Long-Term Care Planning Study: Strengths and Learning Needs of Nursing Staff*

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RÉSUMÉ

La présente étude de planification a été conçue et effectuée dans une province canadienne essentiellement rurale, le Nouveau-Brunswick, afin d'y évaluer les forces et les besoins d'apprentissage de quatre catégories de personnel infirmier en poste dans des maisons de soins infirmiers. Des contrôleurs de soins, des infirmières, des infirmières auxiliaires et des aides gériatriques ont participé à cette étude. Les maisons de soins infirmiers, réparties dans l'ensemble de la province, comprenaient de 38 à 196 lits. Dans les études portant sur la santé et la planification, l'ethnographie comporte un énoncé cohérent des connaissances locales des gens en tant que groupes partageant leur culture (Muecke, 1994). L'étude a tiré ses renseignements de la *Loi sur les maisons de soins infirmiers*, de rapports, de la documentation, et de répondants clés, ainsi que des entrevues avec les participants et des observations qu'ils ont fournies. Les forces de leadership ont défini les rôles des catégories de personnel et soutenu la capacité de chacune afin de déterminer leurs besoins d'apprentissage. En conclusion, les infirmières exerçant leur profession dans les maisons de soins infirmiers peuvent et doivent jouer un rôle actif dans le processus décisionnel en rapport avec leur apprentissage.

ABSTRACT

This planning study was designed and conducted in a predominantly rural Canadian province to examine the strengths and learning needs of four categories of nursing staff practising in New Brunswick nursing homes. Participants included directors of care, registered nurses, licensed practical nurses, and resident attendants. The nursing homes ranged in size from 38 to 196 beds and were located throughout the province. In health and planning studies, ethnography conveys a coherent statement of peoples' local knowledge as culture-sharing groups (Muecke, 1994). The study derived information from the Nursing Home Act, reports, the literature, key informants, and direct observations of and interviews with participants. Leadership strengths defined the roles for categories of staff and supported the capacity of each category to identify their learning needs. In conclusion, nurses practising in nursing homes can and must take an active role in decision making for their learning.

* The author wishes to thank the participants for their time and commitment to specialized learning; similarly, a special thank you to all who participated as key actors and at presentations and offered their insights and encouragement. My colleagues Marilyn Merritt-Gray and Judith MacIntosh have been kind and generous in their feedback as I wrote this manuscript. Thank you to all.

Manuscript received: / manuscrit reçu : 15/08/05

Manuscript accepted: / manuscrit accepté : 17/07/06

Mots clés : vieillissement, maisons de soins infirmiers, personnel infirmier, forces, besoins d'apprentissage, développement communautaire

Keywords: aging, nursing homes, nursing staff, strengths, learning needs, community development

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https://doi.org/10.1353/cja.2007.0016 Published online by Cambridge University Press

Introduction

In 2001, labour negotiations between the Province of New Brunswick Family and Community Services Department and staff in nursing homes reached an impasse. During the ensuing strike, nursing home administrative staff, families, and volunteers filled in to provide basic care for residents, an enlightening experience for many. To encourage staff to return to work, the government intervened with promises of improved working conditions based on a forthcoming report. Having experienced a strike at a large long-term care (LTC) facility in Ontario, I wrote a proposal and received funds from the University of New Brunswick (UNB) to conduct a planning study with nursing staff working in four nursing homes. The purpose of the study was to understand the strengths and learning needs of staff in order to plan appropriate learning opportunities for nurses providing care in nursing homes. The literature was reviewed to describe and interpret the meanings of caring in nursing homes. Following ethnographic rules of evidence (Dorr-Bremme, 1985), and in accordance with ethnography in planning research (Muecke, 1994), the study reflects the beliefs and values of a discrete organizational community. With bottom-up planning, the goal for policy development was to develop gerontological nursing education for staff working in New Brunswick nursing homes. The research questions were, What are the strengths of four categories of nursing staff working in New Brunswick nursing homes? What are the learning needs of the four categories of nursing staff?

Context

The New Brunswick Association of Nursing Homes (NBANH) participated in this study as a partner of the Faculty of Nursing, UNB. The director of education assisted by locating nursing homes throughout the province where staff was prepared to participate in the study. From a geographical perspective, New Brunswick is a small, mainly rural province in Atlantic Canada, with a land-mass of 72,908 kms^2 and a population of 751,400 people—13.5 per cent aged 65 years and over, living in mainly rural areas. By comparison, Ontario, one of the largest provinces in Canada, has a land-mass of 1,076,395 kms^2 and a population of 12,392,700—12.75 per cent aged 65 and over, living mainly in southern, urban areas of the province (National Resources Canada, 2005; Statistics Canada, 2005). In New Brunswick, one third of the population is francophone: 235,090 persons list French as their first language, most of whom live on the Acadian Peninsula and in the northwest of the province. At the time of the study, 4,066 persons resided in nursing homes (there were 61 such homes in all), where care was provided by staff, 20 per cent of whom were registered nurses (RNs), 40 per cent of whom were *licensed practical nurses* (LPNs), and 40 per cent of whom were *resident attendants* (RA) (Director of Education, NBANH, personal communication October 30, 2002). The four nursing homes in this study were selected by NBANH, included one francophone home, and varied in size from 38 to 196 residents. These nursing homes were located in the northeast, southwest, south, and centre of the province.

Literature Review

The literature was reviewed to understand why specialized education is essential for nursing staff practising in LTCs. Aligning quality of care with quality of life in LTCs requires a strategy (Kane, 2001). However, nursing home decision makers do not recognize specialized education as a strategy to support the quality of care and ultimately the quality of life in New Brunswick. In a study of nursing homes in New York State, Deutschman (2001) found that the six most frequently mentioned opportunities for change were education, communication, quality staff, interdisciplinary teams, offering more personal care choices and understanding the individual needs of residents, and improving communication with families (p. 32). The American National Gerontological Nursing Association (NGNA) recognized that nurses working in a variety of settings required specialized educational resources to care for older adults (Ebersole & Hess, 1998), and the NGNA Core Curriculum was developed to encompass the knowledge required by nurses to provide basic care (Luggen & Meiner, 2001). Gerontological nursing care is holistic, and means assessing and interpreting individual residents' behaviours within their environment on the basis of knowledge about psychosocial functioning (Miller, 2004). In addition, physical illness presents differently in older adults than in younger persons (Ebersole & Hess, 1998), so enhancing nurses' ability to do a needs assessment in LTC requires continuing education to support learning based on research (Daley & Wilson, 2001). To support learning among non-professionals in nursing homes, educators must understand the individual learner and her/his interrupted learning path as well as the socio-economic status of participants (Crossan, Field, Gallacher, & Merrill, 2003). To overcome these difficulties, some have adopted the concept of a *teaching nursing home*, to be created through a collaborative partnership among staff, residents, families, and university faculty. The aim is to create within the nursing home an environment

https://doi.org/10.1353/cja.2007.0016 Published online by Cambridge University Press

for living, working, and learning (Davies, Powell, & Aveyard, 2002).

High and low nursing turn-over in nursing homes may be associated with the availability of education. Using data collected from directors of care (DoCs) in the United States, Brannon, Zinn, Mor, and Davis (2002) found that personnel fixated on custodial care could be a liability to nursing facilities that were expected to respond to more complex care needs and demonstrate improved outcomes. Qualified supervisors were likely to set higher standards and provide staff with feedback related to the provision of care. Sites that served as clinical training sites were 3 times more likely to be in the high turn-over group. It appeared to the researchers that trained nursing assistants moved on to other facilities (Brannon et al., 2002, pp. 165–166), a method of spreading informed care within a region. In rural Saskatchewan, Morgan, Semchuk, Stewart, and D'Arcy (2002) found that NAs who were transferred from acute care experienced greater psychological strain, possibly because there was more freedom for decision making on the job and many were inadequately trained and had inadequate skills for working in nursing homes. Mental health disorders are prevalent among residents in nursing homes and cause significant morbidity and an increase in costs. Educators in rural and remote areas of Australia are confronting the mental health issue with an educational initiative that may prove a useful guide in New Brunswick (Chang et al., 2002).

Daley and Wilson (2001) used focus groups to study the value, in determining the content of any educational program, of conducting needs assessments with staff as compared to imposing educational programs. Areas of learning needs identified in assessments with staff included pain and comfort, grief management, communication skills, and spiritual care (p. 116). Another concern was that professional practice programs are intended to attract, retain, and reward RNs (Robinson, Eck, Keck, & Wells, 2003). In regions with limited resources, a teaching nursing home created through a partnership among nursing homes and universities would promote strong collaborative relationships, methods for shared decision making about program and service mix, and research (Kaeser, Musser, & Andreoli, 1989). Further, Brannon et al. (2002) found that specialized learning is required among all levels of nursing home staff, beginning with middle management.

Policy Influences and Care Needs

From a policy perspective, New Brunswick's nursing home regulations for staffing ratios indicate the need to assess managerial and clinical learning requirements. RNs comprise 20 per cent of nursing staff. They manage and coordinate the care of residents by LPNs and RAs. With limited specialized learning in gerontological management and care, RNs are supervising LPNs who deliver 40 per cent of hands-on-care and RAs who provide 40 per cent of care (personal communication with the Director of Education, NBANH, 2002). With staffing ratios in these proportions, RNs are expected to demonstrate managerial and clinical skills. Elsewhere, nursing homes with the best outcomes had a greater percentage of RNs in the staffing mix (Anderson, Hsieh, & Su, 1998). Staffing ratios are a significant consideration in view of findings from epidemiological and longitudinal studies. Eight per cent of Canadians aged 65 and over are at risk for dementia (Canadian Study of Health and Aging, 1994). A U.S. longitudinal study showed that persons with dementia had 5 times the risk for institutionalization compared to others in the community cohort (Bharucha, Pandav, Shen, Dodge, & Ganguli, 2004). In a random sample of New Zealand institutionalized residents, 83 per cent had at least one DSM-III-R psychiatric diagnosis and 79 per cent had at least one behavioural problem (Butler, Fonseka, Barclay, Sembhi, & Wells, 1998). To change health service policy, an expert U.S. panel developed the "Consensus Statement on Improving the Quality of Mental Health Care in U.S. Nursing Homes" (American Geriatrics Society & American Association for Geriatric Psychiatry, 2003). Similarly, mental health policy changes are needed in New Brunswick nursing homes.

To facilitate quality-of-care outcomes, education for transformational leadership in managerial and clinical practice among nursing home RNs is essential. RNs take a leadership role in complex decision making (Anderson & McDaniel, 1998) to facilitate a vision that inspires commitment and empowers people (Leddy & Pepper, 1998). Nursing home residents are older and sicker than others and caring for persons with cognitive impairment and behavioural issues calls for specialized knowledge and skill (Luggen & Meiner, 2001). Therefore, RNs require time and knowledge to engage in planned clinical, managerial, and policy education to support the work of front-line caregivers (Goodridge & Johnson, 1997). The following are the qualities of the transformational leader necessary to promote change in nursing homes:

- Individual consideration (was) exhibited by promoting others' growth, recognizing and supporting others' needs and feelings, and giving positive feedback and recognition.

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- Charisma (was) exhibited by inspiring and motivating, demonstrating enthusiasm, and communicating a positive manner.
- Intellectual stimulation (was) exhibited by creating a questioning environment, acting as a mentor, and challenging others to grow and learn. (Gurka, 1995, p. 170)

It is apparent that transformational leadership is essential in nursing homes where residents are older and sicker; where resources are in short supply; and where professional and ancillary staff are challenged to develop the specialized knowledge, competence, and awareness needed to meet the changing needs of frail, old persons.

Ethnographic Planning Research

Study Participants

Fifteen participants from four nursing homes included four DoCs, three RNs, four LPNs, and four RAs. The interviews were conducted over a 6 month period to accommodate staff availability, the time required to travel to their homes, and my teaching responsibilities. Staffing in the nursing homes was stretched to the limit, and one RN was not available the day interviews were conducted at her facility. Each participant signed the consent form as required by the Ethics Committee at UNB. The participants practised in four nursing homes, located in the north, central, and southern regions of the province, homes that ranged in size from a 38- to a 196-bed capacity. As the researcher, I had practised in LTC and as a Clinical Nurse Specialist (Geriatrics), and observed barriers to care in the work environment. The facilities were designed during the 1970s and presented a challenge for the development of the homelike environments necessary to maintain the capabilities of cognitively and physically frail residents.

Ethnography

In health and planning studies, Muecke (1994) points out, an *ethnography* conveys a coherent statement of people's local knowledge as a culture-sharing group. However, prolonged fieldwork is incompatible with the limits on funding agencies' budgets and schedules. For this reason, planners fit their ideas to local contexts for rapid appraisal, and nurses adapt their practice to clients' beliefs and social context (Muecke, 1994, pp. 197–198). As a planning project for nursing, this study was approached in the following ways:

- deriving information from the intent of the Nursing Home Act, the Staffing Regulations, Nursing Home Reports; from the literature; and from key informants (also referred to as *shadow participants*) (Qualitative Workshop with M. Mayan, 5 Aug. 2003)
- carrying out direct observation of and open-ended interviews with four categories of nursing staff in four nursing homes
- applying an iterative process of continually subjecting knowledge to testing and reaffirmation with local people and their resources (Muecke, 1994)

Nursing homes are clearly organizations with a distinctive culture and belief system that governs the nursing staff's interaction for the provision of care. It was critical, therefore, to select ethnography based on organization theory to guide a planning study where knowledge and learning are the focus. Constitutive-ethnographic theory of social organization is used within educational anthropology (Dorr-Bremme, 1985), where, according to Goodenough (as cited in Dorr-Bremme, 1985), shared operating principles constitute a group's culture. For groups, a culture consists of whatever individuals know or believe in order to function in an acceptable manner with other members. Dorr-Bremme (1985) has written that groups construct patterns of interaction and behaviour that display their sociocultural knowledge. In turn, groups project their social meanings and views of reality to others and make those meanings and views available to them. They construct learning by drawing on their understanding of meaning and reality.

In this study, DoCs recruited participants to represent different staffing categories. The interviews were guided by an open-ended questionnaire, constructed from the literature and with nursing experts. During the interviews, each participant discussed the social meaning and her/his view of the strengths and learning needs of the category to which s/he belonged and corroborated the information provided by those in the other three categories by answering questions relevant to those categories. The following five principles were used to guide the fieldwork:

1. Treat the program's definition and boundaries as problematic.
2. Focus inquiry on central interactional events.
3. Emphasize ethnographic observation.
4. Use interviews to guide and explicate observation.
5. Use ethnographic rules of evidence. (Dorr-Bremme, 1985, pp. 72–77).

In the analysis stage, I listened to the participants' interviews on audio tape and read the transcribed interviews many times. To organize the data for analysis, I used NUDIST 6 to record free nodes, to tag text, and to write memos. I found that this process helped me to sort and then to analyse (using word

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processing) the data, handwritten memos of my observations, and the literature.

Results

During the process of coding, patterns reoccurred in a connected and logical manner. These patterns related to participants' "standards for perceiving, believing, evaluating, and acting . . . in situ to organize their affairs" (Dorr-Bremme, 1985, p. 77). Each pattern was a synthesis of the data collected and corroborated by all four categories of staff.

Strengths are fundamental for staff working in a nursing home and provide motivation for learning associated with specialized gerontological care. Learning needs build on the strengths of commitment and personal philosophy. Although some had difficulty with the terminology and with identifying what they needed to learn in gerontological nursing, the interest and will to learn were evident among all participants. The *emic* or cultural ways nursing staff ordered their working lives were distinguished among categories (Dorre-Bremme, 1985, p. 70). Table 1 and the analysis that follows explain the strengths and learning needs of those in the four categories of nursing staff.

Strengths of Nursing Staff

Table 1 shows the codes for the strengths or capacity of each category of staff. Leadership emerged as the core strength, a pattern that flowed and took on a different focus for each of the four categories of nursing staff. Leadership strengths determined the role for each of the four categories of nursing staff and included the three dimensions of *leadership*: a caring attitude, openness to learning, and critical thinking. The leadership pattern, supported by the three dimensions, represents the capacity or potential for change and for the development of gerontological competencies in nursing home practice.

Leadership
Director of care. The DoC leadership role is similar to that of a concert-master. DoCs demonstrated that the spirit and harmony of their leadership qualities were reflected in overall attitude, performance, and activity within the nursing home. I observed the caring ambiance of three of the nursing homes in this study, while the fourth home was under quarantine for influenza and interviews were conducted in the administrative offices. DoCs described leadership as having and sharing a vision; being creative, flexible, adaptable, and empowering; using open and timely communication; managing stress for self and others; being compassionate and a peacemaker; and being fiscally wise in developing a business plan and

Table 1: Strengths of nursing staff in nursing homes

Strengths	Directors of Care	Registered Nurse	Licensed Practical Nurse	Resident Attendant
Leadership Capabilities	• concert master of the nursing home vision board input	• transformational leader • frequently assumes a managerial role	• synthesizer and iterative loop for transformational leadership with RAs and RNs	• frontline, hands-on guide for residents and families
Caring Attitude	• sets the tenor for the home quality of care	• values/enjoys work with older people • guides care provision accordingly	• likes working with older people • values holistic care	• "backbone of the nursing home" • strong relationship with residents
Open to Learning	• always learning • be what you ask of others	• specialized (gerontology) learning • keeps current	• wants to know why we are doing what we are doing—theory	• better care if all the team were involved in education
Critical Thinking	• thinks outside the box means being creative, analytical	• keeps NH running like a home • analyses residents' social and clinical needs, and staff's learning needs	• illustrates critical thinking with resident care examples	• grounded in experiential learning

https://doi.org/10.1353/cja.2007.0016 Published online by Cambridge University Press

knowledgeable about gerontological nursing care, the nursing home system, and policy and management practices. DoCs had access to power through their attendance at board meetings to discuss plans and issues surrounding resident care. Conversely, the lack of resources, both fiscal and human, motivated one DoC to strategize with nurse managers to develop financial plans for their individual resident care units. These financial plans assisted the DoC in better managing the nursing home as a whole. Other DoCs recognized that they needed networks and mentors to control their stress, explore ideas, and receive feedback for future directions. One DoC used her network to promote knowledge and understanding of her nursing home. She became the president of one service club and a member of a group interested in local commerce, where she interacted with other community leaders to promote her role and the needs of the nursing home she managed.

Each of the four DoCs exemplified the leadership challenges and abilities expressed by nursing executive leaders in the Harvard Nursing Executive study. In rapidly changing environments, nursing leaders in the Harvard study created as they went along to manage the ''ambiguity, uncertainty, and paradox'' where ''effective leadership requires imagination and working with incomplete information while innovating'' (Buerhaus et al., 1997, p. 12.). Similarly, I observed the personal and professional behaviours of two long-standing DoCs who exhibited charismatic traits in their dealings with staff. The DoCs' leadership strengths were similar to those in the Delphi study of European nursing executives. The leadership characteristics of the European nursing executives included ''personal and professional strength and charisma, ability to encourage [the] workforce to support and follow, ability to deal with senior multidisciplinary committees and groups on an equal basis'' (Hennessy & Hicks, 2003, p. 445). These strengths did not come easily. Each DoC reflected and discussed how she needed to grow to build relationships, meet the individual needs of staff, and manage in an insecure and changing system of care. Leadership strengths among DoCs are critical as nursing homes experience change and uncertainty amid a climate of diminishing resources.

Registered Nurses. Shared leadership qualities were observed among the participating DoCs and RNs in this study. During this period of uncertainty and overwhelming need, RNs supported the vision of their DoCs. RNs discussed management duties on weekends and off-shifts in nursing homes where they acted as charge nurses and assumed the responsibilities of managing the nursing home, including maintenance, diet, and housekeeping. One RN discussed her clinical strengths and the responsibilities of working in a rural nursing home on weekends, evening, and night shifts. Clinical strengths for her meant being motivated to take an assessment course to maintain the skills critical for residents' care. Another RN described a course she had taken to become a change agent in her nursing home, and although it was something she wanted to do, she had to overcome the anxiety of presenting the process to her colleagues. Each RN played a pivotal leadership role in transforming nursing home life for residents and in promoting growth among ancillary staff. One RN discussed her motivation to learn for her own benefit and to provide leadership for LPNs and RAs. The difficulty for her meant knowing where to find learning resources in addition to *Canadian Nurse*, *Newsweek*, *Time*, and television programs. Each of the RNs sought to change the quality of care to transform nursing homes into places focusing on residents' quality of life. In one nursing home, nursing staff analysed the difficulties that cognitively frail residents experienced at meal times with noise and heightened activity in the dining room. The RNs worked with nursing staff to transform a small and separate room into a quiet and inviting dining area for cognitively frail residents. With limited resources and during a period of uncertainty (Buerhaus et al., 1997), DoCs and RNs shared leadership competencies because both were registered nurses and were transformational agents (Gurka, 1995) in their work with staff and residents.

Licensed Practical Nurses. LPNs worked closely with RNs and, as one LPN commented, ''They are our leaders [and] I go to them constantly'' in relation to caring in the nursing home. Interdisciplinary skills certainly helped in the transformation, as one LPN acknowledged. ''I've been here 20 years and I've done every job in the nursing home and if something is not working, we change it.'' LPNs understood the direction the DoCs and RNs were taking and were able to describe the integration of holistic care for older persons within their practice. LPNs in this study began as RAs, furthered their learning with the support and encouragement of the DoCs, and recognized the need to learn the theory guiding practice. As one observed, ''When you run into a problem with a resident you have no idea how to deal with them because you do not have the educational part of where they are at.''

Resident Attendants. RAs looked to the RNs and LPNs for leadership in care decisions and as sources for learning. Conversely, some RAs questioned the

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value of the role of RNs because of their lack of visibility. ''They are always in the office or putting out their meds. We never see them.'' RAs, who either learned on the job or had taken a 6-week health care aides course, did not always understand RNs' knowledge or what they did in terms of empirical, aesthetic, personal, and ethical ways of knowing (Carper, 1978). As leaders on the frontlines, RAs relied on relationship building, friendship, and life experience to work with and guide residents and their families through the nursing home journey. Unknowingly, they were using the principles of Bell and Troxel's (2003) ''best friends approach'' to caring. In their relationship role with residents, RAs learned and discussed passing their findings on to LPNs and RNs to aid in ongoing assessment.

Caring Attitude

Attitude toward caring is a central dimension for nurses practising in LTC. In gerontological nursing, a caring attitude determines the capacity or potential of nursing staff for professional growth. Ebersole and Hess (1998) have described caring behaviour as advocacy, responsiveness, commitment and presence, competence, and the ability to give meaning to another's life (p. 948). More broadly, society's attitude toward old people subtly involves behaviours associated with ageism and difficult to distinguish in custom or habit. This prevailing attitude, with its subtle behaviours, makes nursing in LTC a challenge for some staff. Researchers have examined instruments to measure health care staff's knowledge of and attitudes toward older people (Cowan, Fitzpatrick, Roberts, & While, 2004), and another group has measured knowledge and attitudes in dementia care. Meuser, Boise, and Morris (2004) found that ''increased specialization or knowledge was more positively reflected in attitude related to management statements for the care of persons with Alzheimer disease among specialist physicians and advanced practice nurses as compared to primary care physicians and physician assistants'' (2004, p. 502). In this study, the strengths of a caring attitude among nursing home staff were reflected in strategies and behaviours and had the potential to form the basis for future learning and caring practice.

Directors of Care. A *caring attitude* was taken to mean, as one DoC commented, ''being what you want others to be'' and was grounded in her specialized knowledge and hands-on gerontological practice. DoCs demonstrated their expectations for quality of care in their behaviours with residents and staff. They discussed how they developed their clinical expertise and built caring relationships with residents and staff. Through their own caring attitudes, DoCs recognized potential among ancillary staff and encouraged the further development of a caring attitude among staff members. To illustrate the potential for this behaviour, one LPN discussed the encouragement she received from her DoC: ''She kept saying, 'You would make a good nurse.' She was the one who got me to take the Geriatric Aids Course and then the Registered Nursing Assistant (LPN) course.''

Registered Nurses. RNs valued their practice with older adults by describing their ability to overcome barriers to residents' care. One RN discussed overcoming the challenges of building relationships with other disciplines to locate and provide rehabilitation for physically infirm residents and psycho-geriatric care for persons with depression or dementia. Other RNs discussed travelling to other provinces to access the learning she and her colleagues required to change care in their nursing homes. One of the barriers observed that impeded RNs' caring attitude was the unavailability in nursing homes of the computers needed to retrieve best-practice guidelines and emerging evidence from journals publishing well-designed studies. The Canadian Gerontological Nursing Association (CGNA) has recognized this difficulty for RNs and is addressing specialized education in its 2004–2007 Strategic Plan (CGNA, 2005).

Licensed Practical Nurses. LPNs recognized the interdisciplinary and inter-sectoral nature of their work and the need to have a caring attitude. As one explained, ''You have got to be a people person. We have to learn . . . to treat a human being . . . people don't know how to talk to people and some people have to be educated to do that . . . to communicate with older people.'' Learning to communicate with cognitively frail people requires a nursing home to be dedicated to teaching and learning among the staff. An LPN recognized that, in nursing homes, the full- and part-time staffing complement is large; for example, a 38-bed home had 55 housekeeping, dietary, and nursing staff working with residents. Ensuring that all staff interacts appropriately with persons who have lost or are losing their ability to verbalize means learning communication skills. In their *Best Friends* approach, Bell and Troxel (2003) discuss improving communication through clues and cues. Communication skills mean that staff learn to use clues from a well-informed history to provide cues to the resident with severe language difficulties (pp. 79–80).

Resident Attendants. Similarly, an RA described her caring attitude as beginning with a loving relationship

https://doi.org/10.1353/cja.2007.0016 Published online by Cambridge University Press

with grandparents, where caring for residents meant dedication and new experiences every day. RAs in this study described developing strong relationships with residents and their families that sustained them through bad days. Intuitively and experientially, they understood the meaning of each resident's life (Ebersole & Hess, 1998).

Open to Learning

Director of Care. One DoC summarized the strengths among the DoCs in this study as knowledge of the elderly and openness to new learning for change. Their role demanded an ability to understand the *multi-skills* essential for managing a nursing home, including training nursing and ancillary staff and keeping abreast of changes in policy and technology. As one DoC stated, "[B]e what you ask of others"; in other words, demonstrate continuous learning yourself. Similarly, a new DoC, who had previously worked in acute care, learned to participate in committee decision making and was eager to have "grassroots caregivers" participate and make decisions in committees that affected care. She set goals for herself and would pose questions to the grassroot caregiver committees directed at setting goals for clinical expertise, including "What are the key areas we should be focusing on? What are the key competencies of the LPN and the RN?" These questions are highly relevant, as the roles of RNs and LPNs change. Moreover, nursing staff collaborated with the DoCs because they believed that continuous learning for all categories of staff was essential to enhanced care in nursing homes. The availability of education is critical, as Brannon et al. (2002) found, because personnel fixated on custodial practices may be a liability to nursing facilities, and nursing homes are expected to respond to more complex care problems and demonstrate improved outcomes. In Brannon et al.'s study, qualified supervisors were likely to set higher standards and provide practice feedback for staff.

Registered Nurses.

> My strength was to go [back to university] and to be able to know that I could do it . . . that others wanted to learn about my experiences . . . I've had courses . . . different workshops . . . to improving quality . . . I guess I need to know the legislative aspect of our health care system and how the monies are divided . . . where it goes and who makes the decisions.

One RN felt she was strong in her practice and still wanted to know more about working with people with Alzheimer's disease: "The more I work with them the more I want to learn." She was not alone in her openness to specialized learning. Another RN discussed the assessment course she took as a "power-packed day", and described her wish to return the next day to learn more. For her, learning depended on motivation and support from the facility itself. For the RNs in this study, and as Robinson et al. (2003) have shown, professional practice programs were attractive, and they continued to practise in nursing homes and were rewarded in their efforts.

Licensed Practical Nurses. Among the LPN participants, managing workload and managing resident and staff interactions were closely tied to learning: "We get caught up with the tasks rather than looking at the whole. We get lost [and] we need to see things more openly." This quotation from an LPN reflected the personal value and eye-opening experience of a workshop she attended. Another LPN recognized that openness to learning came with confidence gained through "someone's faith in you" and through the cultural attitude of a caring nursing home. In her case, learning helped her to develop the self-confidence to complete the LPN program and supported her desire for ongoing education.

Resident Attendants. Other nursing staff referred to RAs as the "backbone of the nursing home" and as team members valued for their reporting skills. While this was certainly observed, RAs also described their caring attitude and communication skills as critical to their work in nursing homes. "I recognize personality and . . . but it would be nice to have somebody who specialized . . . to come and talk with the staff." RAs concluded, as Davies et al. (2002) have argued, that it would be better if all the team were involved in education. Perceptive RAs recognized and learned from RNs. Anderson et al. (1998) found that outcomes improved where the ratio of well-educated RNs to RA staff was higher and RNs practised closely with RAs.

Critical Thinking

Nursing home care is often regarded as custodial, task-oriented, and regimented, with little imagination required. As the poor cousins in the health care system, LTC nurses in this study found ways to improvise and create meaningful activities for older persons and learning for themselves. The small dining room for residents with dementia cited earlier is a case in point. Nurses designed the space and decorated it with articles brought from home to make the room feel home-like for residents who needed cues to live a more normal life. They were practising *critical thinking* as described by Cody (2002): "a creative/constructive, relational/dialogical process" (p. 184) where thinkers apply concepts only in

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situations with which they have a personal connection or with other people with whom they have a personal relationship. Moreover, they had "predispositions to think of things and their interrelationships in particular ways" (p. 188). Their thinking took place in a small, informal working group where information was shared, reworked, and acted upon.

Directors of Care. DoCs described "thinking outside the box" and of being creative and analytical in their role. DoCs thought about and understood gerontological care in relation to current practice, the residents and staff, and the LTC system within the political and economic context of a small, poorly resourced province. One DoC, new to her position, discussed setting up a wound-care program with grassroots participation by staff. As she thought, she recognized issues: "getting help from community partners . . . [staff] had never before been asked to sit on a committee . . . or participate . . . how do I get their information into a committee . . . make them feel comfortable within the committee structure . . . how do I set up the committee so it works?" Like Thayer-Bacon (2000), with her analogy of the quilting bee, this DoC recognized the need to transform critical thinking into collaborative, constructive thinking, where participants contribute their personal voice, intuition and imagination to benefit all. Like the nursing executives in the Harvard study (Buerhaus et al., 1997), DoCs used critical, constructive thinking to create as they went along, amid ambiguity, uncertainty, and paradox. Their strength and ability to think critically is a valuable resource that needs to be recognized and supported.

Registered Nurses. For RNs, critical thinking meant creativity and thinking about how to keep the nursing home running like a home. This meant that they analysed their assessments of residents in terms of residents' social and clinical needs. Some thought of the courses they had taken and synthesized their new learning with their learning as staff about resident care: "[T]hey [university faculty] are speaking from a different perspective . . . but we are living right in the experience of what happens as people are aging probably in a non-healthy way . . . [other] students appreciate our experience but we also gain from them." One RN deliberated about health promotion and about how to keep the residents healthy and how to reach out to the community to teach "good lifestyle habits" in order to help older adults remain in the community longer. The RNs also used creative/constructive thinking to examine the relevance of their thought processes within the context of caring for older adults. These findings echoed those of Kinnaird (2004).

Licensed Practical Nurses. In their thinking, LPNs are the "heart and soul" of resident care. LPNs intuitively understood Cody's (2002) explanation of critical thinking. They understood the creative/constructive, relational/dialogical aspects of critical thinking discussed earlier. In her discussion of caring for persons with Alzheimer's disease, an LPN illustrated the connection between residents' care needs and her learning needs: "There are so many different types and stages. When you go in to do their personal care and you run into a problem with the resident, you have no idea how to deal with them because you do not know the educational part of what stage they are at." A second LPN discussed the relational aspect of care: "I find like everyone, there are some of them that will go through a routine. But they are different because we are all different. . . . So we are all going to be different when we are sick." As they provided hands-on care, LPNs' critical thinking was relational/dialogical and in harmony with residents' individual situations.

Resident Attendants

RAs are relational in their critical thinking and grounded in their experiences with residents and the culture of the nursing home. In her comparison of work in a restaurant with that in the nursing home, one RA pointed out her relational experience of caring for residents: "People skills . . . working in the kitchen over there. . . . That just didn't happen, like you didn't see anybody, you were always in the kitchen." However, the greater their exposure to learning associated with resident conditions, the broader their perspective for residents' care. One thoughtful RA analysed working in a nursing home where donated funds were set aside specifically for educational purposes, including workshops with highly knowledgeable facilitators. This RA's insight supports the findings of the Anderson et al. (1998) study, where specialized care was shown to be crucial to quality LTC.

The strengths shown in this study were distinct among the four categories of nursing staff and defined their roles. Knowledge and understanding of their strengths fostered in all staff the capacity to learn and to change nursing home care for residents' quality of life. Table 2 and the analysis that follows describe the learning needs of the four categories of nursing staff.

Learning Needs of Nursing Staff

Table 2 illustrates the patterns of learning needs as corroborated by all four categories of nursing staff. Learning needs were closely intertwined and indicated the varying depth and breadth of

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Table 2: Learning Needs in Nursing Homes

Directors of Care	Registered Nurses	Licensed Practical Nurses	Resident Attendants
• policy and NH system	• role of the RN in NHs	• understanding work structures	• gerontological attendant knowledge and skills
• management practices	• gerontological/clinical knowledge and skill	• family dynamics	• communication and interpersonal skills
• business plan	• resident case management	• dementia care	• learn and understand family dynamics
• HR and staff development	• policy and NH system	• palliative care and maintaining residents' abilities	
• gerontological knowledge and skill	• management and organizational knowledge and skills		
• managing own stress by developing a network	• locating creating and accessing learning opportunities	• support and encourage work environments for learning and personal development	• supportive and informative work environment for specific learning needs
• choosing/working with a mentor			
• mentoring others			
• studying design, therapeutic, and quality of life environments for residents and staff	• understand and create an enabling environment for physical and ADRD care	• learning new ways to care on an Alzheimer Unit for health maintenance	• learn behavioural management skills
	• develop recreation and social support as health promotion for residents		• lifting and positioning residents
• gerontological nursing including standards of care—evidence-based and best practice guidelines for use in LTC	• gerontology and psycho-geriatrics • aging A & P pharmacology • assessment diagnosis planning and evaluating individual care needs • teaching and learning skills • family-centred care	• gerontological nursing as holistic care: physical emotional and spiritual; skin and incontinence care; eating programs; health promotion; and quality of life	• in-service at least once a month include families to ''share the learning so we're all doing the same [care]''

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gerontological knowledge and skill among the four nursing categories. Joy, Carter, and Smith (2000) reviewed the literature to assess the broad educational needs of British nurses transferring into community and facility LTC. It was clear from their review that nurses felt inadequately prepared to cope with the high numbers of older clients and the work environment. Nurses practising in nursing homes required competencies associated with re-assessment, to prevent hospitalization and to develop the skills needed to continue to promote residents' independence (p. 1041). Few studies, however, have examined learning needs from the perspective of nursing home staff.

Directors of Care

Staff retention in nursing homes is a critical issue. In this study, two of the four DoCs were new to their positions and had transferred from acute care. One long-standing DoC recognized the retention problem: ''[O]ne big thing is stress management . . . how to create a balance . . . and this is for staff as well as DoCs . . . I've seen my colleagues burn out . . . never return because they haven't learned to cope.'' Retention is clearly a problem for all nursing home staff, including DoCs and executive directors (EDs). An average of six new EDs appear at annual association meetings (personal communication with an ED, October 2003). ED turnover is worth noting, since two of the four nursing home EDs were previously DoCs and had moved into ED positions from other nursing homes or hospitals within their communities. The established DoCs learned from courses, networking, and a mentor: ''I learned from the Nurse Unit Administration course . . . the long-term care management course . . . a year specific for administrators of long-term care . . . and networking . . . you have to be visible in the community . . . mentorship . . . background, how the system works.'' Without continuing education, a network, and a mentor who contributes to policy and managerial learning, DoCs experience overwhelming stress as managers in nursing homes. As Anderson, Issel, and McDaniel (2003) have shown, nursing homes are complex, adaptive systems, and resident outcomes are dependent on identified nursing management practices. Similarly, Brannon et al., (2002) showed that human resource practices and supervisory staff with managerial training are more likely to set expectations for staff selection and quality outcomes.

The four DoCs were at different stages in their learning and this was true also for those coming from acute care specialties and learning the subspecialties of LTC. Providing dementia care and designing facilities specifically to meet residents' needs was a learning objective for one DoC:

> [O]ne of the learning needs that I'm working . . . to bring to the staff and to change our whole culture and approach to things is dementia care. I'm in the process of taking the Alzheimer workshops . . . I think I'm going onto module four now. I will bring it back to the staff because our plans for the new facility will be that for most residents it will be dementia friendly. Environment is a large portion of this. . . . [W]e don't have the appropriate environment so how do we make our environment more appropriate and how do we deal with challenging behaviour?

This DoC was responsible for learning to design a facility based on resident programs and nursing care that enhanced the quality of life of LTC residents. She sought opportunities to learn gerontological nursing:

> You get little bits and pieces when you go to workshops. It's nice to see the multidisciplinary . . . the different dimensions . . . the physiotherapy and the doctors and the nurses and everybody being together in the same group. I thought that was very, very useful to be able to network with people like that and see their perspectives.

Her networking and collaborative insight were shared by other DoCs. Another DoC was concerned with guiding nurses to establish and review policies to meet standards of care. ''You need to know what's happening out there and what the resources are because it is more than . . . writing a policy and saying yes, we are happy with that. It is understanding that there is evidence-based practice.''

Registered Nurses

As Weiss, Malone, Merighi, and Benner (2002) have shown, RNs connect legislative and funding policy decisions with nursing care issues. In the present study, RNs were also aware of the need for managerial skills, especially for RNs working in small rural homes. They recognized that managerial leadership was required in nursing homes where the RN was ''called the charge nurse because we are also in charge of maintenance, laundry, kitchen, so you have to oversee every facet of the operation, you know, the full time you are on duty''. RNs were concerned about deficiencies in continuous learning. As one commented, ''[T]here's a need to keep skills up there with acute care.'' An RN preceptor commented on orientating newly hired RNs: ''I only have three days to whip them into shape.'' RNs recognized the need to ''share the vision'' with new staff and to make sure that staff was there for the resident and family: ''It is the resident's home.'' This approach was seen to

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be in the best interest of the staff. At the same time, it was apparent that RNs functioned with different levels of expertise in specialized gerontological care. Most of their learning came through in-service education. RNs were encouraged to provide staff in-service without resources or preparation time. Similarly, RNs relied on staff in-service given by others for their continuous learning. Another RN noted the lack of collaboration among universities and colleges. She had taken courses in a social gerontology program from one university and asked why that program and a distance WebCT program offered by a local university were not combined for a degree in geriatric practice aimed at RNs working in nursing homes. ''I know I would be very interested in that.'' Another RN commented on the need to learn to develop relationships with community therapists to support interdisciplinary, collaborative practice in nursing homes. ''I can put her name down and she's here right away.'' She learned to build collaborative relationships with therapists from the extramural program (Acute Home Care) to help maintain residents' abilities.

Although this was not discussed in the RN interviews, elderly residents suffer infections and chronic illnesses and many are terminally ill. Also, there is a need for knowledgeable and ongoing pain and palliative assessment. An LTC prospective study established the relationship between infections and decline among residents with functional impairments (Bula, Ghilardi, Wietlisbach, Petignat, & Francioli, 2004). As observed, the lack of pain assessment and pain management among younger, seriously ill residents and among older adults (Hanks-Bell, Halvey, & Paice, 2004; Teno, Kabumoto, Wetle, Roy, & Mor, 2004) needs to be addressed as an RN learning need for practice in nursing homes.

RNs recognized the need to link theory and practice in gerontological care in order to interpret the behaviours of cognitively impaired residents, recognize signs of depression, identify drug actions and interactions, understand family dynamics, and promote health – chiefly to help residents maintain the independence that improves their quality of life. They acknowledged that ancillary staff did not understand the knowledge and critical thinking that guide the assessment and diagnostic skills required in RN practice.

Other countries have experienced similar concerns. In Scotland, concern for improved nursing home care led to the development and evaluation of Project 2000 to educate RNs in managing and practising clinically in nursing homes (Runciman, Dewar, & Goulbourne, 2002). Dedicated funding for continuous staff learning is an issue in New Brunswick. Nursing homes are funded for 2.75 hours of care per resident per 24-hour day, compared to 3.75 hours per day at Department of Veterans' Affairs–managed nursing homes (personal communication with a nursing home ED, October 2003). In Australia, a successful rural program was mounted using distance education to address similar problems where nurses lacked sufficient mental health knowledge and skill to meet clients' needs (Chang et al., 2002). Based on New Brunswick's demographic data, specialized gerontological care will require innovative initiatives for high-quality resident outcomes.

Licensed Practical Nurses

''We're here to care for the person, not his illness.'' This LPN reflected the beliefs of her colleagues and understood that the social component of care is essential (Morgan et al., 2002). The structure of caring in nursing homes is changing on many levels to reflect this belief while at the same time addressing the increase in acuity rates among residents. The changing structure requires the introduction of the interdisciplinary care and health promotion integral to the care of older adults. All categories of nursing staff care for residents who are very old and are becoming progressively more frail physically and cognitively. One participant expressed LPNs' motivation for learning: ''If I were more educated for that person...''. LPNs understood the need to learn theory to guide the practice of caring for diverse residents with specific health needs. Another LPN described Lewy Body Dementia in graphic terms, describing the falls and recognizing the freedom required by the person to maintain her/his abilities and quality of life. LPNs discussed the need to understand concepts fully – such as holistic care, health promotion, health maintenance, palliative care, and eating programs – and to know how to implement these concepts appropriately in their nursing homes. Most enjoyed attending workshops but looked to their DoCs and RNs for day-to-day clinical and managerial leadership. In addition, LPNs recognized that it ''takes a lot to change your own behaviour''. Change in behaviour can best be addressed in familiar settings with trusted and credible instructors; this explains why LPNs relied on the DoC to support and encourage them to begin learning for practice and advancement. Earlier, an LPN described how the DoC provided the environment and guided and encouraged her to complete the Geriatric Aid Course and, later, the LPN program. As a learning environment, a teaching nursing home (Davies et al., 2002) would support staff development and would offer an opportunity for students to participate in an interesting and rewarding career option with committed nursing staff.

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Resident Attendants
RNs and LPNs described RAs as the backbone of the nursing home. In this study, the RA participants discussed beginning work in nursing homes with on-the-job training before completing the Geriatric Aid Course. All participating nursing staff agreed that the 6-week course prepared entry-level RAs to care for residents and that continuous learning was essential in nursing homes. A Canadian study found that a nursing assistant training program had a significant impact on job performance, attitudes, and relationships (Goodridge & Johnson, 1997). RAs were the first line of contact with residents and their families and described their experiences with sensitivity preparation and understanding changes in resident behaviour. They described the intricacies of lifting and positioning, bathing, feeding, and interacting with residents. Knowledge of family dynamics, communication, and interpersonal skills would help to alleviate the stress of interaction with residents and families. To create a win-win situation for newly admitted residents, their families, and staff, Shalom Village in Hamilton ON implemented a successful program where a clinical nurse specialist admits and works with the resident, family members, and the staff to establish resident-centred care (Lori Schindel-Martin, personal communication, May 2004). As shown in Table 2, although not specifically identified, RAs recognized the learning needs associated with their providing care for physically and cognitively frail residents. One RA stated it well: ''[A]t least once a month in-service'', with families included, is essential to ''share the learning so we're all doing the same [care]''.

Planning for Specialized Learning

Recruitment and retention are nursing home issues in New Brunswick and elsewhere. This study has shown the strengths of all four categories of nursing staff as the basis for creating an environment designed for living, working, and learning (Davies et al., 2002). Based on existing strengths, capacity building through learning (Minkler & Wallerstein, 2005) is a strategy for community development within the nursing home structure. Although rarely seen as communities by the public at large, those who work and live in nursing homes understand the meaning of the nursing home as a community. The term *community* is derived from the Latin *communitas*, meaning ''common or shared'', the *-ty* suffix meaning ''to have the quality of'' (Labonté, 2005, p. 84). While each nursing home may be seen as a community, the nursing home association within a jurisdiction assumes a shared position for institutional relations. Hence, the *nursing home community* comes together *within the dynamic act of being together* (Labonté, 2005, p. 84*). Being together* sets the tone for authentic partnerships and community development, based on collaboration for the common good (Labonté, 2005) of residents, their families, and staff. DoC and RNs, as this study illustrates, have the strengths to facilitate and organize communities and are distinct from the government and NBANH stakeholders (Gray, as cited in Labonté, 2005, p. 93). Thus, their bottom-up or *emic* understanding can lead to the dynamic and transformational change needed throughout the nursing home community.

Based on ethnography, this planning study has defined the roles and values of categories of nursing staff and described their strengths and their ability to recognize their learning needs for practice in nursing homes. Role definition assists in the development of a structure and process for learning nursing home management and clinical practice. Gathering in a focus group or quilting bee, as described by Thayer-Bacon (2000), would add to nursing staff's participation in ongoing decision making. With limited resources and support, nursing staff have already begun the process of transformational leadership (Leddy & Pepper, 1998). In the present study, RN staff recognized that collaboration among universities would promote gerontological nursing as a specialty by linking the social and clinical courses in care of older adults. Researchers have illustrated the values of nurse-led care and have shown the value of teaching nursing homes (Kaeser et al., 1989; Richardson & Cunliffe, 2003). Teaching nursing homes would work in partnership with colleges and universities and would utilize advanced practice nurses (APN) to plan individualized care with residents, families, and staff, as illustrated in the Shalom Village model cited earlier. Moreover, RNs in this study valued clinical workshops with APNs and saw expert teaching as a means of continuous learning. Manley (1997) has illustrated how the conceptual framework of advanced practice nursing contributes to the development and empowerment of staff, to nursing practice, and to the transformational culture of the agency for quality [resident] outcomes. Through collaborative learning and practice, there are many ways to provide specialized gerontological learning for urban and rural nursing homes, including WebCT and learning modules like those developed in Australia (Chang et al., 2002). Authentic partnerships and collaboration are needed among governments, provincial nursing home associations, universities, and colleges, with nurses in nursing homes taking an active role to facilitate this process.

https://doi.org/10.1353/cja.2007.0016 Published online by Cambridge University Press

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https://doi.org/10.1353/cja.2007.0016 Published online by Cambridge University Press

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https://doi.org/10.1353/cja.2007.0016 Published online by Cambridge University Press