identified in the first meeting, and determined five additional goals. Facility #2 tackled one new need, and determined three goals in the course of a day. When meeting on their own, groups were concerned whether they were proceeding as the program was intended. It may have been beneficial for the groups to have set more goals during the initial goal setting meeting with the facilitator. This would have allowed the groups to gain additional experience with goal setting, while having the facilitator present as a resource, should questions arise.

> We were all concerned whether we were doing it right or not. You were always second guessing, where do we go from here?

<u>Recommendation</u>. That several goals be set at the initial meeting with the facilitator so that groups feel confident about the process when they meet independently.

3.2.3.6 Examples. Another frustration with the process was the perceived lack of examples provided in the binder for each guideline. Although the facilitator mentioned in passing that there were some examples in the binder, they were not examined in the course of the goal setting meetings. When on their own the team members did not refer to them either. Yet, during the focus group interviews several team members stated that it would have been helpful to have examples to follow, or to at least give them some ideas that could be adapted to the specific needs of their facility.

> Samples are wonderful, they really are. Because I think we came out of a few of these now, feeling four hours, we spent *four hours* where we got one thing done. None of us have that kind of time to lose, when you could have given us a sample, and we could have looked, oh yah, we can apply this. Now if we do this, this and this… Like I said, I don't believe in reinventing the wheel. I don't think it has to be dragged out of each one of us.

> Like we knew what our needs were. We knew what needed to be fixed. Give us some tools

to fix it that are easy to use. We'll change it to fit our facility.

Every guideline has at least one example listed at the end of the section along with a list of resources. In addition, some guidelines include sample Care Plans, for example, or other tools that could be used to address needs that might arise from that particular guideline. However, the examples and tools provided in the binder were not actively used in the initial meetings with the facilitator. Had this been done at least once during the first goal setting meeting, team members may have felt more confident using these resources themselves.

In addition, the placement of these examples and resources is at the very end of each section in the binder. This is unfortunate. Before the examples are given there are numerous EC Program worksheets placed in the binder, including "Current Successes and Future Needs", "The SMART Principle", "Goal Setting" for each guideline, and "Goal Worksheet Update", which is to be completed at six and 12 months. These worksheets are present in every section, and are redundant. A more user-friendly approach might be to have a section dedicated to the worksheets, thus eliminating the redundancy, and have the examples and resources placed directly after the assessment questions. This would make the resources a natural extension of the process. Team members would also be more likely to look at the resources, since they would be conveniently placed in the binder.

Recommendation. That a section in the EC binder be added specifically for the worksheets (allowing them to be photocopied as needed) and place the examples and resources directly after the assessment for each guideline.

3.2.3.7 Timing of Meetings. The timing of the meetings was an issue for some of the participants. During the focus group interviews, several team members voiced frustration over the length of time between the meetings. They felt that they lost momentum when too much

time elapsed. As the dates in Appendix F show, the minimum amount of time between meetings was three and a half weeks, while the greatest amount of time between meetings (in Facility #2) was 13 weeks. In both facilities, the time between meetings with the Alzheimer Society facilitator present was seven weeks. This is what some of the team members had to say about this issue.

> The meetings weren't soon enough. There was almost too long in between. We lost what we were working on.

> I think if you kind of run [the meetings] a little closer together it would be more helpful.

<u>Recommendation</u>. That the assessment meeting and the goal setting meeting be scheduled as closely together as possible to ensure that momentum is maintained.

3.2.3.8 Terminology. At the top of every printed page there are the words "Do Not Copy". This was noticed by all team members. Yet, there were times when team members were required to write on the pages within the binder, and especially during the goal setting sessions, there were simply not enough of these pages provided in the binder. This necessitated that the page be photocopied many times, despite the instructions at the top not to do so. The instruction to "Not Copy" was likely to prevent facilities from purchasing only one binder and photocopying it for the team members. Since the program cannot function without the presence of a representative from the Alzheimer Society, this problem can easily be monitored and dealt with by the representative.

On page nine of the binder, in the Instruction section, mention is made of "Support to the Pilot Sites". (9) This does not apply to current users of the binder, and should be changed to reflect the target users of the program.

<u>Recommendation</u>. That the "Do Not Copy" phrase be removed from the binder. Change wording to reflect targeted users of the binder.

3.2.4 Communication

An integral component of the EC Program is developing communication strategies. Although communication is mentioned throughout the EC binder, and was mentioned by the facilitator, there were times when communication was lacking. This communication refers to two areas, that of communicating the process that is the EC Program, and the communication between the stakeholders within the program. Each will be discussed in turn.

3.2.4.1 Instructions. At the first meeting, the team members were given the EC binder. With the assistance of the Alzheimer Society facilitator, the team members were introduced to the different components within the binder. However, the intent of the program is that it is ongoing. When it came time for the team members to meet independently, several weeks or months had elapsed since the meeting with the Alzheimer Society facilitator. Many team members had questions as to how they were to proceed with the program on their own. The instructions in the binder are very limited in this respect, and do not offer clear direction for the teams. The EC binder was not viewed by team members as a helpful resource with respect to group process and how to conduct meetings. Some of the contributing factors have been mentioned above, but the main difficulty is in the lack of instructions at a number of levels.

3.2.4.2 Facilitator. The facilitator in this project was frustrated with the outline of the binder, and felt that it did not offer practical guidance in leading a group through the EC Program. She stated that in addition to better facilitator training there could be better instructions for the facilitator with regards to how to facilitate the process. She felt that the program needed to "be pared down" to make it more manageable. She found it frustrating as well when team members were asked to rate items that had no knowledge of, yet there was no room in the rating system to answer "I don't know". However, caution would be needed when revisiting how the

process is explained in the binder, since the needs of the facilitator might differ from those of the team members in general.

In this research, it became very evident that for information to be truly learned, there had to be a core amount of information taught, and there had to be a secondary source that could be accessed at a later date. For instance, once the facilitator training has been revamped to better meet the learning needs of the facilitators, it might be beneficial to have a binder that facilitators could reference when questions arose during the implementation of the program.

Recommendation. That the creation of a separate manual for facilitators be created that would assist them in guiding groups through the EC Program.

The facilitator also voiced some frustration with the communication between herself and the Alzheimer Society of Canada. The EC Program is a national program, yet at the time of this research, there was no staff person in the head office who was in charge of the program. Thus, when the facilitator had questions, there was no one in authority to provide guidance. As of November 2006, there is a person in the position. Although this project does not assess the communication between the different Alzheimer Societies, it is important to note that communication between facilitators of the EC Program and the Alzheimer Society of Canada plays a role in the success or failure of the program at the local level.

3.2.4.3 Team Members. All team members who were part of this project felt that they were inadequately prepared to engage in the EC Program at the very start. This included both facility managers, particularly the manager from Facility #2 who started her job after the program had been initiated. Other than some initial contacts with the Alzheimer Society facilitator to arrange dates, there was little communication between facility managers and the facilitator. In addition, there was no resource sent to the facilities to educate them about what

would occur once the program began.

As part of the program, it was the responsibility of the on-site coordinator (or in these cases the facility manager) to find staff willing to participate in the EC Program. Other than a short paragraph introducing the program, these individuals knew virtually nothing about the EC Program. After the team members were in place, EC binders were ordered. The first time that team members saw the binder was on the first day of the assessment meeting with the facilitator. These are some quotes from the participants regarding the first day of assessment and seeing the binder.

> And before, not to give out the binders or nothing ahead of time, like we were given NO information. You just go in cold turkey.
>
> *Interviewer:* At that point (the first meeting), what did you know about the program?
> *Participant:* Absolutely nothing.
>
> I didn't figure out what was going on until we struggled our way through that problem solving as to how to do the goal setting, and even the first one of those was [difficult]."

Some of the team members went so far as to say that there was an element of "secrecy" surrounding the program.

> I was going away, and I asked if I could take [the EC binder] with me, and I was told NO. You cannot. Because I wanted to be prepared for the next [meeting] when I came back.
>
> I couldn't make sense of the secrecy of the binder, quite frankly. I was leaving the country. What was I going to do with it? …Anything I've ever done, any committees I've ever sat on I've always had information and a pre-exercise to do or had some insight before I went into that room. If we would have a chance to take this home and read it a little bit instead all of all just coming sitting down at a binder at the table. You know, and seeing it for the first time.
>
> Even if they don't want to give out the binder, I don't know if it's a big secret or what it is at least let me have one of those handouts! So people know what they're getting into, ahead of time… What they're committing to.

The team members in these facilities would have appreciated more information about the program before the initial assessment meeting. They did not feel that they were adequately

prepared or that they knew what was expected of them prior to the assessment meeting. This sense of inadequacy could have been avoided by offering more information as the team was being organized.

<u>Recommendation</u>. That some recruitment information be developed for potential team members outlining the EC Program, the Guidelines for Care, and the responsibilities team members are expected to undertake.

Another form of communication that might be useful is the development of a pre-workshop. This workshop could be conducted by the facilitator as a way of introducing herself to the staff, as well as a method of providing more information about the EC Program to the team members as well as the general staff. Armed with understanding of the program, the general staff may be more inclined to support initiatives chosen by the team members at a later date. Ideally this workshop would be conducted in person. In addition, this would be a venue to review the process that team members will experience with EC so they are prepared for the first meeting.

<u>Recommendation</u>. That a pre-workshop be created for team members and general staff of facilities that have agreed to implement the EC Program.

Tied in with the need for more general information for potential team members is the lack of instructions in the binder itself. The goal of the program is for facilities to be able to conduct the goal setting meetings independently once the facilitator has left. The reality in small rural facilities is that several months may transpire between these meetings, and much can be forgotten in this time, regardless of how well the facilitator conducted the initial meetings. A "contingency plan" would act as a resource for team members wanting to review the process as it was intended. In addition, a clearly articulated process would assist those members who may

have missed a meeting to familiarize themselves with what to expect during the meetings.

This "contingency plan" could take various forms. One necessity has already been mentioned, that of revamping the instructions in the binder to make them more user-friendly. Another option would be to have a booklet that contains the Guidelines for Care, sample assessment questions, the SMART principles, an example of a need that is broken down into goals and tasks, and some guidelines for differentiating a goal from an objective. The options are truly endless, especially in the technological age that now exists. A PowerPoint presentation could be designed that guides participants through the steps in the process. Promotional materials could be provided on-line or on a CD to participating facilities. The Alzheimer Society web-site could offer practical solutions to common needs that arise in facilities implementing the program.

The purpose of this program is to assist facilities in enhancing the care they provide for residents with dementia. Anything that can make the program easy to use can only help facilities to stay on task, and continue on with the program. Ideally this program should be set up so that anyone could pick up the binder and feel that they would be able to participate meaningfully in the program. A resource with clear and simple instructions could also be helpful when the original team members are trying to recruit other staff members to participate in the program. Such a resource would ensure that the information being given to staff members was consistent and accurate.

<u>Recommendation</u>. That a "how-to" resource be provided that gives a condensed version of the program that team members and general staff can refer to before and during the program.

3.2.4.4 Group Competency. Both facilities felt unsure of themselves when they were

required to continue with the process of EC on their own. This was particularly evident in Facility #2 where more time elapsed between meetings.

> Do other people struggle like we struggled? It was horrible.
>
> We were floundering. Nobody really knew what was going on.
>
> *Interviewer:* When you were doing it on your own, what were you thinking when you walked in the room and there was no facilitator there?
> *Participant:* Sink or swim.

When asked what would have made the process easier for them, several team members stated that having the facilitator present for more meetings would have been helpful.

> [The facilitator] should have been there to get us through a couple times of it so we could have been more confident, that we were doing it right, or at least on track …
>
> [We needed] a little more guidance for the longer term.
>
> It would have been very beneficial to have the facilitator here at least for the first of [the new facility manager's] meetings.

Having the facilitator attend more of the EC team meetings may have been beneficial and may deserve some consideration for future program development. However, had team members been given more resources in the binder, and had the initial communication with the facilitator been stronger, team members may not have felt the need to have more contact with the facilitator over time. If the following were already in place, it is possible that the team members would not have felt the need to have the facilitator present for additional meetings:

- A facilitator who had received training in group process and understood how the EC Program was intended to be implemented
- More preparatory communication between the facilitator and the on-site coordinator
- A preparatory resource that was available to team members before the program was formally initiated, and could be used throughout the program

- Clear instructions in the binder
- Meetings that were closer together

Even with all these in place, it is worth considering ongoing contact between the facilitator and the on-site coordinator. As it is now outlined in the binder on page nine, the onus is on the facility conducting the EC Program to contact the Alzheimer Society if needed. (9, p.9) Facility #2 stated that a more formal follow-up process with the facilitator would have been appreciated.

> It would be helpful for [the facilitator] to make a return visit after we've been doing it on our own for a while. Just to make sure we are doing it right.
>
> There wasn't appropriate follow-up [from the Alzheimer Society].

<u>Recommendation</u>. That the number of times that the facilitator meets with the team members as a group be reviewed. Provide follow-up that ensures that the facility continues on with the EC Program.

Group competency was hindered by another factor that was the product of the location of the meetings. During the seven-month observation period, all the meetings took place within the facilities where the EC Program was being implemented. The result of this was that there were constant interruptions and distractions, including general staff knocking on the door, the phone ringing in the meeting room, and the ambient noises of the facility (such as buzzers going off and door alarms sounding). These distractions kept the groups from functioning to their greatest potential.

One alternative would be to have EC meetings in a location outside of the facility where the program is being implemented. This could be a challenge for small rural facilities, where alternate meeting spaces might not exist. In addition, having access to staff within the meetings might be the only way those individuals would be able to participate in the program. Where it is

not feasible to meet outside of the facility, it is important that every effort is made to ensure that the EC meetings are not interrupted. Suggestions would be to disconnect the telephone in the room during the meeting, to arrange for specific break times where the staff on duty can talk with those in the meetings if necessary, and to choose a meeting space as far removed from the nursing station as is possible.

<u>Recommendation</u>. That efforts be made to keep distractions during the meetings to a minimum.

3.2.4.5 Communication with General Staff. Implementing the EC Program will affect every staff member to some degree. Keeping all staff informed of changes is imperative. Although communication strategies were discussed throughout the program, final decisions were ultimately left to the team members. In Facility #1, the EC Program had been running for five months before a general staff meeting was called to inform general staff of the program and subsequent goals for the facility. Their other main source of information dissemination was a bulletin board outside the dining room. Team members felt confident that the bulletin board would provide the general staff with all the information they required about the EC Program.

> I think putting those [bulletin] boards up and putting things down was helpful. At least to give people the opportunity to say, here, this is what we're doing. If they chose to read it. That's up to the individual. I felt good that we were able to say, ok, this is what we're doing.

We're not just telling them [about the EC Program], they're actually able to visualize it.

Despite the effort to inform general staff of the EC Program using the bulletin board, interviews with the general staff indicated that very few of them had taken the time or effort to read what was posted on the bulletin board. Only three of the eleven staff members interviewed had read any of the information on the bulletin board.

This is compared to Facility #2 where only two months transpired between initiation of

the EC Program and the first general staff meeting. In addition to the general staff meeting, Facility #2 implemented weekly resident care meetings that were open to all staff, as well as a binder that contained minutes from these meetings that all staff members were required to read and initial. Of the ten staff members interviewed at this facility, nine had attended at least one of the weekly staff meetings, and all nine had read the minutes from the meetings they had missed. The tenth staff member interviewed had not attended any meetings nor read any of the meeting minutes.

The result of these communication initiatives was that in Facility #2, the general staff were aware of the program, supported the initiation of the program in their facility, and could name the specific goals that had been set out by the team members. In Facility #1, the general staff were less knowledgeable about what the EC Program was, were ambivalent about the program, and were unaware of the specific goals that had been set by the team members. These differences indicate a need for specific communication strategies with general staff that are initiated before the EC Program begins, and that are successful in communicating the information needed from the team member meetings.

Recommendation. That determining specific communication strategies with general staff be a priority during the initial goal setting meeting. These strategies should be implemented early on in the EC Program.

3.3 General Comments

From the list of recommendations above, it is clear that team members experienced frustrations with the EC Program at a number of levels. Many of these frustrations stemmed from lack of preparatory information, and lack of a communication strategy that included the general staff. However, despite these frustrations, when asked, every team member was positive

about the EC Program in general. When asked whether team members would recommend this program to other facilities, this is what they had to say.

> I think all of our attitudes have changed. They have gotten better.
>
> We can make a difference.
>
> For the facility and for myself, [the EC Program] has improved things 100%.
>
> I would recommend it too. I think we've already seen some good changes come from [the EC Program]. And I think as we carry on and continue more good things will come.
>
> Yah, I feel the same. I think [the EC Program] has opened up the whole communication between all departments and I've seen some really good things come.

From these quotes, it is evident that the EC Program was viewed by team members as a positive influence within their facilities, particularly among the staff members who participated in the program. Communication was increased between departments, and staff members felt that they had the power to initiate change within the facilities. This study, however, did not look at outcomes for the residents who live in these institutions. This study also did not follow the facilities over time to see whether the program was continued after the initial seven-month period.

<u>Recommendation</u>. That this program continue to be evaluated to expand our knowledge of how the program develops over time, and to determine whether there have been improvements in resident care.

CHAPTER FOUR
THE PROCESS OF BUILDING EFFECTIVE TEAMS

The two purposes of this study were to conduct a process evaluation of the EC Program and to develop theory relating to the implementation of a program in two rural long-term care facilities. This chapter describes the theory that was developed through data analysis. At the outset of the study period, the facility manager gathered a group of individuals together in each of the two facilities to form what became the EC teams. Although the EC Program binder used the term "team" to describe these groups of individuals, early observations of the program indicated that these groups did not function as teams initially. Rather, the groups were a collection of individuals who were merely gathered together. Over the course of the study, a transformation occurred, where these groups of individuals began to function more cohesively as one unit. Through observing this change over time and interviewing team members and general staff, I developed a theory to explain the transformation, entitled *The Process of Building Effective Teams*. Key categories were identified that contributed to the process of team building. These categories are: trust, respectful and open communication, transformational leadership, creating change collectively, and enhanced team culture. A depiction of the theory can be seen in Figure 4.1.

I observed both groups through the entire implementation of the EC Program, from the initial meetings with the Alzheimer Society facilitator to the later meetings when the groups were functioning independently. It was evident from the outset that the participants were hopeful that the EC Program would provide them with a tool that would assist them in making changes to enhance the care of the residents with dementia. From the very beginning, there was a degree of trust between the team members, combined with the hope that the EC Program would be of benefit to their facilities. The team members in each site were also familiar with one another, at

least by name, and this provided the foundation on which trust was built. Throughout the process of building effective teams, trust grew between the team members, as they worked through facility assessments and developed goals to address their facility's needs. In the diagram, this increasing level of trust is indicated by the broadening of the triangle as the teams progress through the process over time.

The trust between the team members was enhanced by the respectful and open communication strategies that were implemented throughout the EC Program. Even though the team members were familiar with one another by name, they had never before been in a group setting of this nature, where every member was encouraged to contribute and where every voice was heard. These communication strategies were established by those in leadership positions, the facilitator from the Alzheimer Society and the facility managers, and these leaders ensured that the communication strategies were consistently applied throughout the program's implementation. As team members experienced support from others, and were encouraged to contribute throughout the process, trust between team members grew.

The leaders in this process not only ensured that the communication strategies were implemented consistently, they also enabled the EC Program to proceed as it was intended. I observed several incidents where discussions would lose focus, or where certain team members had remained quiet throughout the meeting. It was at such times that the leaders would refocus the discussion, or ask for everyone's opinion on a certain idea. Thus, the leadership was invaluable in providing guidance throughout the study period.

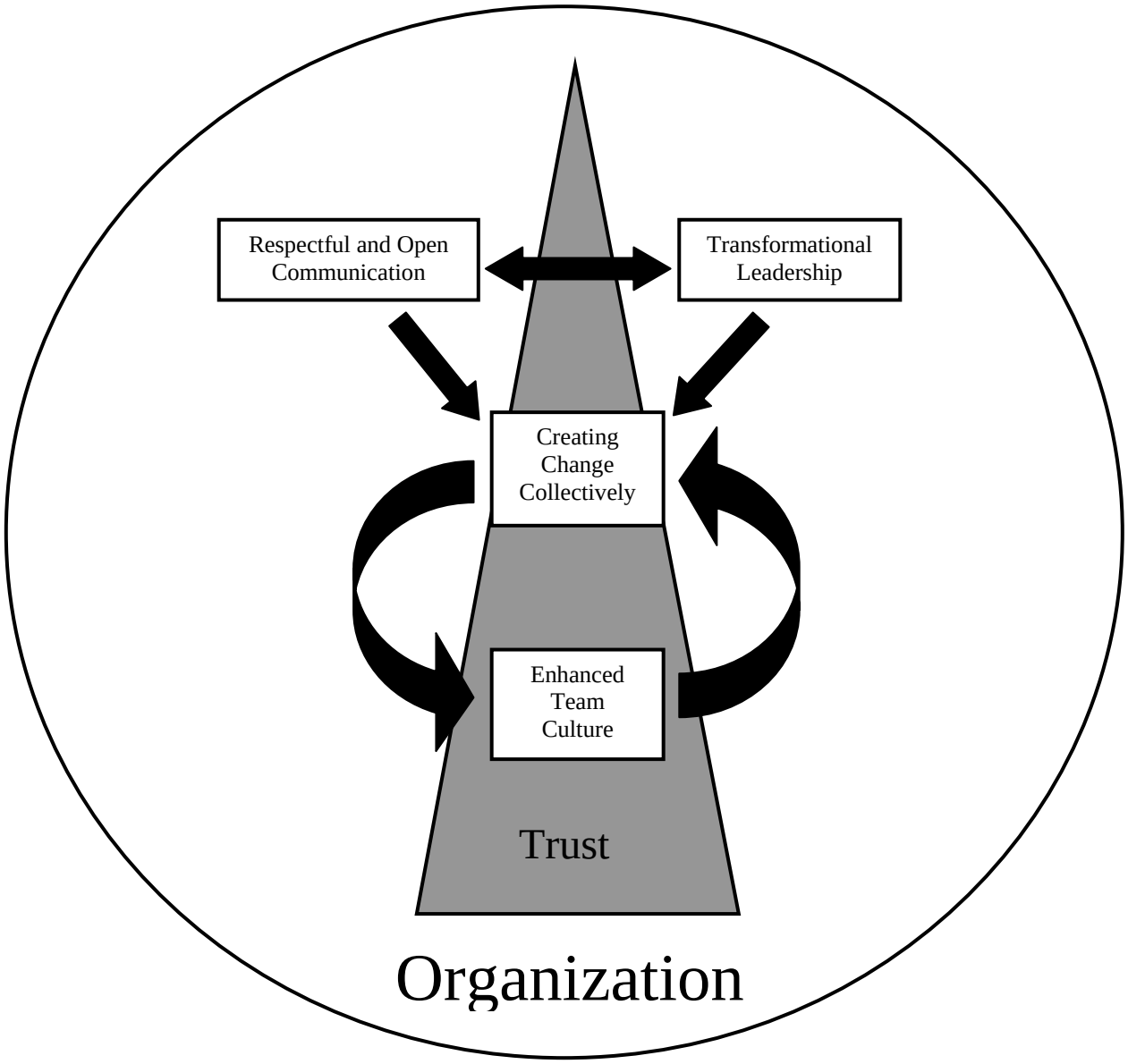
As Figure 4.1 shows, respectful and open communication and transformational leadership, coupled with growing trust between team members, allowed for these groups to collectively create change within their facilities. Through the EC Program, team members

collectively identified needs within their facilities, outlined goals that would address the needs, and determined who would be responsible for each task. Strong communication skills were required for goal setting to occur successfully. Leadership was required repeatedly to ensure that the process stayed focused. As goals were accomplished and results were observed, trust between team members continued to increase.

Through the process of creating change collectively, team culture was enhanced. As the cycle of identifying a need, setting goals, and seeing results was repeated, the teams grew more cohesive. Team morale increased. The teams became hopeful that their efforts would result in continued positive change being made for the residents with dementia. The relationship between the categories of enhanced team culture and creating change collectively became reciprocal. As the team culture grew, the team members felt more confident in creating change collectively, which in turn positively influenced the team culture. At the conclusion of the study period, the existing teams were expanding to incorporate other general staff members from the facilities. The teams were hopeful that the success of their goal implementation would encourage other staff members who had not participated in the process to join the team. The theory of the *Process of Building Effective Teams* is depicted in the following diagram.

Figure 4.1

Process of Building Effective Teams



4.1 Trust

Throughout this project, several categories became evident. One category that underlay all aspects of the research project was that of trust. The word "trust" seemed the best descriptor for the following attitudes and behaviors that were demonstrated throughout the project by the team members: inter-reliance among team members, assurance of respectful communication between team members, and confidence in others' strengths and abilities to accomplish assigned tasks.

At the beginning of the project, the facility manager recruited staff members from each department to participate in the implementation of the EC Program. Due to the small size of both facilities, all the team members knew one another to some extent. However, the EC Program was the first time that these individuals had participated in a project as a group. During the focus group interviews, several team members stated that at the beginning they were skeptical about the ability of the EC Program to produce any benefits to the residents. Even with this skepticism, these individuals agreed to participate in the program. The fact that the team members agreed to participate in the program demonstrates an element of trust with fellow coworkers, since it was made clear by the facility manager that the process would entail working as a group with other staff members. However, this trust was initially tenuous. For example, at the first meetings it was evident that some team members were more willing to speak out during the meetings than others. Even as some team members were speaking, some moments of discomfort were observed, where the speakers would speak very quietly, or would not make eye contact with fellow team members. Initially, the body language of a few of the team members indicated tension, with arms and legs being crossed.

Although present to some degree from the outset, the level of trust between the team members increased over time. This was due to the common experiences they shared in an atmosphere that was conducive to the process of building effective teams. This atmosphere included communication strategies that ensured that every team member could participate in the program without fear of negative responses from others. The trust also increased due to the transformational leadership that enabled the groups to develop and implement goals within the facilities. The increase in the level of trust between team members was observed during later meetings, where team members who previously had remained quiet during the meetings were openly sharing their opinions. Eye contact between team members became the norm. Lively discussions amongst the team members occurred during breaks in the day. On a number of occasions, the team members offered to stay later than was originally agreed upon in order to complete the work they had begun.

The development of common goals also had a unifying effect on the groups, and aided in the development of trust. With effective leadership, the teams became optimistic that the goals they were setting could be achieved. At times, team members did not agree on the course of action that should be employed. Tensions were present. However, with the ground rules for relational communication in place, and a leader that mediated effectively, team members were able to work through the disagreements. As the groups created change collectively, individuals within the teams trusted that other team members would accomplish the tasks that they had agreed to perform. Since the goals were divided into several tasks, each potentially being the responsibility of different team members, the individuals within the groups had to trust that other team members would complete the tasks they were assigned. Clearly delineating the tasks, assigning team members to each task, and establishing timelines assisted with the inter-reliance

between team members. As more of the tasks were completed, other team members became optimistic that the goals they had determined could be implemented successfully. This was encouraging to the groups.

> I'm only as good as the team working with me.
>
> I will live and breathe [the EC Program]. I think as I recall at that staff meeting where we finally did get organized. But this [pointing to the EC binder] makes my job ten times easier. And it does. But then I've got a great team to work with.
>
> [The facility staff] is a family now. You need that.

During the interviews at the conclusion of the project, *every* team member stated that the implementation of the EC Program had been a positive experience, despite frustrations and challenges in the process, and would recommend it to other facilities. All team members stated that they had felt free to voice their opinions during the meetings, and had felt supported by fellow team members. As cohesive units, the teams were able to create changes within the facilities, to enhance the care provided to the residents, and this was a great source of pride for the teams. Thus, in this project, trust was present from the outset between the team members, although it appeared quite tenuous. Through the program implementation process, trust increased, and became an important factor in the process of team building.

4.2 Respectful and Open Communication

In the process of building effective teams, communication was central. For the purposes of this study, communication can be viewed in two ways. The first is how information is passed on between two individuals or groups of individuals. Examples of this form of communication are the process by which the facility manager passed on information regarding changes to a policy within the facility, or how the nursing staff communicated a change in dietary needs of one of the residents to the kitchen staff. The second form of communication was relational, or

the tenor behind the words being communicated. An example of this would be how individuals within the group discussed and resolved differences, whether the discussion was respectful or whether the discussion dissolved into an argument.

During the first meetings, it was clear that staff members who worked at these facilities felt that they did not often have the opportunity to discuss issues of importance with the facility manager or with staff members in other departments. Although there were scheduled general staff meetings periodically, they were not well attended in either facility. During the focus group interviews, one participant stated, "I think as a facility as a whole, there was no communication." Another commented, "We were dysfunctional." With the facility manager initially only working part time in each facility, the transfer of information from management to general staff was a challenge. Communication between members of the various departments was sporadic. This lack of communication was viewed as the norm, and the staff members worked within this norm. At the initial meetings, the relational communication between team members appeared tentative. It was clear that these individuals had never met in this manner before, and were uncertain what was expected of them.

As the project progressed, the theme of communication emerged in three distinct ways: communication between staff and the facility manager, communication between staff members of different departments, and communication between those participating in the EC Program and the rest of the general staff. Each will be discussed in turn.

4.2.1 Communication Between Staff Members and the Facility Manager

In this study, one facility manager was initially responsible for both facilities, and divided her time between the two. The facilities were situated 50 km away from each other, which meant that she could not easily negotiate between the two without considering travel time. In

addition, demands from the health region dictated that she attend frequent meetings in a town that was situated approximately 100 km away from her residence. This meant that on average the facility manager was physically present in each facility two days per week. This made it difficult for staff in either facility to discuss issues with her in person and equally, for the facility manager to disseminate information to staff members. Because of the lack of access to the facility manager as well as the inconsistent dissemination of information to all staff members, morale amongst the staff was compromised. As one participant stated, "Excuse the expression but [staff morale] was in the toilet. We had no guidance, and we worked with no guidance for some time."

In addition, the structure within the facilities complicated the ability of information to flow freely between general staff and the facility manager. Initially within both facilities, there was a structure that placed the facility manager in a dominant position, with the majority of communication going from her to the staff members of various departments. Little communication was exchanged. That is, the general staff did not feel that they had a consistent communication process by which they could meaningfully express their opinions to the facility manager. Most of the information regarding resident and staff issues was disseminated by the facility managers to others on staff.

With the implementation of the EC Program, the staff members who participated in the EC meetings were able to discuss issues of importance to staff and residents with the facility managers. Within the EC meetings, all participants could exchange ideas, and have their opinions heard. In addition, information that pertained to the EC Program was distributed to all team members at the same time. Because of the nature of the program, information dissemination did not necessarily originate with the facility managers. For example, at several

times throughout the program team members distributed updates on how goals were being achieved. The EC Program provided a forum by which communication occurred between the facility managers and the team members.

4.2.2 Communication Between Staff Members of Various Departments

As mentioned above, the individuals who participated in the team meetings during the implementation of the EC Program had never met before in this way. Even though all team members were acquainted with one another as co-workers, the forum of gathering together in team meetings was new. Because of this, communication between the members as it related to the implementation of the program was a unique experience. Observations of these meetings highlighted several aspects of how information was communicated between team members as well as how team members related to one another in the team meeting setting.

4.2.2.1 Communicating Respectfully. In this study, at least one individual from every department participated in the facility assessment and goal setting sessions. When the EC Program began, certain "rules" were introduced by the Alzheimer Society facilitator, and applied to all conversations. These rules included encouraging all team members to participate in the discussions, respecting every person's opinion, and giving equal weight to each person's suggestions. With these guidelines in place, participants felt free to speak, knowing that they would be listened to respectfully.

> I appreciate those comments because you don't know how other people are feeling, and I think there has been a great amount of opportunity to be real, and to share, and in doing that, everybody wins, because then we hear other people's voices.
>
> I think people felt pretty free to give their ideas and be listened to. [The Alzheimer Society facilitator] had said specifically, she enforced many times during that time that she was just facilitating, that she was needing our input. She needed our opinions, for [the EC Program] to work.
>
> During the meeting, even at the end of the meeting our goals were the same, even if we

> had different discussions and stuff, we all still ended up agreeing at the end as to what our goal was.
>
> I think [the EC Program] opened up the whole communication between all departments and I've seen some really good things come.

4.2.2.2 Exchange of Information. As the EC Program was implemented, a great deal of information was conveyed between team members. The EC Program allowed representatives from each department to be present at the table, at the same time, with equal weight given to their input. This was significant. Every member of the team, at some point through the program, mentioned how helpful it was to hear other disciplines' perspectives, and to have their own opinions heard in return. It was evident that even though these rural facilities may have been small in size, staff in one department did not understand fully how other departments functioned on a day-to-day basis.

In the study, this lack of understanding between departments became apparent as each individual was asked to rate various categories relating to the functioning of the facility. For example, when team members were rating the effectiveness of their resident care plans, several individuals were forced to give the category a poor rating, not because the care plans were being done inadequately but rather because the team members had no knowledge of resident care plans. The nurses and special care aides were very knowledgeable regarding resident care plans since they were the ones who created and implemented them. Other departments, such as maintenance and kitchen staff, did not know resident care plans even existed. As the goal development process continued, each team member became more aware of other departments' roles and responsibilities. In addition, through this dialogue, the team members came to see how each department influenced the others and thus became less insular.

> It was hard not to be defensive in some of those instances. You know, like for example, when we talked about the care plan. I mean, I think we do a really good job with that in

> relation to the *care* department, and that's a good thing, but what was evident there was that some of the [other departments] didn't know what we do.
>
> I think you got to see opinions from nursing, housekeeping, kitchen. It wasn't just one opinion on what affected that resident. It was where you see it from your experience and where they saw it from theirs. It was a sharing thing.
>
> [The EC Program] has been really good to make each area of the building feel important, and recognized, and kind of opening Nursing's eyes to maybe some of the issues that Maintenance has, and maybe explaining things to Maintenance that we do. It's been really good that way. It's a great communication tool.

4.2.2.3 Openness to New Ideas. The result of establishing the ground rules for communication and exchanging information was that team members felt free to express their opinions within the group without fear of negative responses from others. As time progressed, team members began to see the goal setting meetings as opportunities to learn about other departments within the facilities. As team members shared openly with one another, trust was established, and all participants became open to hearing new ideas. This openness to new ideas did not mean that all team members were in agreement, but it did allow for sharing in a way that had not occurred before.

> What I found with our facility, personally, and myself and my job, we didn't have the teamwork. We didn't have the cohesive group that would even get together. And maybe somebody had a really good idea but it wasn't like a group. That's happening now. Or Special Care Aides and Nurses were having their own weekly meetings about what the needs were [of the residents] while Maintenance and Kitchen and Activity had no idea what they were discussing. So if nothing else, [the EC Program] has gotten that together.

As team members participated in the EC Program over time, it was evident that the way in which team members interacted with one another was changing. The team members who initially were individuals representing their departments were becoming more cohesive as a group. Team members were sharing thoughts and feelings that were not in evidence at the beginning of the program. Participants felt comfortable in the later sessions to voice opinions that they would not have done in earlier meetings.

4.2.3 Communication Between EC Team and General Staff

Although the assessment of the facilities was done exclusively by the EC team in each facility, the goals that were developed had an impact on all staff within both facilities to some degree. As such, communication with the general staff was vital for goal implementation and thus for achieving results. Without communication with the general staff, the groups would not have been able to create change within the facilities. The goals developed by the EC teams varied in scope. For instance, several of the goals could be managed by the team members alone and did not have an impact on the daily routines of the general staff. An example was the creation of the informational binder, which was completed by one staff member with the intent of offering general information to visitors about their town and their facility. This binder was seen as useful by the general staff but its existence did not influence how the staff members completed their duties each day.

For the goals that were managed by team members alone, communication to general staff became one of simply relaying information regarding the goals. This informational communication occurred verbally, primarily at staff meetings, and in writing, such as minutes from the goal setting meetings posted on a bulletin board. The purpose of communicating this information to the general staff was to keep them apprised of the work that was being done at the team meetings. Team members felt it was important to keep the goal setting process transparent to the general staff. This was to promote understanding and trust between the team members and the general staff. Part of the rationale for this was due to the fact that later in the process the general staff would be encouraged to join the team and establishing communication patterns early on in the process would facilitate expansion of the team at a later date.

> And we will actually, like even as far as communication to the staff, we were able to take that a step further. Like I think previously there was, at least for me, a bit of frustration

> as to exactly what to say to the staff and how to communicate to them that you know, we're really excited about this, and this is what we're doing. And we were able to, as a result of that meeting, put up boards and communicate to the staff, 'Here, this is what we're doing.'

Other goals, however, necessitated adding duties to the routine of the general staff. For instance, in Facility #2 the team members formulated a goal to improve how resident care plans were written and resident information disseminated to staff. This required that the registered nurse who worked the night shift transfer information from the old care plan to the new one that was going to be implemented. For the goals that had an effect on staff members outside of the EC team, communication of changes to the daily routine became vital. Without compliance by the general staff, certain goals established by the teams could not be achieved. Thus, creating change in the facilities would not have been possible. Communicating planned changes to routine was a challenge for both teams in this study. Each facility in the study utilized different communication strategies, with differing results.

As the first goal of the EC Program, Facility #2 decided to implement a weekly staff meeting. This meeting was to include all staff from every department. The purpose of these meetings was to discuss residents and their care, and to inform staff of any changes to daily routine that were going to be implemented in the near future. These meetings had several results that went beyond the dissemination of resident information. First of all, every department was present, so the meetings assisted with inter-departmental understanding. Secondly, general staff members in this facility became knowledgeable about the EC Program, and were open to changes because they were kept informed throughout the process. Thirdly, these staff meetings provided a clear forum where all staff members could provide input if they chose. In this facility, communicating with general staff was a priority early on in the implementation of the EC Program, and resulted in compliance by the staff to the proposed changes made by the team

members. Thus, the team in facility #2 was able to create change. In addition, communication with general staff from the outset facilitated the expansion of the EC team later in the process because the general staff had an understanding of the EC Program.

In Facility #1, weekly staff meetings were not implemented as a goal for the EC Program. Rather, their communication strategy consisted of word of mouth and the creation of a centrally located bulletin board on which EC Program information and updates were posted. When it came time to include the general staff in the EC Program, team members anticipated negativity from the general staff members. General staff were less aware of the EC Program compared to Facility #2, even with the presence of the bulletin board. In addition, the general staff felt there was no forum for them to have a voice in the EC Program. Without effectively communicating changes to general staff, goal implementation was a challenge and thus creating change was more difficult for the team. In addition, since the general staff in this facility did not fully understand the EC Program, expanding the team later in the process was also more difficult.

This example shows that although information dissemination regarding changes to routine is important, it could be viewed as secondary to the *process* of communication. As long as this process for communication was in place staff members were more understanding of each other and were willing to consider changes within the workplace. There was security for staff members knowing that there was an opportunity to express concerns or have input if they so desired. As well, goal implementation was not possible in many cases without the assistance of general staff members. Thus, without a successful communication process, the team members would not have been able to create change within their facilities. The conditions for a successful communication process are discussed more fully in the following section.

4.2.4 Conditions for a Successful Communication Process

4.2.4.1 Information Dissemination. Results from the analysis of this study indicated that when goals were developed that affected the daily routine of general staff, communication of the changes was vital. Communication of changes to daily routine was both verbal and written. Verbal communication most often took place at general staff meetings to which all staff members were invited to attend. Team members would give the rationale for the intended changes and explain how the changes were to take place. For instance, when Facility #2 chose to make changes to the resident care plans, this was communicated to all staff at a general meeting. In addition to the verbal communication was written communication, or a list of instructions, intended to assist staff members when implementing the changes to the daily routine. The intent of the verbal and written communication was to ensure consistency in the information dissemination. That is, all staff had access to the same information at the same time.

Dissemination of information was critical to goal attainment in many instances. For example, if the nurses were unaware that they were to make changes to the care plans, the task would not have been completed. As well, detailed instructions were required to ensure that all nurses completed the task in the same way, thus maintaining consistency. Without dissemination of information in a consistent fashion, creating change within the facilities would not have been possible.

4.2.4.2 Repetition of Information. Team members acknowledged the importance of presenting information on an ongoing basis, particularly when changes to routine were being implemented. Not only would this ensure that the information was reinforced for current staff, it would allow for new staff to become informed as well. To acknowledge the fact that individuals learn in different ways, team members indicated that the information needed to be presented in a

variety of ways, including verbal reports, notices, posters, minutes of meetings etc.

In Facility #2 where weekly staff meetings were implemented, information regarding goals was repeated in a number of ways. Firstly, it was stated verbally at the meetings. Secondly, staff members were required to read the minutes from the meetings and initial the page. Thirdly, the goals were posted on a bulletin board. In this facility, the general staff were more aware of the goals and the EC Program in general than in Facility #1 where the repetition of information was not done to the same extent. Thus, repetition of information facilitated the accomplishment of goals, and ultimately success with creating change. Without the repetition of information, goal attainment was hindered, as was evident in Facility #1.

4.2.4.3 Open Dialogue. As team members communicated their goals to the general staff, the team stressed the point that the opinion of every worker was not only heard, but valued, whether they were part of the EC team or not. This meant that a clear process for open dialogue must be evident to the general staff, and be accessible to all. At the weekly meetings in Facility #2, team members clearly articulated that input from all staff was encouraged. This process for communication included bulletin boards, general staff meetings where questions and comments were welcomed, weekly care meetings, sheets posted where suggestions for agenda items could be made, and the inclusion of any interested individuals in EC initiatives. In Facility #1, where open dialogue with general staff was not as apparent, there was more skepticism towards the EC Program, and less interest in the goals that the team members were implementing. The general staff did not feel they had any influence on the setting of goals or in the goal implementation process.

Open dialogue facilitated goal attainment and the creation of change within the facilities. In addition, open dialogue between the team members and the general staff that was

demonstrated in Facility #2 assisted in the establishment of trust. This was evident when I interviewed the general staff at the end of the project. The general staff in Facility #2 were not only more knowledgeable about the EC Program than the general staff in Facility #1, they were also obviously proud of what the team members had accomplished and felt that they had contributed to the process by actively participating in the weekly meetings. As well, the general staff in Facility #2 expected that they would continue to be included in the EC Program in the future, and several general staff members were open to joining the EC team at a later date. Thus, expansion of the EC team was plausible due to the establishment of open dialogue.

Communication was a strong theme in this research. As team members learned to trust one another, communication between members was enhanced, which was integral to the process of team building. The facility managers were part of the EC teams and as such were accessible to the rest of the team members. Information regarding the program was disseminated to all team members at the same time and in the same fashion. Team members learned to speak to each other with respect and to value the opinions of every team member. This respectful communication reduced barriers between the team members, allowing trust to increase. This change in group dynamics was observed in both sites over time, where team members became less inhibited within the meetings.

General staff were involved in the program to different extents in the two sites. A process of communication was established in Facility #2 that ensured that all staff members could contribute meaningfully to the EC Program if they desired. This was accomplished in the weekly meetings. During the observation period for the study, both EC teams became cohesive units, and experienced some initial successes with the goals that they chose to implement. However, differences between the two teams became apparent during the general staff interviews

and focus group interviews at the conclusion of the study. During the focus group interviews, members from both teams expressed satisfaction with the process of communicating the EC goals to the general staff. Both EC teams felt that the general staff in their facilities were informed about the EC Program. However, interviews with general staff members at both sites indicated a difference between the two sites in how informed general staff actually were regarding the EC Program. General staff in Facility #1 knew very little about the program whereas all the general staff interviewed in Facility #2 were aware of the program and the goals that had been set by the team. Therefore, the EC team in Facility #1 misjudged how effective their communication with general staff had been.

Near the end of the study period the EC team from Facility #2 was encouraging others from the general staff to assist with the completion of tasks. Even though as a whole the general staff in Facility #2 knew very little about the EC Program, volunteers came forth to join the team. However, those who volunteered had prior knowledge of the program, not from the information on the bulletin board, but from friends who were already on the EC team. Others of these volunteers were aware of the EC Program because they had been asked by the facility manager at the beginning of the project to be on the EC team, but had declined. Thus, all the volunteers were informed regarding the program but from sources that did not originate with the EC team. In Facility #1, all of the general staff interviewed were aware of the EC Program. The EC team from Facility #1 did not hold a general staff meeting at the end of the study period, so it is not known how many general staff members would have volunteered to join the EC team. However, even without being asked to join the EC team itself, the general staff in Facility #1 felt that they had contributed to the EC Program through their participation in the weekly meetings.

4.3 Transformational Leadership

The third category that was very strong in the research was that of leadership. At the outset of the project, the majority of the leadership for the EC Program was provided by the facilitator from the Alzheimer Society. This was in large part due to the fact that she alone knew about the EC Program and how it was to be implemented. The facilitator provided the background information that was required to implement the EC Program. She set the ground rules for communication that were mentioned earlier, ensuring that all team members were given the opportunity to contribute ideas, as well as ensuring that all communicating was done respectfully. The facilitator provided the framework by which the facility assessments as well as the setting of goals were accomplished. She was an invaluable resource to the group in the early days of the project.

The facility managers also provided leadership throughout the program. At the outset, leadership was exhibited by ensuring that the team members were assembled from all facility departments and that physical space was available for the team meetings. As time progressed and the facilitator was no longer part of the program, the facility managers assumed much of the responsibility for ensuring that the groups remained on task, and for ensuring that the communication remained respectful. At certain points, leadership was also exhibited by team members. This was evidenced, for instance, when the new facility manager in Facility #2 first arrived. When she was uncertain as to facility-specific procedures, one of the team members would assume responsibility for leading the group.

Within this study, it became clear that leadership was required from the outset and throughout the implementation of the EC Program. This study highlighted several leadership attributes that affected how the team members interacted amongst themselves and how the group

was able to transform into a team. These transformational leadership attributes include the following.

4.3.1 Visionary

This study demonstrated that effective leaders have a vision for the future. In the planning stages of this project, the facility manager acknowledged that the care that was being provided for the residents in the two facilities could be improved upon, and she saw the EC Program as a tool that could be implemented to create change. She had a clear sense of the direction in which she envisioned the facilities moving, and capitalized on the opportunities that the EC Program provided that would assist in attaining her vision for the two facilities.

> I know I had a vision, and I could see where [the EC Program] would help.

> I'm glad we've [implemented the EC Program]. The program is getting staff to think of things in new ways. We're using it as a tool for future change. It's given us a process.

4.3.2 Organizer

Coordinating team meetings was time consuming. With the vision intact, the facility manager engaged the staff in the process of program implementation by assembling the team members, arranging the meeting spaces, and contacting the facilitator from the Alzheimer Society to decide meeting dates. In addition, the facility manager became the time keeper during the meetings, ensuring that meetings were started on time, breaks were taken as scheduled, and the meetings ended at the appropriate time. This assisted the groups to stay focused on the timelines that had been set out at the outset of the program.

4.3.3 Educator

Another attribute of leadership that became evident during this project was that of educator. This was demonstrated in a variety of ways throughout the study. Initially, as team members were being recruited, the facility manager was responsible for conveying information regarding how the EC Program would be implemented, and the rationale for making these changes within the facilities. This background information prepared the team members for the process of change in which they would participate.

During the implementation of the program, there were many instances where the team members required clarification on the assessment questions as well as the goal setting procedure. In response to these questions, those in leadership positions often needed to educate the team members on various aspects of caring for residents with dementia or on the aspects of group decision making. While the facilitator from the Alzheimer Society was present, the team members looked to her as an educational resource. This ensured that all participants were interpreting the questions in a similar fashion. As the program progressed and the facilitator was no longer present, the facility managers became the educational resource for the teams.

4.3.4 Mediator

During the facility assessment and goal development phase, leadership was needed to ensure that the participants communicated respectfully with one another. During the meetings, issues would arise and would instigate heated discussions among the team members. Particularly at these times, the facilitator or facility manager would use mediation skills to ensure that all participants felt free to voice their opinions, and to ensure that team members were respectful of one another.

4.3.5 Mentor

In this study, the leaders were not only required to act as mediators among the team members, they were valued for their ability to be role models for the staff. The facilitator and the facility managers were viewed as positive and energetic, and were encouraging to those around them. During the entire eight month observation period, these leaders spoke with respect to all team members, remained open to suggestions from all team members, and accepted constructive criticism from fellow team members.

4.3.6 Overseer

Leaders were valued for their ability to oversee all aspects of the EC Program, and to see the "big picture". The EC Program was new to all team members. At times in the study, the team members became focused on individual tasks and lost sight of the overall goal or need within the facility. During these times, leadership was needed to remind team members of the rationale for implementing the goal in order to keep the process on track. The facilitator or facility manager would often stop the discussion and refocus the group. Without this refocusing, the teams would not have been able to progress successfully through the EC Program. In this way, the team members were made aware of how all the smaller tasks that they were performing fit into the larger picture that was the EC Program.

> I thought [the facilitator] did an amazing job and was keeping everybody on track, and keeping everything going.

4.3.7 Supporter

Although the EC Program allowed for all team members to have equal say in the process, it was clear that the facility manager was in a unique position within the group. By definition, the facility manager had access to information about the facility that no one else had and her

approval was required in order for the goals to be set in motion. Even though many of the goals were initiated by other team members, ultimately the support from the facility manager was required if the goals were to be implemented and succeed. When the team members felt confident that they had the support of management behind them, the role of the manager was seen as a positive influence on the process. This support also meant that there would be follow-through on the goals, especially when the goals entailed money or staff time.

4.3.8 Policy Developer

Team members identified a need to have clear facility policies that addressed general topics affecting all staff members. These policies would ensure that all staff members were treated equitably and would assure fair treatment by management. When new duties were being assigned to general staff members, it was important that facility policies reflect and support the changes to routine. For instance, in Facility #2, team members wanted to encourage staff from all departments to contribute to the creation and updating of resident care plans. The issue of resident confidentiality arose, as well as which departments should have access to resident information. Within this goal, one of the tasks for the facility manager was to investigate which policies or procedures in their facility would need to be amended to support this change to the routine.

Through observations of team meetings over seven months and a series of interviews, the themes of *respectful and open communication* and *transformational leadership* became central to the theory of the process of building effective teams. In the two study facilities, individuals from various departments were gathered together in order to implement the EC Program. However, these gatherings of individuals transformed into teams that functioned as cohesive units, and this was due in part to how the team members communicated among themselves, with the facilitator

and facility managers, and with other staff members. In addition, the leadership by the facilitator and the facility managers ensured that all communication was done in a respectful fashion and allowed for the EC Program to proceed as it was intended. Communication and leadership were integral in the process of building effective teams.

Respectful and open communication partnered with transformational leadership enabled the two EC teams to create change collectively. The EC program provided the teams with a tool by which the team members could assess their facilities and develop goals to address the identified deficits. However, respectful and open communication as well as transformational leadership provided the foundation on which the program could proceed. In the next section, the category of *Creating Change Collectively* will be discussed.

4.4 Creating Change Collectively

The EC Program consists of two main phases, facility assessment and goal setting. The intent of these phases is to assist facilities make changes that will enhance the care provided to residents with dementia. The development of communication strategies and transformational leadership facilitated the groups' abilities to collectively create change within the facilities. These acts of creating change, of setting and accomplishing goals, influenced how the groups perceived themselves and empowered them in a variety of ways. As the team meetings were observed over the seven-month period, it became evident that the development and accomplishing of common goals was central to the process of building effective teams. Several goal setting strategies were highlighted in this study. These strategies facilitated each team's ability to not only set goals, but to ensure that the goals would be accomplished, thus creating change within the facility. The strategies included the following.

4.4.1 Taking Ownership

As goals were being developed, various team members began to assume roles in a number of capacities. This was evident in the meetings themselves, where team members not only identified gaps in the process, but volunteered to fill those gaps. For instance, one of the registered nurses in Facility #2 recognized that there had not been a recorder assigned to take minutes of the meeting and offered to take on this responsibility. This proved invaluable to the group, as she often asked questions of the group in order to write clear notes. This assisted the group to stay focused. Other team members took it upon themselves to explain various protocols and procedures within their facility to the facility manager, who was new to her position. These examples demonstrate how the team members took ownership within the process, and assisted in the process of team building.

4.4.2 Creating Manageable Tasks

During the implementation of the EC Program, the EC teams were required to determine the needs of their facilities and then establish goals to address those needs. Each goal was then further delineated into a series of tasks that outlined how the goal was to be achieved. Part of this delineation process was to decide upon tasks that were manageable, that is, tasks that were clear, able to be accomplished by individual team members or small groups, and of a duration that was acceptable to the team as a whole. By creating manageable tasks the team members were able to envision how the goals would ultimately be achieved. In addition, manageable tasks ensured that the team members assigned to each task would not feel overwhelmed, and therefore would be more likely to complete the task

4.4.3 Shared Division of Labor

Once the goals had been broken down into manageable tasks, the EC teams felt that all team members should contribute as they were able to the completion of the tasks. All team members were encouraged to volunteer for various tasks, particularly if they had an interest or skill in that area. At various times in the study, team members became very concerned that the tasks be mutually shared, with the onus for task completion *not* being placed on single team members. As the study progressed, team members were increasingly aware of the time commitment each had offered in the past, and tried to ensure that the work was shared by all team members.

> I think we've worked really good as a whole group. Like everybody's taken their little jobs and done 'em. I think we do work well together.

4.4.4 Discerning Gifts

As the EC teams divided the tasks among team members, another phenomenon occurred, that of discerning one another's gifts and encouraging them to take on tasks. In Facility #2, for instance, the EC team decided to post updates of the program on a bulletin board. The team decided that it would be appropriate to decorate the bulletin board to make it more inviting for staff to read. Volunteers were asked for, but no one expressed an interest in decorating the bulletin board. At that point, one team member acknowledged the creative skills of someone within the group, and suggested that she would do an excellent job with the board. With this affirmation, the "creative" team member agreed to the task. Through the encouragement of others, several team members felt the support needed in order for them to tackle certain tasks that otherwise they may not have volunteered to do.

4.4.5 Expansion of Roles

As tasks were delineated and divided among the team members, individuals were given responsibilities in areas beyond their departmental duties. Due to the nature of the EC Program, the EC teams were assessing areas of their facilities that traditionally would not fall under any one department, such as the physical environment. Because of the nature of the goals being set, team members were given opportunities to complete tasks that were outside of their regular job descriptions. Through observations, it was evident that many of the team members were excited about these new possibilities and welcomed the opportunity to expand their roles within the facility.

For example, in Facility #1, one of the goals determined by the group was to develop an informational binder for families and visitors to the facility. The objective for this project was to provide any information that might be required by visitors from outside of the town. This would include a list of hotels, restaurants, pharmacies, service stations, etc. One of the team members had an interest in this area, and offered to compile the information for the binder. This team member approached staff at the town office for information, other staff members from the facility, as well as individuals from the community. The team member compiled the information electronically, and eventually created a comprehensive list of all services in the community. The information binder was well received by the general staff, and the team member responsible was encouraged to send the electronic version to the town, so that the information could be added to the town's website. At the completion of this task, the team member was very excited to show fellow staff members the new binder at the general staff meeting.

4.4.6. Setting Achievable Goals

An important aspect of the theme *Creating Change Collectively* was for the teams to see changes occurring because of their work. At the beginning of the goal setting meetings, the facilitator from the Alzheimer Society stressed that the goals being set should be attainable and encouraged teams to set initial goals that would be attainable in a short period of time. By doing this, teams were able to see "results" from the meetings quickly, and were thereby encouraged that their efforts would truly make a difference in the lives of the residents in the facility. As the teams experienced "success" with goal attainment, they became optimistic that other goals could be accomplished.

4.4.7 Creation of Timelines

Part of the process that ensured goal attainment was for teams to determine specific dates by which tasks were to be accomplished. Determining timelines had the effect of outlining expectations for those assigned to the task, and encouraged the group as a whole that progress was being made with regard to the implementation of the goal. This proved significant for several team members, who initially had been skeptical that changes would occur as a result of implementing the program. The creation of timelines transformed theory into reality. Team members had identified needs and determined goals that would address the needs. The creation of timelines made those goals seem attainable.

4.4.8 Diffusion of Power

The effect of dividing the tasks among all team members was that the power to effect change became shared between all participants. Even the smallest of tasks was seen as beneficial to the success of the overarching goal. The facility manager continued to have a unique role in the process of developing goals. Due to the scope of her job description, certain tasks could only

be completed by the facility manager. However, as team members shared openly about their own duties within their departments, they began to understand how the duties of the facility manager fit into workings of the facility as a whole. Team members were aware that the facility manager had unique responsibilities, but through the process of goal setting, trust was built between the facility manager and the other team members. For the facility manager, this meant entrusting team members with the responsibility of making changes within the facility. For the team members, this meant *accepting* the responsibility for the changes they envisioned, knowing that they had the support of their facility manager.

Creating change collectively was an important element of the process of building effective teams. The setting and accomplishing of goals assisted in the transformation of individuals within a group into a unified team. Having said this, creating change collectively was strongly influenced by the nature of the communication between team members, the facility managers and the general staff. First of all, creating change collectively required that the team members communicate with one another. Obviously, without this, goals could not have been set. This communication between team members was not always easy. Team members did not always agree with one another. It was evident at times that certain team members were keeping their tempers in check. However, the teams were able to work through the difficult moments and to establish goals that were acceptable to all.

Creating change collectively was also influenced by the communication between the team members and the facility managers. As the goals were being determined, it was beneficial to have the facility managers present at the table. As was mentioned earlier, often the goals required support from management, in that they required funds or staff time in order to be implemented. Goals at this level needed the approval of management. With the facility

managers sitting at the table, this approval could be obtained immediately, and thus the process could proceed immediately.

Many of the goals that were set required that others from the general staff change their daily routines to some degree. Thus, communication with the general staff was vital in order for these goals to be accomplished. Those directly involved in changes to routine needed information in order to make the necessary changes. Team members in both facilities clearly outlined expectations for staff in these instances, since they were acutely aware that if clear instructions were not given, the change to routine would not be made consistently by all staff, and the goal would not be achieved. Results would not have been seen. However, from the interviews with the general staff, it was evident that at times information was not being disseminated to all staff as effectively as the team members believed, particularly in Facility #1.

At various points throughout the goal setting and implementation period, strong leadership was required to ensure that the teams were able to create change collectively. At several points in the process, the team members struggled to stay focused on the tasks at hand. During the focus group interviews, several team members voiced frustration with the amount of time it took the group to establish goals. These team members felt that they had not been very productive with their time together. When the groups were struggling, leadership was required to refocus the discussion. This was vital to the process. In these instances, the facility managers continued to act as educators, mediators, and organizers within the process. Thus, respectful and open communication and transformational leadership facilitated the groups' abilities to create change collectively, thus influencing the process of building effective teams.

4.5 Enhanced Team Culture

The consequence of creating change collectively, with the influence of communication

strategies and transformational leadership, was the enhancement of team culture. Over the course of seven months, two groups of individuals transformed into two effective teams, each unique yet with similar properties. The teams from the two facilities tackled different needs, and struggled with different challenges along the process, yet both teams exhibited common traits. The properties of effective team culture include the following.

4.5.1 Increased Staff Morale

Early observations of this program made it clear that many of the team members participating in the meetings did not feel that they had the ability to create change in their facility. Through the EC Program, goals were set that would allow for changes on a number of levels. As goals were set and tasks completed, the group began to understand that their actions were making a difference to the residents in the facility, and there was a general sense of accomplishment. Staff morale was enhanced because of these accomplishments. The teams were proud that every team member was able to contribute to the process for change.

> After I left the last meeting, I was really excited because I thought, you know, this is really going to improve their daily life. I was excited to know that we were going to do something that the residents were going to really be able to benefit from.
>
> We were kind of a dysfunctional facility, and now we're sort of on to functioning.
>
> I'm proud of us because we've accomplished a lot.
>
> [The EC Program's] been good for morale. Made us work towards being more of a team.
>
> I think my feeling was at the end of the [goal setting] meeting we had clear direction and we were going somewhere. I felt good about that.
>
> I think of us as a committee and in the few meetings we've had, I think we've accomplished a lot. Brainstormed a lot. I think we've come a long ways. Like if I thought we've had had all this done when we first started these meetings I would have thought we'd never have got there. But even if we just had the goals set and never mind what we have now. We've done a lot.
>
> When we come up with a decision, as a group in here, it is followed through on. Whether

> that is because of *this* [pointing to the EC binder], whether it's because [the facility manager] is committed to this, and is following through, which I feel is what it is, this facility is only going to improve if we stay the track on [the EC Program].

As the process for communication with the general staff was implemented, the general staff became aware of the initiatives that were being implemented by team members. Even though the general staff may not have been part of the goal development process, there was pride that co-workers were affecting change within their facility. This had the effect of increasing staff morale as a whole.

4.5.2 Increased Optimism

Once the program had been underway for a few months, team members began to see results from their actions, and became very confident that this would lead to further successes. There was a great deal of optimism that once changes began to happen, others would follow. This optimism was also applied to the excitement that the team felt for the program. They were confident that their excitement would spread to the general staff, and would only continue to grow.

> There were plans that were being made and *many* plans *still* to be made. That's going to enhance everything. Like everybody going to win. Like the residents are going to win. The staff is going to win. When people are winning, people want what we have.
>
> A small group of positive people eventually becomes a large group of positive people.

4.5.3 Understanding of Group Process

One of the consequences of respectful and open communication, transformational leadership, and creating change collectively was that the teams became aware of group process. That is, individuals came to understand the roles of staff members in other departments, how the departments were interdependent, how individuals could work cooperatively toward a common goal, and how to respectfully address challenges within a group setting. As challenges were

tackled and overcome, the understanding between team members increased, and assisted in the building of the team.

4.5.4 Cohesiveness

Over the seven months of this study, relationships developed between the team members that had not been present prior to the implementation of the program. As the team members shared experiences and had success with the goals, cohesiveness developed within the groups. The EC Program provided the framework from which team building occurred. There was a sense that the teams as units could accomplish the goals that they set out to accomplish, if the team members all worked together. Individuals within the teams felt the support of the others on the team, which empowered the individuals to complete tasks. Cohesiveness within the groups was enhanced by the teams working together towards common goals.

4.5.5 Team Expansion

The overall intent of the EC Program was to eventually include all staff members in the development of goals. Because of the goal implementation process, general staff members were already participants in the EC Program insofar as they were required to change their daily duties because of the goals set by the teams. Toward this end, team members needed to communicate changes to the general staff if the goals were to succeed. A natural extension of this communication was to expand the original team by including the general staff in future goal development. Team members were confident that their excitement would spread to the general staff, and that the team would continue to grow.

Communication between the team members and the general staff served two purposes. Firstly, many of the goals could not be achieved without the assistance of the general staff, and thus information needed to be passed on to those involved in the changes. In this way, results

were made possible. Goals were achieved. Secondly, communication was required for team recruitment. Team members took pride in outlining the changes that the team had already made within the facilities, in which some of the general staff had already participated. These successes were seen as an encouragement for others to join a team that was creating change in the facility.

> But I think we're starting somewhere and I think as we become more excited and as other people on staff start to recognize us as getting along, doing something, being productive, maybe this is a pipe dream, but I believe everybody else is, there's going to be a lot of other people who are going to come on board and who're going to get excited about what we're doing because they're going to see results.

An example of team recruitment was evident in Facility #1. At a general meeting, team members introduced a goal that had been discussed in one of the team meetings, that of redecorating an unused room so it could be used as a quiet room for visiting families. Team members asked whether anyone from the general staff would like to assist with this goal. Several people volunteered their time, and thus became members of the EC team. As such, these new members would have the opportunity to become involved in the development of new goals in the future.

4.5.6 Shared Power

An important component in the process of building effective teams is that of shared of power. For the purpose of this study, power is defined as the ability to effect change within these long-term care facilities. Prior to the implementation of the EC Program, the majority of the power to effect change was with facility managers. Facility managers have the authority to dictate changes to staff routine and staff assignments within every department in the facility. In actuality the facility manager has *power over* every worker. No other staff member in the facility has the same amount of authority over other staff members as the facility manager. This has implications for the process of building effective teams. In order for the process of building

effective teams to occur, the facility manager must be willing to share the power, or authority to create change, and the team members must be willing to accept the responsibility for the changes that will be implemented. There must be a transition from the facility manager having *power over* the staff members to the facility manager having *power with* the staff members.

By implementing the EC Program, the study facilities underwent a shift in their organizations. At the beginning of the project, the individual departments were quite insular. Staff within the departments had limited understanding of how the other departments operated on a day to day basis, and had no control or power to make changes outside of their own departments. In addition, communication occurred primarily between the facility manager and each department. Communication *between* departments was limited.

After the implementation of the EC Program, the departments had a greater understanding of how the others functioned, and had a process for communication that increased inter-departmental contact. Communication with the facility managers was also enhanced through the program. Individuals from each of the departments had participated in and taken ownership for creating change within their facilities. The power to create change was *shared* by the facility managers and members from all departments. Although the facility managers remained in positions of authority within the facilities, other team members were empowered to participate in initiatives that would enhance the care provided to their residents.

Within this study, creating change collectively was instrumental in the enhancement of team culture. The goal setting process focused the efforts of the teams, and the successful implementation of the goals provided a true sense of accomplishment to team members when they were able to observe positive changes in the lives of the residents within the facilities. Even though frustrations with the process of goal setting were present, the groups became more

cohesive as they negotiated through the difficult situations. Ultimately, the enhancement of care to residents with dementia gave meaning to their efforts, and was a source of pride. As the teams created changes within the facilities, team culture continued to grow stronger. As the team culture grew, the ability to create change was enhanced, which in turn strengthened the team culture. Thus, these two categories, creating change collectively and enhanced team culture, became a cycle.

Throughout this process of team building, trust continued to increase between team members. In effect, trust was required at every stage of the process. From the first meeting, team members needed to trust one another at a number of levels if the process was to succeed. As the teams learned to communicate and began to create change collectively, trust was reinforced. Within this process, trust was also necessary for the facility managers to relinquish some of their power in order for the team members to achieve their goals.

4.6 Theory Summary

In this theory, *The Process of Building Effective Teams*, five components were outlined: trust, respectful and open communication, transformational leadership, creating change collectively, and enhanced team culture. Each has been described, and each is vital to the process of building effective teams. As relationships are established between team members throughout this process, effective teams emerge. These teams are the result of positive communication between team members, the presence of strong leadership, and the ability of the groups to create change collectively. Trust is established, and allows for the teams to grow not only by the recruitment of others, but by reinforcing the relationships between team members. The building of enhanced team culture is the product of time and effort.

CHAPTER FIVE
DISCUSSION

The theory generated through this project, *The Process of Building Effective Teams*, arose as part of the process evaluation of the EC Program. This evaluation identified strengths of the program, as well as areas that could be improved upon. Throughout seven months of observation, focus group interviews, and individual interviews with general staff, I analyzed data and developed the theory *The Process of Building Effective Teams*. This theory explains the transformation that was observed in two groups of individuals from different facilities. At the outset, these groups were collections of individuals gathered together. By the end of the project, these groups had become cohesive units that functioned as effective teams. In this process, organizational change occurred. In this chapter, the evaluation of the EC Program and the theory *The Process of Building Effective Teams* will be discussed as they relate to the context of the Alzheimer Society of Canada, and as they relate to the body of literature in organizational change.

5.1 The Alzheimer Society of Canada

In October, 2005, I participated in a conference call with several members of the Alzheimer Society of Canada. The intent of this call was to include vital stakeholders in the planning stages of the research project so that questions of importance to the staff from the Alzheimer Society might be addressed in this research, since the EC Program was a product of their organization. Through this conversation, several facts became apparent. The first was that the context from which the EC Program was written and intended to be used was urban. When it was explained that the two potential study sites were small rural facilities, one of the members from the Alzheimer Society of Canada questioned whether the EC Program would be applicable

to such small facilities, since there would be a limited number of departments that could send representatives to participate in the EC teams. It was felt that the EC Program was most effective with a diverse group of professionals participating.

This urban bias was also apparent in the "Instructions" section of the EC Program manual, where it states that "the areas that should be represented [on the EC team] include; nursing (both supervisory and front-line staff), dietary, housekeeping, laundry, recreation, OT, PT, social work, family, administration, board members, and a representative from your local Alzheimer Society." (9, p.7) In small rural Saskatchewan long-term care facilities, it is unlikely that the staff would include members from all the disciplines listed, particularly occupational therapy, physiotherapy and social work. Rural institutions do not have access to these kinds of professionals to the same degree as their urban counterparts. (29)

The second area of concern that arose from the conference call with members from the Alzheimer Society of Canada was the nature of the planned program evaluation. Several members initially were not supportive of a process evaluation of the EC Program. They felt that the most meaningful information would be garnered by an outcome evaluation that could potentially show the efficacy of the program in the area of enhanced care for residents with dementia. It was only after a lengthy discussion that these members supported the project as a process evaluation. The benefits of such an evaluation were carefully outlined by my advisor, Dr. Debra Morgan, who stated that it was useful to know not only whether a program was working, but why it was working.

By completing a process evaluation of the EC Program in two rural settings, several insights were gained. The first insight was that the EC Program was viewed as beneficial by staff from the participating sites, but for reasons that members from the Alzheimer Society of

Canada may not have anticipated. During the focus group interviews, every team member stated that the EC Program was a positive influence within their facility. However, this positive influence was due to the fact that team culture had developed through the implementation of the EC Program. Although team members were optimistic that their participation in the program would lead to measurable outcomes in the area of enhanced care for residents with dementia, they felt that the program had not been implemented long enough for them to observe significant changes in that area. Therefore, even without measurable changes being seen in the care of residents with dementia, team members in the participating sites viewed the EC Program as beneficial.

This study highlighted the value of enhancing team culture within facilities. As part of the EC Program, it states that EC teams should be assembled, comprised of members from all departments within the facility. However, the focus of the program is on resident outcomes, that is, enhanced care for residents with dementia. Although enhanced care is ultimately the goal for the EC team, benefits may be seen prior to this as team members build trust and learn to function as a cohesive unit. Had this study focused only on resident outcomes, the value of building effective teams may have been overshadowed.

The second insight that was gained by completing a process evaluation of the EC Program in two rural facilities was that the EC Program can be successfully adapted by small facilities that do not have staff from a wide range of professions. During the conference call, members from the Alzheimer Society of Canada were skeptical that the program would be effective in small facilities that did not have consistent support from professionals such as physiotherapists and social workers. This study indicated that the program can have benefits to facilities, even without the support from these groups of professionals.

These benefits were seen because of the team building that occurred in each of the study facilities. Team building took place within a rural context, and was influenced by this rural context. In rural settings, the roles of family and community are central. Long-term care facilities are viewed as extensions of the community. Often, staff members know one another from other contexts. They are frequently relatives, friends, or neighbors. Staff members may attend the same church or belong to the same community group. Development of team culture within the workplace may be enhanced by the fact that at least some of the staff members would be familiar with one another from contexts outside of the workplace.

Another factor that may influence the building of effective teams within the rural context is the value of self-reliance that permeates rural life. One of the positive aspects of the EC Program as it relates to its adaptation by rural facilities is that the program is not prescriptive in nature. That is, the EC Program is based on Guidelines for Care, from which each facility develops its own list of needs and subsequent goals. Although examples are provided in the EC binder, at no time are facilities expected to conform to predetermined procedures or activities. Facilities are encouraged to develop goals that are specific to their sites. This aspect of the EC Program was appreciated by team members in the study facilities, and was mentioned in the focus group interviews at the conclusion of the study.

Conducting a process evaluation of the EC Program within two rural facilities allowed for the development of the theory, *The Process of Building Effective Teams*. This study illustrates the centrality of building effective teams to the implementation of the EC Program in small rural facilities. The stated goal of the EC Program is to enhance care for the person with Alzheimer Disease. (9) Although this goal is obtained through the formation of teams as outlined in the EC binder, the building of team culture as a goal in and of itself is not stated. Yet,

in these two rural sites, team building arose as the core category of the study. The importance of team building as a goal itself is not articulated in the EC binder. This finding may have implications for future implementation of this program in other small rural facilities.

5.2 Organizational Change

The implementation of the EC Program resulted in organizational change within the two rural facilities. At the outset of the project, the facilities in the study had a structure that placed the facility manager in charge of the front line staff, with the majority of information being transferred from the facility manager to the front line staff, but little information being transferred from the front line staff to the facility manager. During the implementation of the EC Program, a shift occurred. The facility manager and the front line staff began to share the tasks that enabled them to evaluate their facility and to establish goals to meet identified needs. Decision-making power was shared, in that all team members influenced the goal setting process, and were able to facilitate changes within the facility. The EC teams became effective and cohesive units. Team culture was enhanced as the EC Program progressed.

This organizational change was a process that took place over time. The process is described in the theory *The Process of Building Effective Teams.* This theory incorporates five categories: trust, respectful and open communication, transformational leadership, creating change collectively, and enhanced team culture. Each category will be discussed in this section as it relates to the current literature on the subject.

5.2.1 Respectful and Open Communication

Literature abounds on the importance of communication within organizations that want to create change. (56-60) In essence, the EC Program is a tool for change. The goal of the program as a whole is to enhance the care of residents with dementia, and this necessitates changes within

the facility to achieve this goal. The Ontario Prevention Clearinghouse provides resources to organizations wanting to create change within the workplace. In one of their publications, they state,

> Communication is an important part of creating change. Good communication doesn't just happen automatically, however, it requires attention, energy and respect for others…. Effective communication is about how information is shared, how input is sought, and how decisions are made. Key indicators of effective communication include:
>
> - More information about issues and process
> - Sooner, more often, and on demand
> - A variety of forms and channels
> - More opportunity for input and discussion
> - Clear guidelines for influencing decisions
> - Opportunities for ongoing dialogue (39, Article 4)

Using these indicators as guidelines, the efficacy of the communication during the implementation of the EC Program in the two facilities can be assessed. As was indicated in the process evaluation, the initial information regarding the intent of the program was not made clear to the team members. During the focus group interviews, many team members voiced frustration with the limited amount of information they had been given initially. They felt that they had not understood adequately what was to be expected of them during the EC team meetings. Several members stated that they would have benefited from clearer instructions at the outset. Thus, more information about the process of implementing the EC Program at an earlier time would have been appreciated by the team members. Providing information in a variety of forms and channels also arose as part of the process evaluation. This was evident particularly with respect to the team members communicating their goals with the general staff. In the facility where multiple avenues of communication were employed, the general staff was more informed regarding the EC Program as a whole.

During the EC team meetings, all team members were able to participate in the process of evaluating their facility and setting goals to address identified needs. In the team meeting setting, communication between all members was effective. The leadership, both formal and informal, encouraged respectful communication between all team members, and as a result, trust grew among team members. All team members were encouraged to provide input and join in discussions. Since the team meetings were scheduled in advance, team members could be confident that there would be opportunity for ongoing dialogue.

The challenge for both facilities was in communicating effectively with the general staff. At the end of the study period, the initial teams were attempting to include members from the general staff in the implementation of goals. This was viewed not only as part of the EC Program, but also as an important part of the team building process. Facility #2 had communicated more effectively with the general staff, due to their initial goal of weekly staff meetings. This strategy would have utilized several of the indicators mentioned above, those of providing information early on, providing information in a variety of forms (the minutes of the meetings were posted afterwards), and allowing for input and ongoing dialogue. Thus, according to the categories outlined by the authors at the Ontario Prevention Clearinghouse (39), Facility #2 would have been creating a climate that was more conducive for change than Facility #1.

The centrality of communication in the process of building effective teams and the resultant organizational change cannot be over emphasized. As Gibson and Barsade state, "Communication is one of the most important aspects of organizational change, yet managers often underestimate how much communication is needed during change processes."(7, p.28) A free flow of information to all staff members facilitates successful organizations. (61) When effective communication was evident, team members felt they were informed, included, and

ultimately respected. At the outset of this project, the team members did not feel that they had received sufficient information prior to the first EC meetings, and this lack of information was a source of frustration for several team members.

Communication processes offer the conduit through which innovation, learning, trust, and emotional comfort occur. (59-60) The frustration felt by the team members initially inhibited the process of team building and the development of trust. This study would suggest that in order for organizational change to take place in small rural facilities, communication is central, not only because it provides the conduit for innovation to occur, but because it provides the conduit through which team culture is enhanced.

5.2.2 Transformational Leadership

The five categories in the theory *The Process of Building Effective Teams* are inter-related. Each influences the others. The communication processes that were discussed in the above section are clearly influenced by the leadership within those facilities. For example, the EC Program would not have been introduced in the two study facilities had it not been for the vision of the facility manager and her commitment to the program. Initially, it was her role to communicate what she knew of the program to staff members as she was attempting to find participants for the EC teams. Within the team meetings, the guidelines for respectful communication between team members were introduced by the facilitator from the Alzheimer Society and later by the facility managers. These rules were reinforced throughout the project by the leaders modeling respectful communication with fellow team members. Within the context of organizational change, Gibson and Barsade state,

> Effective leadership is essential to driving [organizational] cultural change. Though culture change may be the result of environmental forces or political upheaval…, *managed* change implies active and intentional leadership in all aspects of the change process. To successfully manage change, leaders must create and sustain a vision of the

> future state; role model appropriate behaviors; manage shifting political coalitions; and manage the anxiety that naturally results from change. (7, p.24, Italics in the original)

The leadership described by Gibson and Barsade correlates with the leadership attributes that were outlined in the theory section above. (7) According to the theory, effective leadership attributes included being a visionary, an organizer, an educator, a mediator, a mentor, an overseer, a supporter, and a policy developer. Thus, it would follow that these leadership attributes would be conducive to managing organizational change within long-term care facilities.

Although organizational change was indeed an outcome of the EC Program, in that all team members became enabled to create change, this study demonstrated the centrality of building effective teams within rural settings as the avenue for organizational change. In rural settings, long-term care facilities are viewed as extensions of the community. Relationships within those facilities are of great importance to the staff members who work there. As such, the relationships between staff members and the facility managers in the study facilities are significant, in that they dictate what changes will be considered and what roles staff members can play in the implementation of those changes. The nature of the relationship between the leadership and the staff members impacts how changes within facilities are managed. As Deutschman states,

> …to adapt to change, there must be collaboration and flexibility. To encourage creativity and risk-taking, there is a need for mutual respect. Although change usually begins with leadership, communication and interpersonal behaviors make it work. Participation must replace control. (61, p.39)

Deutschman highlights key points for successful organizational change; collaboration, flexibility, respect, communication, interpersonal behaviors, and participation. (61) Leaders within long-term care facilities influence all of these aspects, and ultimately the relationship between

supervisors and the direct care workers impacts whether the workers feel valued and respected in the workplace. (63-66) As this study indicated, a respectful relationship between facility managers and staff members forms the foundation for creating change collectively and building effective teams.

McCormack et al state the importance of leadership as well with respect to its connection with teamwork. They note the benefits of transformational leadership which recognizes each worker as a valuable contributor within the facility. (67) With a transformational leader, a culture is created whereby everyone is viewed as a leader in some capacity within the organization. This style of leadership can influence the prevailing organizational culture so that teamwork and shared decision making processes are valued. (67) Bourbonnais et al write that sound leadership is needed not only to ensure the success of participatory interventions (of which the EC Program is one), but that sound leadership improves caregivers' quality of life. (68) In a program such as the EC Program, even with team members or 'champions' who are willing to initiate improvements within facilities, it depends on senior leaders to create an institutional culture that is ready to accept change, and to ensure the spread of the chosen improvements. (69)

The EC Program provided the context through which the organizational change occurred in the two study facilities. The program is structured in such a way as to encourage the development of multi-disciplinary teams with the goal of enhancing the care of residents with dementia. The program requires strong leadership in order for the change process to proceed, even as the power to create change is distributed among the team members. Without the leadership at the outset by the Alzheimer Society facilitator and later on in the process by the facility managers, the EC Program likely would not have been successful.

5.2.3 Creating Change Collectively

The overarching goal of the EC Program is to enhance the care of residents with dementia in long-term care facilities. This goal entails making changes to how care is delivered by care staff on the floor, which is guided by the leadership at the management level within those facilities. In this study, the purpose was not to conduct an outcome evaluation of the program. Changes to resident care due to the implementation of the EC Program in the two study facilities were not measured. However, changes did occur in other ways, primarily in how the facility managers shared power with the team members so all could be involved in setting and accomplishing goals.

In the theory, creating change collectively was achieved through taking ownership, creating manageable tasks, sharing labor, discerning gifts, expansion of roles, creating timelines, and the diffusion of power. The diffusion of power, the shared decision-making, required that the facility managers relinquish some control of the day to day management of the facility and allow the team members to make decisions that traditionally would not have been made by front line staff. In the literature, this diffusion of power could be considered empowering to general staff. Gruss et al. state,

> *Empowerment* is the process whereby organizational factors and job characteristics create an environment that may result in employee perceptions of having control and access to power within the organization, resulting in positive employee, organization, and family outcomes. (70, p.209, Italics in the original)

Staff empowerment has been shown to reduce work-related stress and improve the perceptions of the work environment among staff. (71-4) The importance of creating change collectively within this theory cannot be over-stated. Front-line workers experience high levels of job stress. (70) Part of the job stress is related to a lack of decision-making authority. (70) The EC Program addresses this issue and allows for all staff to contribute in the goal setting process.

The process of creating change collectively empowered the team members in both study facilities. During the focus group interviews, all the team members stated that the program had been beneficial, even without measured changes to the enhancement of care for residents with dementia. The benefits stated by the team members were relational in nature as teams were built, and indicated improved perceptions of the work environment within the study facilities. During the seven-month observation period, the barriers between members of the various departments were reduced. Within this study, empowerment of the team members was seen within the context of creating change collectively. This study identified strategies for creating change collectively that are applicable to small rural long-term care facilities. Thus, the process evaluation provided insights into how the EC Program could facilitate staff empowerment through the process of building effective teams.

5.2.4 Enhanced Team Culture

The theory developed during this study describes the process of building effective teams. During the observation period, team members from both facilities became cohesive units that functioned as effective teams. Team culture was enhanced. Although the EC Program dictates that teams are assembled in order to evaluate the facility and set goals, the teams were viewed as a means towards accomplishing results outside of the team setting, that is, enhanced care for the residents with dementia. However, this study indicated that there were benefits in the creation of effective teams, benefits that were not articulated by the members of the Alzheimer Society of Canada at the outset of the project. These benefits included increases staff morale, increased optimism, an understanding of group process, group cohesiveness and shared power.

This study did not measure the outcomes of the EC Program on the facilities as a whole, that is, how effective the implementation of the program was in enhancing the care of the

residents with dementia. However, the team members stated during the focus group interviews that they were optimistic that the goals they were implementing would result in enhanced care for the residents. In this study, team culture was enhanced due to a combination of benefits, such as increased staff morale and optimism in the enhanced care for residents. Even during the seven-month study period, team members were proud of the progress they had made in the areas where specific goals had been set and were being implemented. What this study indicated was the centrality of team building in rural facilities.

In the literature, teamwork is indicated as beneficial when working with residents with dementia. As McAiney notes,

> Being able to work effectively as a team is essential when working with ADRD [*Alzheimer Disease and Related Dementia*] residents because of the physical and mental demands of the job. Not only is it necessary to work with other staff to lift and transfer residents, but staff must also be able to rely on each other for emotional support and relief. (71, p.19)

McAiney states that teamwork assists in empowering special care aides, and ultimately in creating a positive work environment for staff and improvement in the quality of the staff's work. (71) However, Lescoe-Long cautions that teams need a stronger sense of purpose than mere camaraderie. (75) Rather, teams are most effective when they are encouraged to make decisions and problem solve as self-managing bodies. (75-76) Teams that are allowed to make decisions and problem solve can be agents of change within long-term care facilities. Gibson and Barsade indicate that staff participation within teams is essential in order for organizational change to occur and that this participation must be real and meaningful, with clear indications of how their ideas will be used. (7) Ultimately, when front line staff are encouraged to participate in problem solving, the solutions tend to be more creative and effective than when they are not involved. (77)

It should be noted that other factors beyond the implementation of the EC program in these facilities may have contributed to the enhanced team culture that was observed. For instance, during the study period a full-time manager was hired for one of the facilities. This meant that each facility had a manager, whereas previously one manager divided her time between the two sites. The presence of management in the facilities on a daily basis would likely have an impact on staff morale and how departments communicated with one another.

5.2.5 Trust

In the research, trust arose as an important component in the process of building effective teams. Trust was evident to some degree at the beginning of the project and increased as the team members implemented the EC Program. Trust was present at a number of levels. Trust was needed at the outset, as team members agreed to participate in the program. Team members needed to believe that the EC Program would be of some benefit to the facility in order for them to participate. Since the team members were acquainted with one another by nature of being coworkers, the team members were at minimum familiar with the names and faces of those participating in the program. With the ground rules clearly articulated by the facilitator from the Alzheimer Society, the familiarity amongst team members could develop into greater trust.

As the EC Program was implemented over time, the level of trust continued to grow. As team members set goals and completed tasks, team members began to trust the process, and to trust one another to accomplish the tasks that were agreed upon. Respectful relationships developed and nurtured the trust between team members. Trust became integral to the process of building effective teams.

Authors from the Ontario Prevention Clearinghouse introduce five levels of readiness in order for organizations to implement change. The authors state that an organization must

successfully meet the requirements of one level in order to face the challenges at the subsequent levels. (39) The five levels include providing supportive workplace conditions, creating a climate for change, building a culture of shared accountability, enhancing capacity for learning and nurturing learning communities. The most fundamental level, providing supportive workplace conditions, has the building of trust as its central tenet. These authors indicate that trust can only be established by understanding that workers have lives that go beyond their job descriptions, and that workers need to feel valued and supported for who they are, and not just for what they produce. (39) Without trust, organizations cannot proceed to the next level of readiness.

McDonald writes of the value of respectful relationships within the workplace. (63) She states,

> Trust is always at the heart of respect. When direct care workers don't trust their supervisors or managers to provide real support, they find other ways to protect themselves, shutting down the communication necessary for real understanding and respect to grow. (63, p.10)

McDonald acknowledges the importance of trust in the workplace for the purposes of staff recruitment and retention. McDonald's premise is that if organizations operationalize respect, and actively work at increasing respect shown between staff members and between staff members and their supervisors, there will be a reduction in the turnover rate. (63)

One study evaluated the effectiveness of an intervention on a long-term care unit. The intervention was participatory in nature. (78) That is, opportunities were created for employees in the facility to identify needs on the unit and to create simple action plans. The goal of the intervention was to improve the psychosocial environment on the unit. The key messages from the project were that interventions aimed at improving the social environment are most effective when the healthcare workers participate in the planning and implementation of the intervention;

that it is a challenge to involve managers in participatory interventions; that it is a challenge to establish and maintain trust within work teams, but that participatory interventions can have positive outcomes such as reductions in absenteeism and job strain. (78)

In many ways the conclusions drawn in this study mirrored the conclusions found in the process evaluation of the EC Program. The EC Program was participatory in nature. The facilitator from the Alzheimer Society stressed from the outset the importance of managerial support for the implementation of the EC Program if it was to be successful. The theory developed during the implementation process highlighted the importance of trust between team members in order for change to take place within the facilities. Although the outcomes are unknown in the study sites with regards to worker absenteeism or job strain after the implementation of the EC Program, the importance of supportive leadership, of trust, of creating change collectively, and of enhanced team culture were evident during the project.

In the case of the Ontario Prevention Clearinghouse, the purpose for writing about levels of readiness for organizations is to assist in successful organizational change. (39) Trust, as mentioned above, is central to the first level, and is essential in order for organizations to move forward with any kind of change. Trust plays a vital role in the health of an organization, both in terms of job satisfaction for its workers, and in terms of creating an atmosphere in the workplace that is conducive for change. The centrality of trust in this study as it relates to the process of building effective teams is in keeping with the tenets of these three sources.

The centrality of trust between coworkers, and between staff members and their supervisors has implications for the implementation of the EC Program in other facilities, particularly those in rural settings. Given the importance of community in rural facilities, it is not surprising that trust was a key category. Trust between members is a defining element of

community. It is an important distinction that trust within the process of building effective teams had benefits for the team members themselves, and was not only useful toward the end of enhanced care for residents with dementia. As the EC Program is implemented in other rural facilities, it could be beneficial to spend considerable time on group development that builds trust between team members.

5.2.6 The Process of Building Effective Teams

The theory that was developed throughout this project was a product of several factors. It developed within the context of the implementation of the EC Program in two rural facilities. As a result of the implementation of the program, the facilities underwent organizational change that empowered team members to create change within their facilities. Team culture was enhanced. The emergence of effective teams changed the cultural milieu of the facilities. The values inherently present in rural areas, such as self-reliance and the centrality of community, were strengthened as trust between the team members grew over time. Respectful relationships were nurtured. Staff members from various departments, who originally had little contact with staff members from other departments, were collectively creating change in their facility. Team members began to embrace a working atmosphere that emphasized inter-departmental collaboration over insular departments. The cultural shift also extended to the general staff, as team members sought to include others in the setting and implementation of new goals, such as creating a new quiet room for families.

Authors from the Ontario Health Promotion Resource Centre state that organizations typically base their strategy for creating change on one of two emotions, either fear or hope. (39) The results of this study would indicate that the EC Program is a hope-based intervention. In this study team members were empowered to create change within their workplace. In the study,

fear played no role in the program. In the end, both facilities experienced an organizational shift. It could be argued that Lewin's metaphor of the ice-cube could be applied to these two facilities, at least to some degree. (36) These two facilities did indeed change. The ice-cube did melt in the process of implementing the EC Program. However, it is debatable whether the ice-cube froze again into another state or whether the facilities remain in a state where ongoing change is the norm. That question remains unanswered to date.

One framework that offers a comparison to the theory stated in this thesis is outlined by Kitson, Harvey and McCormack. This framework is multidimensional, stating that successful implementation of any intervention "is a function of the relation between the nature of the evidence, the context in which the proposed change is to be implemented, and the mechanisms by which the change is facilitated." (79, p.150) These three dimensions, evidence, context, and facilitation, influence how effectively facilities are able to incorporate best-practice evidence into their daily routines, depending on whether the dimension is rated as low or high. For instance, a highly rated example of evidence would be the presence of evidence-based guidelines. A highly rated example of context would be clear leadership. A highly rated example of facilitation would be the presence of respect and empathy in the workplace. (79) When the evidence is robust, the context is receptive to change, and when the change process is facilitated appropriately, the more likely knowledge transfer is to occur resulting in improved resident outcomes. (67)

The dimensions listed in the framework are in keeping with the five key categories that were developed in the theory. The EC Program is based on eleven Guidelines for Care that were developed by the Alzheimer Society of Canada, an organization that sponsors and conducts research on dementia care. In addition, the Alzheimer Society provides a facilitator to any participating facility, ensuring strong leadership at the outset of the implementation process of

the EC Program. Before the program is implemented, the manager of the facility must be supportive of the project, or the program will not be implemented. The EC team is utilized throughout the entire program implementation, thus ensuring participation from staff members representing various departments. Using the framework as a guide, the EC Program would rate quite high in the three dimensions of context, evidence and facilitation. This rating would indicate the likelihood of knowledge translation within the facilities implementing the EC Program, which could result in improved resident outcomes.

5.2.7 The Interplay between the Theory and the Process Evaluation

The theory *The Process of Building Effective Teams* developed as the process evaluation of the EC Program was being conducted. The result of the process evaluation was a list of recommendations (Appendix M) that could be made to the EC Program in order to make it more sensitive to the unique needs of rural facilities. These recommendations are very concrete in nature. The theory that was developed throughout this project is abstract in nature, dealing with concepts and ideas. There were times that I felt very conflicted trying to negotiate between the concrete nature of the program evaluation and the abstract nature of theory development. Yet the two are intertwined. The theory would not have been developed had it not been for the process evaluation of the EC Program.

Even as the theory developed in conjunction with the process evaluation, there is merit in reversing the connection, reviewing the EC Program through the lens of the theory *The Process of Building Effective Teams*. What ultimately brings the two components together is the ability of the theory to inform the process evaluation. As the discussion with the members of the Alzheimer Societies of Canada and Saskatchewan indicated, the EC Program's intent is to enhance the care of residents with dementia. Although team building is not a stated goal of the

program per se, it was critical to creating change, the ultimate goal of the program. Thus, if the EC Program is to reach its potential efficacy in rural facilities, more attention is needed during the program implementation for team building initiatives, as the recommendations state in the process evaluation.

5.3 Research Strengths

A major strength of this research is its rural context. To date, the context of much of the research in long-term care has been urban. It cannot be assumed that programs that are successfully implemented in large urban facilities can be scaled down and utilized in small rural facilities. This study provides insight into how the EC Program could be further developed to meet the unique needs of rural facilities.

This research was conducted in two rural facilities. This allowed for comparisons between two sites, which added depth to the data that was collected. Subtle differences in the implementation of the program were observed that may not have been evident if the research had been conducted in only one site. The study was also conducted over the course of seven months. This was beneficial on a number of levels. Firstly, I was able to observe the implementation process from the beginning. I was able to be present for every EC meeting in both sites, which meant that there were no gaps in data collection. Secondly, I was able to watch the team members over time, and observe changes in such things as eye contact and body language. These changes would not have been as evident if the research had been conducted over a shorter period of time. Thirdly, when it came time for me to conduct the focus group interviews at the end of the study, the team members were comfortable with my presence, and were quite free with their comments. Had this familiarity not been there, the team members may not have been so candid with their comments.

The variety of data collection methods added strength to the research. Conducting focus group interviews allowed for all the team members to comment on the implementation process of the EC Program. Observation over time provided data collection of subtle body language and nuanced understanding of certain comments, since I became familiar with the team members as individuals. Interviews with numerous general staff members provided information from another perspective, from those individuals who had not been part of the EC team, but whose jobs would be influenced by the goals set by the team.

Finally, my familiarity with caring for residents in rural long-term care facilities is a strength of this study. I have eight years experience working as a nurse in a rural nursing home. This experience provided insight into how the study sites functioned on a day to day basis, and provided context for understanding many of the issues that arose during the study. Without this experience, I may have placed different emphasis on statements that were made by the team members, or I may have overlooked areas of importance to the team members.

5.4 Research Limitations

There are several limitations of this research. The first is that this research was conducted in only two sites. Gathering data from more than one facility elicited some divergent information and added depth to the study. However, including more sites in the study may have allowed other categories to emerge in the theory than the ones presented in this document. The second limitation of this research is that the two study sites were located in close proximity, and initially the same facility manager was responsible for both sites. It is difficult to say whether these two sites, geographically located in the same general area and managed by the same person, are representative of all rural long-term care facilities in Saskatchewan. The conclusions in the study may not apply to other facilities in other areas of rural Saskatchewan.

Another limitation in this study is that I was not able to conduct personal interviews with the team members in either site. Although most of the team members were present for the focus group interviews, it is possible that there was pressure to conform to the views expressed by coworkers. Had personal interviews been conducted, the individual team members may have felt more comfortable expressing unique views on the interview questions.

It is also important to note that I have eight years of experience working as a nurse in a rural long-term care facility. Although this allowed me some insight into how the study facilities operate, it may also have biased my perspective on certain issues. I may have coded certain phrases in a certain way due to the fact that those are issues in the facility where I work, and not necessarily because they are issues in the study sites. Although every effort was made to remain true to the grounded theory methodology, I am a product of my experiences, and view the world from a unique perspective. I did use several strategies to manage this bias. They included removing myself from my workplace for periods of time to work on the analysis of the data, spending close to a year working on the analysis as a whole, and meeting with my supervisors periodically to review my progress and to offer insights into my analysis.

5.5 Research and Practice Implications

The theory that was developed through this study indicates that developing programs for rural facilities is more complex than simply sizing down programs that are intended for urban facilities. Rural facilities are situated in a cultural milieu that differs from their urban counterparts, and program developers need to take this milieu into account if the programs are to be effective in rural Saskatchewan. Community is important to rural dwellers, and permeates the workplace. Programs that embrace the value of community are more likely to succeed in rural sites. This study has clear recommendations for the Alzheimer Society of Canada so that future

development of the EC Program can be sensitive to the unique needs of rural facilities.

This study was a process evaluation of the EC Program. As such, the focus was not on resident outcomes, but rather on discovering whether the program was being implemented as it was intended. The theory that was developed in the process indicated that one outcome of implementing the EC Program in two rural facilities was the building of teams. Further research focusing on an outcomes evaluation would add invaluable insights into the EC Program. The current study showed the value of team building as a benefit of implementing the EC Program. It would be beneficial to measure how residents within the facilities viewed their care after the EC Program was implemented, and whether there was a perception of enhanced care as a result.

Generally speaking, this study highlighted that valuable knowledge can be gained by conducting studies that center around caring for individuals with dementia in rural Saskatchewan. There continues to be an urban bias around research as well as program development since many of the resources are concentrated in urban settings. Unfortunately, this urban-centricity means that those living in rural areas do not have access to research that is rural specific. Further research concentrating on rural long-term care facilities would address this disparity.

5.6 Concluding Statement

This project is important. At the heart of this discussion are older individuals living in rural Saskatchewan, facing the devastating effects of dementia as well as the reality of living in a long-term care facility. These are our moms and dads, grandparents, neighbours, friends, and some day could be each one of us. Few of us look forward to being placed in one of these facilities. Most would prefer to avoid them altogether. One report suggested that close to 30% of those sampled would “rather die” than move permanently into a long-term care facility. (80)

Clearly, much needs to be done to change the negative image many people have about living in these facilities.

This project has the potential to affect a number of people whose voices are not being heard. First, those with dementia often can no longer advocate on their own behalf. Second, older individuals in general are not always treated with the respect or dignity that they deserve. Finally, those in rural areas face challenges that are typically unheard of in urban centers. The EC Program has the potential to address these areas. It addresses the needs of individuals with dementia who are living in long-term care facilities. Its mandate is to ensure that these individuals live in environments that optimize their abilities. An evaluation focusing on this program in a rural setting, making this tool adaptive to rural needs, is one small step towards creating facilities that we might one day actually *want* to live in.

References

1. American Psychological Association (APA). *DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders(4th ed. TR)*. Washington: Author; 2000.

2. Canadian Study of Health & Aging Working Group. The incidence of dementia in Canada. *Neurolog.* 2000; 55: 66-73.

3. Canadian Study of Health and Aging Working Group. Canadian study of health and aging: Study methods and prevalence of dementia. *Canadian Medical Association Journal.* 1994; 159(6): 899-913.

4. Statistics Canada. *Portrait of the Canadian Population in 2006, by Age and Sex, 2006 Census.* Ottawa: Minister of Industry, catalogue No. 97-551, 2006.

5. Ebly E, et al. Prevalence and type of dementia in the very old: Results from the Canadian study of health and aging. *Neurology.* 1994; 44: 1593-1600.

6. Rowles GD, Beaulieu JE, Myers WW, editors. *Long-term Care for the Rural Elderly.* New York: Springer; 1996.

7. Gibson DE, Barsade SG. Managing organizational culture change: The case of long-term care. *Journal of Social Work in Long-Term Care.* 2003; 2(1/2): 11-34.

8. Morgan DG, Semchuk KM, Stewart NJ, D'Arcy C. The physical and social environments of small rural nursing homes: Assessing supportiveness for residents with dementia. *Canadian Journal on Aging.* 2003; 22(3): 283-296.

9. Alzheimer Society of Canada. *Enhancing Care Through the Guidelines for Care.* Toronto: Alzheimer Society of Canada; 2001.

10. Canadian Study of Health and Aging Working Group. Canadian study of health and aging: Study methods and prevalence of dementia. And personal communication by Alzheimer Society of Saskatchewan . Cited by the Report of the Provincial Advisory Committee of Older Persons. *A strategy for Alzheimer Disease and Related Dementias in Saskatchewan.* Regina: Alzheimer Society of Saskatchewan; 2002.

11. McEwan K, Maxwell D, Gutman G. Basic facts and figures about dementia patients in institutions. In: Gutman G, editor. *Shelter and Care of Persons with Dementia.* Vancouver: The Gerontology Research Centre; 1992. p. 3-17.

12. Holmes D, Ramirez M. Models for individuals with Alzheimer disease: Beyond the special care framework. *Journal of Social Work in Long-Term Care.* 2003; 2(1/2): 175-181.

13. Report of the Provincial Advisory Committee of Older Persons. *A Strategy for Alzheimer Disease and Related Dementias in Saskatchewan*. Regina: Alzheimer Society of Saskatchewan;

2004.

14. Morgan DG, Stewart NJ. The importance of the social environment in dementia care. *Western Journal of Nursing Research.* 1997; 19(6): 740-761.

15. Ryden M, Bossenmaier M, McLachlan C. Aggressive behavior in cognitively impaired nursing home residents. *Research in Nursing and Health.* 1991; 14: 87-95.

16. Nasman B, Bucht G, Eriksson S. Behavioral symptoms in the institutionalized elderly: Relationship to dementia. *International Journal of Geriatric Psychiatry.* 1993; 8: 843-849.

17. Frazier C, Sherlock L. Staffing patterns and training for competent dementia care. In Aronson M, editor. *Reshaping Dementia Care: Practice and Policy in Long-term Care.* London: Sage; 1994.

18. Boettcher IF, Kemeny B, Deshon RP, Stevens AB. A system to develop staff behaviors for person-centered care. *Alzheimers Care Quarterly.* 2004; 5(3): 188-200.

19. Beck C, Ortigara A, Mercer S, Shue V. Enabling and empowering certified nursing assistants for quality dementia care. *International Journal of Geriatric Psychiatry.* 1999; 14: 197-212.

20. Aronson M, Cox D, Guastadisegni P, et al. Dementia and the nursing home: Association with care needs. *J Amer Geriatr Soc.* 1992; 40(1): 27-33.

21. Morgan DG, Semchuk KM, Stewart NJ, D'Arcy C. Job strain among staff of rural nursing homes: A comparison of nurses, aides, and activity workers. *JONA.* 2002; 32(3): 152-161.

22. Health Canada. *Canada's Aging Population* (Cat. H39-608/2002E). Ottawa: Division of Aging and Seniors; 2002.

23. Pampalon R. Health discrepancies in rural areas in Quebec. *Soc Sci Med.* 1991;33(4): 355-361.

24. Leipert B, Reutter L. Women's health and community health nursing practice in geographically isolated settings: A Canadian perspective. *Health Care Women.* 1998; 19(6): 575-88.

25. Bushy A. When your client lives in a rural area part I: Rural health care delivery issues. *Issues in Mental Health Nursing.* 1993 15: 253-66.

26. Pitblado JR, Pong RW, Irvine A, Nagarajan KV, Sahai V, Zelmer J, Dunikowski L, Pearson DA. *Assessing Rural Health: Toward Developing Health Indicators for Rural Canada.* Health Canada: Centre for Rural and Northern Health Research; 1999.

27. Du Plessis V, Beshiri R, Bollman R, Clemenson H. Definitions of rural. *Rural and Small*

Town Canada Analysis Bulletin. 2001.

28. Elliot D. *Sask Trends Monitor*, July Issue (vol XXIV,7). 2007.

29. Rural Health. *Rural Health in Rural Hands: Strategic Directions for Rural, Remote, Northern and Aboriginal Communities*. Health Canada. 2002. Available from: URL: http://www.hc-sc.gc.ca/english/ruralhealth/rural_hands.html

30. Greenhalgh T, Robert G, MacFarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly.* 2004; 82(4): 1-33.

31. Leon J, Cheng C, Alvarez R. Trends in special care: Changes in SCU from 1991 to 1995 ('95/'96 TSC). *Journal of Mental Health and Aging.* 1997; 3(2): 149-168.

32. Siehl C, Martin J. The role of symbolic management. How can managers effectively transmit organizational culture? In Hunt J, Hosking D, Schriesheim C, Stewart R, editors. *Leaders and Managers: International Perspectives on Managerial Behavior and Leadership.* Elmsford: Pergamon; 1984. p. 227-239.

33. Krasnausky P. Being who we say we are: "Culture change" helps two long-term care centers align practice with their sponsors' values. *Health Progress.* 2004; 85(3), 50-54.

34. Berta W, Teare GF, Gilbart E, Ginsburg LS, Lemieux-Charles L, Davis D, Rappolt S. The contingencies of organizational learning in long-term care: Factors that affect innovation adoption. *Health Care Manage Rev.* 2005; 30(4): 282-92.

35. Bolognese AF. *Employee Resistance to Organizational Change* [Online]. 2002 [cited 2007 March 05]: Available from: URL: http://www.newfoundations.com/OrgTheory/Bolognese721.html

36. Lewin K. *Resolving Social Conflicts & Field Theory in Social Science.* Washington: American Psychological Association; 1997.

37. Ministry of Agriculture, Food and Rural Affairs, Government of Ontario. *Understanding Change.* 1997 March; 5 screens. Available from: URL: http://www.omafra.gov.on.ca/english/rural/facts/91-014.htm

38. Wons E. *Organizational Change: An Ethical, Means-based, Approach to Organizational Change.* 1999; about 3 screens. Available from: URL: http://www.jpc-training.com/change/review.htm

39. Ontario Prevention Clearinghouse: *Health Promotion Resource Centre Articles 1- 6* [Online]. [2003?] [cited 2006 Jan 23]. Available from: URL: http://www.opc.on.ca/english/our_programs/hlth_promo/resources/org cap.htm

40. Bigbee J, The uniqueness of rural nursing. *Nurs Clin North Am.* 1993; 28(1): 131-44.

41. Forbes-Chilibeck, E. Have you heard the one about the farmer's daughter? Gender-bias in the intergenerational transfer of farm land on the Canadian prairies. *Canadian Woman Studies.* 2005; 24.4(Summer-Fall): 26-36.

42. Sullivan MP, Parenteau P, Polansky D, Leon S, Le Clair JK. Shared geriatric mental health care in a rural community. *Canadian Journal of Rural Medicine.* 2007; 12.1(Winter): 22-30.

43. Esreld LE. A case study of senior students' perceptions of factors that shape aspirations in one low-income rural Iowa high school. *Dissertation Abstracts International: The Humanities and Social Sciences.* 2004: 65(2): 460-A.

44. Alzheimer Society of Canada. *Enhancing Capacity for Alzheimer Care in Long-term Care Facilities: Final Report.* Toronto: Alzheimer Society of Canada; 1999.

45. Patton MQ. *Utilization-focused evaluation.* Thousand Oaks: Sage; 1997.

46. Rossi PH, Lipsey MW, Freeman HE. *Evaluation: A systematic approach (7th Edition).* Thousand Oaks: Sage; 2004.

47. King JA, Morris LL, Fitz-Gibbon CT. *How to Assess Program Implementation.* Newberry Park: Sage; 1987.

48. Chelimsky E. *Evaluation for the 21st Century*. Thousand Oaks: Sage; 1997.

49. Glaser BG. *Theoretical Sensitivity.* Mill Valley: The Sociology Press; 1978.

50. Charmaz K. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage; 2006.

51. Mills J, Bonner A, Francis K. Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice.* 2006; 12: 8-13.

52. Stake RE. *Standards-based and Responsive Evaluation.* Thousand Oaks: Sage; 2004.

53. Patton MQ. *Qualitative Research and Evaluation Methods (3rd edition).* Thousand Oaks: Sage; 2002.

54. Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* New York: Aldine de Gruyter; 1967.

55. Lincoln YS, Guba EG. *Naturalistic Inquiry.* Beverly Hills: Sage; 1985.

56. Corazzini K. McConnell ES, Rapp CG, Anderson RA. Providing dementia care: Educating caregivers for person-centered dementia care. *Alzheimers Care Q.* 2004; 5(3):197-206.

57. Bond G, Fiedler FE. The visibility of organizational culture in a long-term care facility. *Journal of Nursing Administration.* 1998; 28(4): 7-9.

58. McConnell CR. Larger, smaller, and flatter: The evolution of the modern health care organization. *Health Care Manager.* 2005; 24(2): 177-88.

59. Laschinger HK, Havens DS. Staff nurse work empowerment and perceived control over nursing practice: Conditions for work effectiveness. *Journal of Nursing Administration.* 1996; 26: 27-35.

60. Havens DS, Wood SO, Leeman J. Improving nursing practice and patient care: Building capacity with appreciative inquiry. *Journal of Nursing Administration.* 2006; 36(10): 463-70.

61. Colon-Emeric CS, Ammarell N, Bailey D, Corazzini K, Lekan-Rutledge D, Piven ML, Utley-Smith Q, Anderson RA. Patterns of medical and nursing staff communication in nursing homes: Implications and insights from complexity science. *Qualitative Health Research.* 2006; 16(2): 173-88.

62. Deutschman M. Interventions to nurture excellence in the nursing home culture. *Journal of Gerontological Nursing.* 2001; August: 37-43.

63. McDonald IJ. Respectful relationships: The heart of better jobs better care. *Better Jobs Better Care Issue Brief.* 2007; 7(April): 1-16.

64. Leiter MP, Harvie P. Correspondence of supervisor and subordinate perspectives during major organizational change. *Journal of Occupational Health Psychology.* 1997; 2(4): 343-352.

65. Golden-Biddle K, Hinings CR, Casebeer A, Pablo A, Reay P. *Organizational Change in Healthcare with Special Reference to Alberta.* Edmonton: Canadian Health Services Research Foundation; 2006.

66. McGilton K, McGillis Hall L, Pringle D, O'Brien-Pallas L, Krejci J. *Identifying and Testing Factors that Influence Supervisors' Abilities to Develop Supportive Relationships with Their Staff.* Ottawa: Canadian Health Services Research Foundation; 2004.

67. McCormack B, Kitson A, Harvey G, Rycroft-Malone J, Titchen A, Seers K. Getting evidence into practice: The meaning of 'context'. *Journal of Advanced Nursing.* 2002; 38(1): 94-104.

68. Bourbonnais R, Vezina M, Durand P, Viens C, Brisson C, Vinet A, Gauthier N, Lavoie-Tremblay M, Alderson M, Dicaire L, Ouellet JP, Boudreau-Levesque D, Harvey C. *Evaluative Research Intervention to Optimize the Psychosocial and Organizational Work Environment for Caregiving Staff.* Ottawa: Canadian Health Services Research Foundation; 2004.

69. Bodenheimer T. *The Science of Spread: How Innovations in Care Become the Norm.* San

Francisco: California HealthCare Foundation; 2007.

70. Gruss V, McCann JJ, Edelman P, Farran CJ. Job stress among nursing home certified nursing assistants: Comparison of empowered and nonempowered work environments. *Alzheimer's Care Quarterly.* 2004; 5(3): 207-216.

71. McAiney CA. The development of the empowered aide model: An intervention for long-term care staff who care for Alzheimer's residents. *Journal of Gerontological Nursing.* 1998; 24(1): 17-22.

72 Laschinger HK, Finegan J, Shamian J, Wilk P. Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding Kanter's model. *JONA.* 2001; 31(5): 260-272.

73. Hill K. Positive organizational scholarship. *Journal of Nursing Administration.* 2007: 37(2): 74-6.

74. Laschinger HK, Finegan J, Shamian J, Wilk P. A longitudinal analysis of the impact of workplace empowerment on work satisfaction. *Journal of Organizational Behavior*. 2004; 25: 527-45.

75. Lescoe-Long M. Keeping frontline workers in long-term care: Research results of an intervention. *Kansas Association of Homes and Services for the Aging: Report.* 2003; December: 1-20.

76. Stone R, Reinhard S, Bowers B, Zimmerman D, Phillips CD, Hawes C, Fielding JA, Jacobson N. Evaluation of the wellspring model for improving nursing home quality. *Institute for the Future of Aging Services.* 2002; August: 1- 43.

77. Nakhnikian E. Quality improvement organizations: Recognizing direct-care workers' role in nursing home quality improvement. *Better Jobs Better Care Issue Brief.* 2004; 4(August): 1-8.

78. Lavoie-Tremblay M, Bourbonnais R, Viens C, Vezina M, Durand PJ, Rochette L. Improving the psychosocial work environment. *Journal of Advanced Nursing.* 2005; 49(6): 655-664.

79. Kitson A, Harvey G, McCormack B. Enabling the implementation of evidence based practice: A conceptual framework. *Quality Health Care.* 1998; 7: 149-158.

80. Kane RA. Long-term care and a good quality of life: Bringing them closer together. *The Gerontologist.* 2001; 41(3): 293-304.

Appendix A

Guidelines for Care

1. Specialized Training and Education for Caregivers
   - All caregivers should have access to training and education which will help them understand the disease process and assist them in their role as caregiver
   - Staff of facilities and agencies should be required to participate in a training and education program on meeting the needs of people with Alzheimer Disease and their caregivers.
   - An orientation program should be provided for all caregivers involved in services for people with Alzheimer Disease.

2. Support for Caregivers
   - All services should meet the needs of family caregivers as well as the needs of the person with Alzheimer Disease.
   - All caregivers should have access to supports and resources to relieve the work and stress which may result from caring for people with Alzheimer Disease

3. Individual Assessment
   - Each individual should receive a comprehensive assessment which will identify his or her needs, strengths and abilities and personal characteristics.
   - Where possible, the assessment should be carried out to a multi-disciplinary team in which each component is carried out by the team member most qualified to administer that particular portion.
   - The assessment should address the social circumstances of the person with Alzheimer Disease and of their caregivers.
   - The assessment process should address the safety and security of the person with Alzheimer Disease.
   - On-going assessments should monitor changes in the individual and his or her circumstances.

4. Individualized Care Planning
   - Care planning for the individual with Alzheimer Disease should be carried out by a multi-disciplinary team.
   - An individualized and comprehensive care plan should be prepared for each individual.

5. Meaningful Programs and Activities
   - Programs for persons with Alzheimer Disease should include the routines of daily living as well as special activities.
   - Programs serving people with Alzheimer Disease should promote well-being and enjoyment; respond to the individual's physical, emotional, spiritual and sensory needs; and encourage as much autonomy as possible
   - Programs and activities should be flexible and change in response to the changing

needs of the person with Alzheimer Disease.

6. Specialized Human Resources
   - Procedures relating to the use of staff and volunteers in facilities and agencies should reflect the special requirements of people with Alzheimer Disease.
   - Performance appraisals should address the special issues facing staff and volunteers who provide care for people with Alzheimer Disease.

7. Supportive Physical Environment
   - The environment should meet the safety and security needs of the individual with Alzheimer Disease.
   - The environment should reduce the confusion of the person with Alzheimer Disease.
   - The environment should contribute to the effective functioning of the individuals with Alzheimer Disease and their caregivers.

8. Transportation
   - Vehicular transportation should be provided in a manner which ensures the safety and emotional comfort of the person with Alzheimer Disease.

9. Decision-Making: Respecting Individual Choice
   - The individual with Alzheimer Disease and/or designated decision-maker should have maximum involvement when decisions about the person with Alzheimer Disease are taking place.
   - If an assessment of competency is required, the assessment should be undertaken by an individual or team which has special skill in making competency assessments.

10. Prevention of and Response to Abuse
    - The emphasis should be on preventing abuse by identifying and alleviating circumstances which are likely to lead to physical, psychosocial or financial abuse or neglect.
    - Facilities and agencies should have a protocol to deal with abuse.
    - Caregivers should take action when they suspect abuse has occurred.

11. Use of Restraints
    - The emphasis should be on eliminating the need to contemplate restraint use by preventing or managing the behavior which leads to the desire to use restraints.
    - Every facility or agency should have a clearly stated protocol on the use of physical, chemical and environmental restraints.
    - Every effort should be made to reduce the negative impact of the experience and preserve the person's dignity.

Appendix B

Ethical Approval of the Research Project by the Behavioral Research Ethics Committee, Office of Research Services, University of Saskatchewan

University of Saskatchewan
Behavioural Research Ethics Board (Beh-REB)

19-Jan-2006

Certificate of Approval with Minor Modifications

PRINCIPAL INVESTIGATOR	DEPARTMENT	BEH#
Debra Morgan	Centre for Agricultural Medicine	06-12

STUDENT RESEARCHER(S)
Anita Bergen

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED (STUDY SITE)
University of Saskatchewan

SPONSOR
CANADIAN INSTITUTES FOR HEALTH RESEARCH (CIHR)

TITLE
Organizational Change in Rural Long-Term Care Facilities: An Implementation Evaluation of a Program Designed to Address the Needs of Residents with Dementia

ORIGINAL APPROVAL DATE	CURRENT RENEWAL DATE
19-Jan-2006	01-Jan-2007

CERTIFICATION

Thank you for submitting the above application to the Behavioural Research Ethics Board for review. The Beh-REB has **approved** your research proposal on ethical grounds, **subject to the following minor modifications:**

- Please offer clarification pertaining to the who will be included as particpants in the project. Also, please clarify exactly how many interviews and/or focus groups each particiapant will be asked to participate in. Please make this clear in the consent form as well as the ethics application.
- Will consent be obtained prior to each interview and/or focus group?

Please send one copy of your revisions to the Ethics Office for our records. **Please highlight or underline any changes made when resubmitting.**

The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

This letter serves as your Certificate of Approval, **effective as of the time that the requested modifications are received by the Ethics Office**. If you require a letter of unconditional approval, please so indicate on your reply, and one will be issued to you.

Please send all correspondence to:

Ethics Office
University of Saskatchewan
Room 306 Kirk Hall, 117 Science Place
Saskatoon SK S7N 5C8

ONGOING REVIEW REQUIREMENTS

The term of this approval is five years. However, the approval must be renewed on an annual basis. In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: *http://www.usask.ca/research/ethical.shtml* .

Dr. Valerie Thompson, Chair
Behavioural Research Ethics Board
University of Saskatchewan

Please send all correspondence to:

Ethics Office
University of Saskatchewan
Room 306 Kirk Hall, 117 Science Place
Saskatoon SK S7N 5C8
Telephone: (306) 966-2084 Fax: (306) 966-2069

Appendix C

Consent Form for Discussion Group Participants

You are invited to participate in a study entitled: *Organizational Change in Rural Lon-Term Care Facilities: An Implementation Evaluation of a Program Designed to Address the Needs of Residents with Dementia.* Please read this form carefully, and feel free to ask questions you might have.

Researcher: My name is Anita Bergen, and I am a graduate student at the University of Saskatchewan in the department of Community Health and Epidemiology. If at any time you have any questions or concerns, I can be reached at camandanita@canada.com . My advisor, Dr. Debra Morgan, will be assisting me with this project, and can be reached at (306)-966-7905, or at debra.morgan@usask.ca.

Purpose and Procedure: The purpose of this study is to evaluate how the Enhancing Care Program is implemented, in an attempt to inform ongoing program improvement that is sensitive to the specific needs of rural facilities. The discussion group that you are participating in will be about one hour in duration. You may be asked to participate in a total of two discussion groups over a three month period.

Potential Benefits: As a participant, you will be given the opportunity to express your opinions and ideas about this program, so that changes can be made to make the program as sensitive as possible to the needs of rural facilities. Ultimately, this could impact not only the lives of people with dementia living in long-term care facilities, but also the working conditions for those caring for these residents. Participation is voluntary, and there are no anticipated risks for participating.

Storage of Data: Discussion group transcripts will be securely stored at the University of Saskatchewan by Dr. Debra Morgan, the principal investigator for the study. The data will be kept for a minimum of 5 years and then destroyed.

Reporting of the Results: The results of this study will be used in various ways. Firstly, it will appear as a thesis, to fulfill the requirements of the program of study of the researcher. Secondly, findings will be submitted to scientific journals for publication. Thirdly, a report will be made and submitted to both the Alzheimer Society and the facility manager of the participating institutions. Finally, presentations may be made at scientific conferences, to the regional health authority, to the Saskatchewan Association of Healthcare Organizations (SAHO), or to the Alzheimer Society.

Confidentiality: The data from this study will be published and presented at conferences; however, your identity will be kept confidential. Although we will report direct quotations from the discussion group, all identifying information will be removed from our report. If, at some later point, you have any second thoughts about your responses, you can contact us, and we will remove your responses from the data base. We will undertake to safeguard the confidentiality of the discussion, but cannot guarantee that other members of the group will do so. We ask that you respect the confidentiality of the other members of the group by not disclosing the contents of

this discussion outside the group, and be aware that others may not respect your confidentiality. Because the participants for this study work in small facilities where co-workers know one another, it is possible that you may be identifiable to other people on the basis of what you have said. Care will be taken in written reports to avoid using quotations that may identify particular individuals.

Right to Withdraw: Your participation is voluntary, and you may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed at your request. You may also refuse to answer individual questions.

Questions: If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researchers at the number provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (date). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect. You can find out about the results of the study by contacting us at any time. A summary of the study findings will be made available to all staff in the participating facilities.

Consent to Participate: I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

_____	_____
(Name of Participant)	(Date)
_____	_____
(Signature of Participant)	(Signature of Researcher)

Appendix D

Consent Form for Individual Interviews

You are invited to participate in a study entitled: *Organizational Change in Rural Lon-Term Care Facilities: An Implementation Evaluation of a Program Designed to Address the Needs of Residents with Dementia.* Please read this form carefully, and feel free to ask questions you might have.

Researcher: My name is Anita Bergen, and I am a graduate student at the University of Saskatchewan in the department of Community Health and Epidemiology. If at any time you have any questions or concerns, I can be reached at camandanita@canada.com . My advisor, Dr. Debra Morgan, will be assisting me with this project, and can be reached at (306)-966-7905, or at debra.morgan@usask.ca.

Purpose and Procedure: The purpose of this study is to evaluate how the Enhancing Care Program is implemented, in an attempt to inform ongoing program improvement that is sensitive to the specific needs of rural facilities. The interview that you are participating in will be between 30 and 60 minutes in duration. This study will be conducted over a six month period, and you may be asked to participate in as many as four interviews over that time.

Potential Benefits: As a participant, you will be given the opportunity to express your opinions and ideas about this program, so that changes can be made to make the program as sensitive as possible to the needs of rural facilities. Ultimately, this could impact not only the lives of people with dementia living in long-term care facilities, but also the working conditions for those caring for these residents. Participation is voluntary, and there are no anticipated risks for participating.

Storage of Data: Interview transcripts will be securely stored at the University of Saskatchewan by Dr. Debra Morgan, the principal investigator for the study. The data will be kept for a minimum of 5 years and then destroyed.

Reporting of the Results: The results of this study will be used in various ways. Firstly, it will appear as a thesis, to fulfill the requirements of the program of study of the researcher. Secondly, findings will be submitted to scientific journals for publication. Thirdly, a report will be made and submitted to both the Alzheimer Society and the facility manager of the participating institutions. Finally, presentations may be made at scientific conferences, to the regional health authority, to the Saskatchewan Association of Healthcare Organizations (SAHO), or to the Alzheimer Society.

Confidentiality: The data from this study will be published and presented at conferences; however, your identity will be kept confidential. Although we will report direct quotations from the interview, all identifying information will be removed from our report. If, at some later point, you have any second thoughts about your responses, you can contact us, and we will remove your responses from the data base.

Right to Withdraw: Your participation is voluntary, and you may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed at your request. You may also refuse to answer individual questions.

Questions: If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researchers at the number provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (date). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect. You can find out about the results of the study by contacting us at any time. A summary of the study findings will be made available to all staff in the participating facilities.

Consent to Participate: I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

_____	_____
(Name of Participant)	(Date)
_____	_____
(Signature of Participant)	(Signature of Researcher)

Appendix E

Data Collection Time-line

Data Collection Technique	Participants	Dates
Telephone Conversations	Executive Director of the Alzheimer Society of SK	September 16, 2005
	Facility Manager from EC Facility	October 5, 2005
Conference Call	Alzheimer Society of Canada Staff Members	October 18, 2005
	Alzheimer Society of SK Staff Members	
Observations of EC Meetings	Facility #1 EC Team	April – October, 2006
	Facility #2 EC Team	
Focus Group Discussion	Facility #1 EC Team	August 31, 2006
Observations	Facility #1 General Staff Meeting	September 12, 2006
Interviews	Facility #1 General Staff	October 5, 2006
Interview	Manager of Facility #1	October 5, 2006
Interviews	Facility #2 General Staff	October 12, 2006
Interview	Facilitator from Alzheimer Society of SK	October 19, 2006
Focus Group Discussion	Facility #2	October 24, 2006
Interview	Manager of Facility #2	October 27, 2006

Appendix F

EC Team Meetings

EC Team Meetings – Facility #1

Meeting	Date
Facility Assessment with Facilitator	April 20, 2006
Facility Assessment without Facilitator	May 16
Goal Setting with Facilitator	June 8
Goal Setting without Facilitator	July 11
Goal Setting without Facilitator	August 31
General Staff Meeting	September 12

EC Team Meetings –Facility #2

Meeting	Date
Facility Assessment with Facilitator	April 19, 2006
Facility Assessment without Facilitator	May 17
Goal Setting with Facilitator	June 9
General Staff Meeting	June 22
Goal Setting without Facilitator	July 18 – Cancelled
Goal Setting without Facilitator	September 8
Goal Setting without Facilitator	October 24

Appendix G

Interview Guide
Focus Group Interview

Introduction

How would you describe the EC Program? What are the key components?
What is the purpose of this program? Why did your facility choose to through it?
Who are the key participants?

Multi-disciplinary Teams

How were members chosen?
Describe the EC Team meetings. Did they proceed as expected?
Did you feel you understood what was expected of you?
Did you feel that your opinions were heard?

Binder

Was it easy to understand?
Comments. Suggestions for improvements.

Rating System

How did you find the rating system?
How did you feel when you had to answer a "1" for not knowing?

Facilitator

What was your experience?
Strengths and weaknesses of having a facilitator present vs doing it on your own.

Staff Morale

How has staff morale changed because of this program?
How has the general staff responded to the program so far?

Summary

Would you recommend this program to other facilities?
General comments about the program. Suggestions for improvements.

Appendix H

Interview Guide
General Staff

What is the EC Program, as you understand it?

How did you learn about it?

What do you think of the new goals for care?

At the beginning of the process, one person from your department was selected to participate in the team meetings. How did you feel about that?

Has anything changed in your department because of the program?

Any suggestions for better communication?

Comments.

Appendix I

Misunderstood Wording from the Binder

1. Clutter
2. Equipment (for example, does it include knives from the kitchen?)
3. Toilet vs bathroom
4. Timely (as in "Care plans reviewed on a *timely* basis")
5. Caregiver (who is a *caregiver?)*
6. Therapeutic
7. Physical functions
8. Spiritual
9. Familiar (as in "The person with Alzheimer Disease has opportunities to participate in *familiar* activities)
10. Grab rails
11. Restraints monitored
12. Restraints reviewed
13. Multi-disciplinary
14. Cross training
15. Generic staffing
16. Companion
17. Socialize
18. Unplanned breaks
19. "Job descriptions outline qualities of applicants."
20. Consistent staffing
21. "Individual access to family members is considered." (Does this mean the facility assists family members to visit the resident or the facility assists the resident to visit the family?)
22. Need vs objective vs goal

Appendix J

Assessment Timelines

Facility #1 – Assessment with Alzheimer Society Facilitator – April 20, 2006

Guideline	Number of Questions
Specialized Training	33 Questions
Individualized Care Planning	6 Questions
Meaningful Programs	14 Questions
Physical Design	29 Questions
Use of Restraints	10 Questions
Total: 5 Guidelines	**Total: 92 Questions**

Facility #1 – Assessment without the Alzheimer Society Facilitator – May 16, 2006

Guideline	Number of Questions
Support for Caregivers	11 Questions
Individualized Assessment	13 Questions
Human Resources	12 Questions
Decision Making	9 Questions
Transportation	7 Questions
Response to Abuse	7 Questions
Total: 6 Guidelines	**Total: 59 Questions**

Facility #2 – Assessment with the Alzheimer Society Facilitator – April 19, 2006

Guideline	Number of Questions
Individualized Assessment	13 Questions
Meaningful Programs	14 Questions
Specialized Training	33 Questions
Individualized Care Planning	6 Questions
Physical Design	29 Questions
Decision Making	9 Questions
Total: 6 Guidelines	**Total: 104 Questions**

Facility #2 – Assessment without the Alzheimer Society Facilitator – May 17, 2006

Guideline	Number of Questions
Support for Caregivers	11 Questions
Human Resources	12 Questions
Use of Restraints	10 Questions
Transportation	7 Questions
Response to Abuse	7 Questions
Total: 5 Guidelines	**Total: 47 Questions**

Appendix K

SMART Principles

Specific: Is the goal specific?
Is it clear?
Will you know if the goal has been achieved?

Measurable: Will you be able to collect information to measure when and how your goal is achieved?

Actionable: Will you be able to take action to achieve this goal?

Relevant: Is it necessary to reach this goal in order to improve your program or residential unit?

Timely: Is this goal realistic right now?

The goal is to be revised until you are able to answer “YES” to all questions.

Appendix L

Goal Setting

Facility #1 – Goals Set with Alzheimer Society Facilitator – June 8, 2006
Need: Consistent orientation fro new family members
Goals:

1. Review existing handbook
2. Develop plan for dissemination of pertinent information

Facility #1 – Goals Set Without Alzheimer Society Facilitator – July 11, 2006
Need: Consistent orientation for new family members
Goals:

1. Develop comprehensive orientation plan
2. Develop admission day information package
3. Develop and implement family orientation session
4. Create a general information binder
5. Develop and implement a communication strategy for information related to EC Program (bulletin board, staff newsletter, orientation packages, monthly EC general staff meetings)

Facility #2 – Goals Set with Alzheimer Society Facilitator – June 9, 2006
Need: Staff rewarded for bringing new ideas
Goals:

1. Plan general staff information meeting
2. Plan facility care team meeting
3. Inform everyone of general staff meeting

Facility #2 – Goals Set without the Alzheimer Society Facilitator – September 8, 2006
Need: Every assessment completed by members of a multi-disciplinary team
Goals:

1. Train and retrain staff regarding tic sheets
2. Educate staff regarding purpose and importance of multi-disciplinary team in the assessment
3. Implementation of assessment process by multi-disciplinary team

Appendix M

List of Recommendations

1. That the Facilitator Training sessions be reviewed by the EC Program Coordinator at the Alzheimer Society of Canada to ensure facilitators are trained in group process, facilitation techniques, goal setting strategies, and dementia care in long-term care facilities.

2. That the Alzheimer Society facilitators initiate communication with on-site coordinators at regular intervals before and during the implementation of the EC Program.

3. That the wording throughout the binder be revised to make all terms clear and unambiguous.

4. That the rating system be modified to include an "I don't know" category.

5. That the Facilitator Training be modified to make it possible that the assessment component be completed in one session.

6. That the assessment questions requiring a rating be reduced in number.

7. That each of the 11 Guidelines for Care has its own separate tab in the binder.

8. That a person be explicitly named as the recorder for the meetings by the on-site coordinator or the facilitator. This will ensure that detailed notes are taken at each meeting and minutes distributed to each team member after the meeting.

9. That the recorder take minutes of the assessment meetings, including successes and needs, and distribute them to all team members and the facilitator prior to the goal setting meeting.

10. That at the end of the assessment meeting, a small committee be struck that would review the needs of the facility, and give them the authority to prioritize them.

11. That a sheet be provided that clearly and simply outlines the process of goal setting, providing definitions and examples of each stage in goal setting (issue, guidelines, objective, need, goal, task).

12. That some group work exercises be added to the introductory section of the assessment meeting that include an overview of group process as well as problem solving strategies.

13. That several goals be set at the initial meeting with the facilitator so that groups feel confident about the process when they meet independently.

14. That a section in the EC binder be added specifically for the worksheets (allowing them to be photocopied as needed) and place the examples and resources directly after the assessment for each guideline.

15. That the assessment meeting and the goal setting meeting be scheduled as closely together as possible to ensure that momentum is maintained.

16. That the “Do Not Copy” phrase be removed from the binder. Change wording to reflect targeted users of the binder.

17. That the creation of a separate manual for facilitators be created that would assist them in guiding groups through the EC Program.

18. That some recruitment information be developed for potential team members outlining the EC Program, the Guidelines for Care, and the responsibilities team members are expected to undertake.

19. That a pre-workshop be created for team members and general staff of facilities that have agreed to implement the EC Program.

20. That a “how-to” resource be provided that gives a condensed version of the program that team members and general staff can refer to before and during the program.

21. That the number of times that the facilitator meets with the team members as a group be reviewed. Provide follow-up that ensures that the facility continues on with the EC Program.

22. That efforts be made to keep distractions during the meetings to a minimum.

23. That determining specific communication strategies with general staff be a priority during the initial goal setting meeting. These strategies should be implemented early on in the EC Program.

24. That this program continue to be evaluated to expand our knowledge of how the program develops over time, and to determine whether there have been improvements in resident care.