Life around ... : Staff's Perceptions of Residents' Adjustment into Long-Term Care*

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RÉSUMÉ

Le déménagement à un établissement de service de soins à long terme peut être particulière-ment traumatique pour de nouveaux résidents. Le personnel peut faciliter cette transition dans un certain nombre de façons. Cependant, les perceptions du personnel du processus de transition et les expériences des résidents joueront un rôle significatif en déterminant le type d'appui qui est donné aux résidents pendant cette transition. Le but de cette recherche était d'examiner les perceptions du personnel d'une personne venant à vivre dans un environnement de soins à long terme. Trois thèmes principaux ont émergé après l'analyse d'entrevues détaillées avec le personnel d'un service de soin à long terme qui englobaient les descriptions de la vie des résidents. Essentiellement, le personnel a décrit comment les résidents ont appris à vivre une vie autour de divers facteurs en trois catégories principaux: *une vie autour des pertes, une vie autour de l'établissement résidentiel, et une vie autour du corps.*

ABSTRACT

The move to a long-term care facility can be particularly traumatic for new residents. Staff can make this transition easier in a number of ways. However, the staff's perceptions of the transition process and residents' experiences will play a significant part in determining the type of support that is given residents during the transition. The purpose of this research was to examine the staff's perceptions of a person's coming to live in a long-term care environment. Using in-depth interviews with staff from one long-term care facility, three main themes emerged that encompassed descriptions of residents' lives. Essentially, the staff described how residents learned to live a life involving various factors in three main categories—*life around losses, life around the institution,* and *life around the body.*

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The move to a long-term care facility can be particularly traumatic for residents. As the long-term care setting is typically premised on a biomedical model (Henderson, 1995), assumptions are made that as people age, illness and disability are inevitable. Accordingly, the focus of care is often on the physical body (Diamond, 1992; Gubrium, 1975). Bodies are viewed as frail, broken down, and undesirable (Twigg, 2004). The dynamics of interactions and relationships between residents and staff in long-term care facilities, although complex, are framed by this focus on bodies. Despite the focus on bodies, interactions between residents and staff, however, are not necessarily determined by this focus, and therefore the complexity of long-term care becomes illuminated. Understanding the process by which residents come

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to live in long-term care, and subsequently become adjusted or accustomed to life in long-term care, then, is important to further our understanding of how a person becomes what might be considered an institutional body (Wiersma, 2007).

Literature Review

Research has examined the transition from home to long-term care and the experiences of residents in adjusting to this environment; however, little of this research has examined the long-term-care staff's perspectives (Davies & Nolan, 2003). Do staff have an understanding of the transition and adjustment processes for residents coming into long-term care, and if so, how do they attempt to ease those processes? These are the questions that have yet to be answered and which directly relate to the emotional care that staff provide to residents.

As early as 1975, researchers documented how residents become "bed and body work" in long-term care (Gubrium, 1975) and how identities of residents are erased. Indeed, the theme of the focus on physical care in long-term care facilities has not changed over the past 30 years or so. More recent research has also documented the nature of care in long-term care facilities as being focused on the physical body (Diamond, 1992; Henderson, 1995; Paterniti, 2000, 2003; Wiersma, 2007). The focus on the physical body not only erases residents' identities but erases the emotional work of staff. The many ways in which staff may care for residents in their day-to-day work is erased in the ways that care is documented in the institution. In his classic ethnography, Diamond illustrated how residents essentially come to be regarded as "decontextualized "beds" because the act of documentation erases residents' identities, as he describes below.

> The procedure had the consequence of moulding the formal records of residents' lives into a history of progressively separate, isolated individuals: reduced to the status of those acted upon, from social relations to individuals, from individuals to patients, to sickness, to units of health service, and ultimately to objects. All these components went together to make up the bed. The leap from person to bed was thus not direct. It followed an ideological pathway: from socially contextualized person to isolated individual, on to patient and disease categories, to bodies and behaviours and tasks done to them, then to the records to code them. "Beds" came into the logic at the end of this conceptual conveyor belt, fully accomplishing the fusion of person and bed, resident and commodity (Diamond, 1992, p. 210).

The process of moving into a long-term care facility and the subsequent adjustment to a new home and way of life has been examined by a few research studies from the residents' perspectives. This research has typically found that residents "make the best" of their transition to nursing homes (Kahn, 1999). Although residents often recognized the necessity of long-term care admission, they had to reconcile themselves to a situation where they had no other options (Kahn). Residents attempted to maintain a facade of normalcy and thus protect families and significant others, despite feeling overwhelmed upon transition to a long-term care facility (Wilson, 1997). Although residents began to develop positive attitudes as they adjusted (Wilson), this may have grown out of a need to make the best of their situations.

The transition to a long-term care facility has also been examined from various perspectives of the family. Cheek and Ballantyne (2001), in examining the search and selection process for family members, found that family members felt a sense of good fortune once a facility was found and the resident was admitted. Guilt and doubt appeared to be common feelings. Families also felt that adjustment was powerful, as their family members had had many life experiences and now had to adjust to a very different lifestyle and home life. Keeping items and personal effects, however, was described by participants as helping the process of adjustment.

The adjustment, then, to an environment where residents become "bed-and-body work" (Gubrium, 1975; Paterniti, 2000, 2003) can be difficult for residents. What is needed is further examination of how staff view this adjustment and how staff view life in the long-term care environment if we are to understand the ways in which staff attempt to ease the transition and to care emotionally for residents.

The findings presented here are part of a larger study examining the socialization of new residents into nursing home culture and life (Wiersma, 2007). Little research has examined this socialization process or the role that staff play in the socialization process of new residents into nursing home life and culture. In order to understand the role that staff play, it is imperative to first begin by understanding how staff view the transition process for residents into long-term care, since it is the staff who provide much of the support for residents during the adjustment and socialization process. Therefore, if adequate and appropriate support is to be given residents during this transition process, we must first understand how staff view this process.

The purpose of this research was to examine the staff's perceptions of a person's coming to live in a long-term care environment. The research objectives were to understand

- the staff's role in the move into long-term care;
- the staff's perspectives of residents' experiences in long-term care in the weeks and months following admission;

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- the organizational context into which residents are coming to live; and
- the role staff might play in the adjustment of residents to the long-term care environment.

Methodology

A qualitative research design was used for this study. The study was informed by the *hermeneutic phenomenological paradigm* (Van Manen, 1997). Hermeneutic phenomenology – the study of people's lifeworlds – aims to gain an understanding of the world in which people live (Van Manen). In studying the lived world, as experienced in everyday situations and relations, the approach focuses on how people are engaged in the experiences of everyday living rather than how people conceptualize the world. Hermeneutic phenomenology focuses on the uniqueness of a particular phenomenon in which personal experience is the starting point. It also offers the possibility of understanding social structures through understanding lived experiences against the backdrop of social structures and settings.

Van Manen (1997) explained that hermeneutic phenomenology encompasses four fundamental existential themes which are part of all people's lifeworlds, regardless of historical, cultural, or social situatedness. He referred to these as "existentials" (p. 101). Four existentials belong to the lifeworld. The first lifeworld existential is lived space or spatiality. Lived space refers to felt space. The experience of lived space is largely pre-verbal (Van Manen, 1997) and pre-reflective (Merleau-Ponty, 1962), yet space can significantly affect how we feel and apply meaning. The second lifeworld existential is the lived body or corporeality. This refers to our bodies in the world, or "being-in-the-world" (Merleau-Ponty). Our bodies are mediators of the world and of knowledge (Shapiro, 1999). The third lifeworld existential is lived time or temporality. This is subjective experienced time as opposed to objective clock time. Lived time refers to our perceptions of time as well as temporal dimensions of past, present, and future. Finally, the last lifeworld existential is the lived other or relationality. This is the lived relation we maintain with others in the interpersonal space that we share (Van Manen). Each of these four lifeworld existentials is important in understanding the long-term care environment. These four elements guided the larger study by sensitizing the researcher to the structures of the lifeworld.

Setting and Participants

Ridgemount Long-Term Care Facility was a home for the aged that was operated by the City of Ridge Mountain (both names are pseudonyms for the facility and place in the study). The building was fairly modern and the facility was large, with more than 100 residents living there. Staffing levels in Ontario at the time this research was completed were determined by a specific funding formula applied by the Ministry of Health and Long-Term Care. The funding formula was based on the care needs of the residents. Thus, there was not a pre-determined ratio of staff to residents, but funding was based on the classification of residents' needs.

Participants were recruited from Ridgemount. As the researcher, I initially had intended only to interview the administrator, director of nursing, the recreation coordinator, and two nurses and health care aides. By interviewing management staff initially, the goal was to gain a better perspective of the transition process and the policies of the facility, as well as to understand how these policies directly impacted the ways in which staff interacted with new residents. Since my contacts were mainly with the management and recreation staff, it was the front-line recreation staff who recommended other nursing staff to participate in the research. Generally, the nursing staff they recommended were staff who had been working at the facility for a number of years and who worked directly with the residents. Thus, snowball sampling was used (Patton, 1990). After staff were recommended, I asked staff who were working full or part-time and who were working directly with residents on a daily basis to participate. In total, in the initial interviews 15 staff participated: three were from management, four were recreation staff (including social work), and eight were nursing staff (RNs, RPNs, and HCAs). The interviews were conducted at the start of the larger research study.

Ethics approval was obtained from the research ethics board of the university, and approval from the senior management team of the facility was also obtained. The facility administrator provided consent for the facility to participate in the study. Informed consent from all participants in the study was also obtained. The staff were provided with an information letter and consent form prior to participating in the interview. After I explained the study and staff read the information letter, they signed the consent form to participate in an interview as well as to have the interview audiotaped.

Interviews

The interviews were semi-structured in nature, and lasted approximately 20 minutes to three hours each. They focused on topics such as (a) the typical routine of the staff member and of residents; (b) the process of the move for residents and the staff's involvement in the move; (c) the policies, rules, and regulations of the department and facility; (d) the adjustment process for

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residents and the staff's assistance; (e) the experiences of residents receiving physical care; (f) residents' views and perceptions of the facility; and (g) staff's perceptions of residents. The interviews were designed to solicit information about the staff's perceptions of residents' experiences, along with the environmental and cultural context of the long-term care facility. By having a flexible, semi-structured approach to the interviews, I was able to gain insight into how staff described their everyday experiences working in long-term care and how they perceived residents' adjustment to the facility.

A general interview was conducted with the administrator, director of nursing, and recreation coordinator to gain an overall idea of the process of admission and the involvement of the nursing department in the admission and transition process. As mentioned, interviews were then conducted with eight nursing staff (including health care aides) and four recreation staff (including a social worker) to gain an overall idea of their perspectives of the process of admission and their involvement in the admission and transition process. Because nursing and recreation staff had the most interaction with residents, I assumed that the practices of these departments significantly affected residents. Therefore, by understanding how these departments operated and their roles, a clear picture of the transition process emerged.

Data Analysis

Data were analyzed using the hermeneutic phenomenological approach (Van Manen, 1997). Phenomenological themes are essentially the structures of the experience (Van Manen). Interview audio recordings were transcribed verbatim. All data were read through numerous times to ensure familiarity with the data and the transcripts. Van Manen has suggested three ways to isolate thematic statements: through (a) a holistic or sententious approach, (b) a selective or highlighting approach, and (c) a detailed or line-by-line approach. Staff interviews were analyzed using the detailed or line-by-line approach. This approach essentially means that the researcher examines every sentence or line, and asks, What does the sentence reveal about the phenomenon or experience being described (Van Manen)? A line-by-line approach ensured that the details of the topics staff discussed were captured by the analysis, as well as ensuring that the essential structures of the phenomenon were illuminated. A set of themes surrounding staff's perceptions of residents' experiences coming into long-term care were identified through the detailed analysis. These were the essential structures of the phenomenon (Halldorsdottir & Hamrin, 1997). The structures of the phenomenon were then compared with the original transcripts to determine whether they fit the data (Halldorsdottir & Hamrin).

Finally, the findings of the research were discussed with a number of staff, including two recreation staff and a resident counsellor. In this way, the phenomenon's essential structures were validated by the participants (Halldorsdottir & Hamrin, 1997). The staff chosen to discuss the findings of the research were those who seemed to have an in-depth understanding of the residents' experiences due to their close relationships with residents, based on my observations and interactions with the staff. Discussing the findings with these staff ensured that the analysis authentically captured staff understandings of a resident's coming to live in a long-term care facility. Although much discussion ensued about the findings, all of the participants were in agreement that these findings represented the staff's perceptions of residents coming to live in the long-term care facility.

Findings

Three main themes emerged out of these initial interviews that reflected the staff's perceptions of the residents' experiences moving into Ridgemount Facility. These themes were by no means mutually exclusive, but seemed to be related to each other and intertwined. Essentially, staff described how residents learned to live life around various factors—*life around losses, life around the institution,* and *life around the body.* Life was lived around these themes—losses, the institution, and the body, meaning that they shaped the residents' lives living in long-term care. The word "around" indicates two things: (a) life happened with losses, the institution, and the body as the central foci and structures of experiences for the residents; and (b) life occurred in spite of these things – that is, residents continued to function despite these factors that now structured their lives.

Life around Losses

Staff described the myriad losses that residents experienced prior to admission as well as upon admission to the facility. The losses mainly revolved around three things: (a) the loss of identity, (b) the loss of possessions, and (c) the loss of relationships. The losses characterized what some staff described as a loss of life.

Many staff felt that residents had lost their past lives, and as a consequence, their identities, upon coming to live in Ridge Mountain.

> *There's a loss of their life coming into [the] institution … people that work here don't know them, have no idea who they are, they only know tidbits about this person. So really, it's almost being like an entity in this building of nothing beforehand. You know, I often make a metaphor of a plane [that] went over and dropped the person off [here]. And, not to be*

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> *disrespectful, but dropped the person off and said, "Here, here's the next person moving in" … and sometimes staff don't want to know anything else about them. Only enough to help with their actual care right now. [Karen, Recreation]*

Because of the amount of paperwork and other tasks associated with an admission, staff often viewed a new admission as paperwork and tasks, rather than as a person. Residents were often labelled even before they entered the facility.

> *I'd like to say that [staff] perceive them as an individual coming with this [unique] background but often what happens is that they perceive the resident as [just] another resident as opposed to Mrs. Smith with all her varied background and knowledge and that kind of thing, so…. They think of them as a new admission. You know, not necessarily Mrs. Smith with her family and her pets that she's left behind in her home and that kind of thing. [Colleen, Management]*

Another significant loss staff described was the loss of residents' possessions. Most obvious, of course, was the loss of residents' homes. The loss of possessions, however, also included treasured items within their homes that residents were not able to take with them into the facility.

> *When you think about leaving your whole home and all your furnishings and coming to one room and you're allowed to bring what, two things? I think it's pretty hard on most of them. [Mary, Nursing]*

Some staff also discussed the relationship between possessions and identity. Possessions tell a story, according to one staff member, and when those possessions are gone, part of the resident's story is gone as well.

Staff also described the loss of relationships that residents experienced. While many staff acknowledged that this loss often occurred prior to admission to the facility, there were some instances when admission to a facility directly caused a loss of a relationship, particularly in the case of spouses who might not be able to share a room or a bed anymore.

> *[One loss is] being in separate beds. And I know people that have never been apart for a night, and then one spouse moves in long-term care. How do you survive that? All of a sudden, you're sleeping alone. Like the person's not even there in the morning: just gone. I mean, that's a death. Really, that's a death …. So it isn't just moving into a facility. It encompasses a whole world of a human being's life. [Karen, Recreation]*

Not only have residents given up many of their outside relationships, but being with a number of strangers in the facility highlights their "alone-ness" and their loneliness.

> *They're lonely. They're lonely. They don't know anybody, and they want to go home. Basically, they want to go home. [Stacey, Nursing]*

The restructuring of residents' lives and the numerous losses and changes they experienced led staff to believe that residents were grieving. Grieving was not just about death or an awareness of mortality, but about the life changes that occur for residents both before admission to long-term care and afterward.

> *[g]rief is not just about death. You know, it's about loss. So I see a lot of grief just in what people lose when they come into long-term care, and we don't even acknowledge that. Because so many people believe that grief is just about death, and I think that's [losses coming into long-term care] [a sequence of losses is] a whole thing there [other category for grief]. [Karen, Management]*

Life around the Institution

Life around the institution consisted of mainly two things: rules and regulations, and rigid routines. Despite the ideals of "home", most staff did not view the facility as "home" in the traditional sense for the residents. Instead, the facility was described as an institution.

Many of the staff discussed, in great detail, the rules and regulations surrounding the institution. These rules and regulations governed both staff and residents' behaviours and routines, such as the requirement that all residents be in the dining room for meals. The rules and regulations did not only concern issues of routines, but also focussed on issues of safety and risk. Risk had to be minimized and safety maintained at the expense of residents' rights, even though it was often stated that the residents' best interests were at heart.

> *And how do you keep that pride and dignity and keep the rules? You know, health and safety: they're at risk for falls. Okay, well, they could fall anywhere … we get to a point, too, where we're trying to be too cautious … "we don't want you walking down the hall anymore because you could fall and break a hip". Well, then they get in the chair and then they're depressed and they get worse cognitively … but I find when they have to give [walking] up, they go downhill very quick. Whereas if they were walking around, they'd be happy. "Don't put me in a chair, I may just walk and break a hip. Then good: Maybe I'll die in a hospital and not come back." [laughter] [Joyce, Recreation]*

The rules and regulations also created numerous behaviour expectations of the residents.

> *[T]here's the residents' conduct. They're supposed to be courteous to staff and you know, you don't want to be abused by them. Things like that. [Joyce, Recreation]*

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According to some staff's descriptions, when residents refused to conform to the behaviour expectations, they were most often labelled "difficult", "resistive", or "aggressive." As a result of this labelling, they were often prescribed medication to make them more compliant.

> *[There are] so many unwritten things that I don't think anybody would ever admit. But if you speak your mind, you're "difficult". If you don't like something and you become frustrated and you have a bad day and maybe have an outburst, you will be labelled "aggressive" and you will be on a PRN [as needed]. And once you get that PRN, you're going to have it every day. And you're going to be stoned. [laughter] If you ring that call bell, even though it's supposed to be there for help, you're "needy". You know? And those are unwritten things [we have to deal with] that are just sad. [Joyce, Recreation]*

In addition to labelling, one staff member described other repercussions that occurred if residents did not exhibit behaviours that were considered "appropriate" or expected.

> *[A resident comes to] "learn that if I cause trouble, it may be a deterrent for how my care is met." And people learn that. And I really would like to say that doesn't happen, but I know it does. I know that it does. Because I know that those individuals who may be deemed difficult or not conforming – their care, as in a sense of hands-on care, may not be lowered, but [it will be altered] in how it's done. As in, "oh, it's so and so. I'm just going to make them wait for 10 minutes. And I'm not going to respond." And the people that live here know it. [Karen, Recreation]*

Ultimately, the rules and regulations, as well as the behaviour expectations and potential repercussions of not conforming to these expectations, however, created residents who were described by staff as compliant and submissive.

> *[B]ut I think that for the most part, when people realize how much they have to conform to survive in here, I mean, I hate to say it like that, but that's a reality. [Residents think] "I have to conform. I have to learn to be nice. I learn that if I don't cause any trouble I will get my needs met." [Karen, Recreation]*

Life around the institution was also characterized by extremely rigid and structured routines. Rigid routines were often dictated by government regulations as well as the routines of the institution. They included getting up too early, going to the dining room for meals, and following prescribed care routines. Staff stated that residents became a part of life in the facility through the routines and schedules, since these were what defined life in the facility.

> *How do they become a part of life? Well, just through some of those regulations and schedules. Like I say, you're a brand-new person and you've come to our home and just how they started fitting in is – maybe the first [is to] get up in the morning, working with the nursing staff, going to a meal. Or they just become part of the routine. And that becomes part of the way they live. [Darlene, Management]*

Life around the Body

Life around the body consisted of two inter-related themes—being a body and being a number. Life around the body led residents to be viewed by staff as a task. Being a "body" focussed on the pre-eminence of the body as a daily part of life. The loss of bodily functions and independence, as well as the increasing dependence on staff, often created situations in which residents felt they were defined only by their bodies.

> *Honestly, I can't see anybody adjusting to not being able to take care of themselves. And that's why they're here: because they can't take care of themselves …. Some of them will think, "Oh, I'm useless now. The nurses have to do everything for me." [Mylana, Nursing]*

Being a body was also defined and reinforced by the focus of staff on body care and the surveillance of the body.

> *I think that part of that [focus] to me would even be how people start to feel that they're just a body, where I hear residents are saying staff are rough. And [staff] may not realize they're being rough. But it's that whole sense of just seeing people as bodies. And rolling people over and moving people and bathe them or do whatever it is that they're doing. [Karen, Recreation]*

Another part of being a body was the toilet. Because residents were dependent on staff for care, they were dependent on staff timing as well. This was particularly problematic with the bathroom, since needing to use the bathroom is often an urgent need. Therefore, residents were sometimes incontinent before staff were able to assist them.

> *But I would think [the] number one [concern for residents is the] bathroom. … nobody wants to soil themselves, and no one wants to admit they need more help there. But sometimes the ones who could still be toileted end up not being toileted. And they get stuck in Depends, and I think that's gotta be really degrading. And you'll see some of them that will just sit and cry. [Joyce, Recreation]*

Body privacy was another aspect of a resident's being regarded as a body. Any privacy or reservations that residents had about their bodies was compromised. Staff had to touch residents in the most intimate places during care, and residents had to adjust to their bodies becoming, in effect, public property.

[S]ometimes your caregiver doesn't really appreciate the amount of privacy that you need and you deserve, and that kind of thing, so they come here and they're bathed by a stranger. They might have an incontinent product changed by a stranger.

They're dressed by a stranger. Maybe in the past they've been dressed by their husband or … somebody familiar. So they now have to come in and they need that care, and it's a strange face looking after them. Over time, that changes and I don't know if that's good or bad – that over time it changes – because maybe they don't think they need as much privacy as they felt they did initially … many nurses – to them it's a task and you forget there's a human being on the other end of that task that might not want to be exposed or might not want you having them see you naked or whatever if they need assistance to dress. [Colleen, Management]

Being a body and being dependent on staff for care often led residents to feel like a nuisance for needing assistance.

That's a hard one but what stands out in my mind is the odd person that thinks they're such a nuisance now: "I'm sorry to ask you for help," "I'm such a nuisance, I can't do it by myself", and "if you don't mind". Lots of times I'll say don't be silly that's what we're paid for, you got to ask us and we'll help. …They feel guilty that they're having to depend on somebody. [Mary, Nursing]

Being a number was closely related to being a body. Residents often had to wait for staff and were at the mercy of staff. Staff seemed cognizant of residents' experiences of being a number, but many felt helpless to change the situation.

And what I find difficult is the routine when it comes to getting washed right away or getting dressed right away. Or they want to get up in the chair … right away, so they want that all to happen right away, and we just can't get there when they need us. And that's the frustrating part, even for Nursing, because they would like to be able to jolly on the spot be able to get everybody up and do everything at once, but we've got 38 people, and it's just impossible. [Glenda, Nursing]

Staff described numerous aspects of life that residents had to adjust to when they moved to long-term care within the context of life around losses, life around the institution, and life around the body. Staff recognized that although they did their best and provided good care for residents, long-term care was still viewed negatively by residents, and indeed, many staff viewed long-term care negatively as well. Staff described the institution as not being home, and residents had to adjust to new meanings of the place where they were living. Essentially, staff described the long-term care facility as the end of the road.

Because they know, this is the last stop. Most people, that's realistic for them – that they're not going anywhere else to live. This is the end of their journey, whenever that will be, but it's the process to the end of the journey… [Karen, Management]

[B]ut you know that it's the end of the road. I think that's what it is. It's the end of the road. [Stacey, Nursing]

Discussion

The staff's descriptions of residents' experiences coming to live in a long-term care facility were similar to what has been described in past research, particularly related to the focus on physical care and the body and institutional structure (Diamond, 1992; Gubrium, 1975; Paterniti, 2000, 2003). Bodywork is defined as a characteristic of carework that "entails working on or through the bodies of others, handling, manipulating, appraising bodies which become the object of the worker's labor" (Twigg, 2004, p. 67). Twigg discusses bodywork in the context of long-term care, in that both residents and staff are marginalized and dominated, as well as dominating, illuminating the complex relations in long-term care. Although staff seemed to have an in-depth understanding of how residents became "bed-and-body work" (Gubrium), the bed-and-body work also defined their roles as staff. Thus, the notion of bodywork captures the work of long-term care staff in many ways.

Interestingly, little research has described the empathy of staff in understanding the losses residents experience while coming to live in long-term care and the associated emotional impacts of the transition and adjustment to long-term care. Although different ways of caring have been illuminated in long-term care (Schirm, Albanese, Garland, Gipson, & Blackmon, 2000), the staff's great understanding of the life situations of residents has not been described in-depth. Staff working in long-term care facilities have often been portrayed as "saints or monsters" (Foner, 1995). Despite some perceptions of staff as uncaring (Foner), staff appear to have a great capacity to empathize with residents. As evidenced by the current study, staff demonstrated an in-depth understanding of the losses and emotional trauma that residents had and continued to experience upon their transition into long-term care.

Particularly pertinent in this study were the overwhelmingly negative ways in which staff described residents' experiences of coming to live in long-term care. Previous research has described how residents minimized the negative aspects of living in long-term care and made the best of it (Kahn, 1999), and how residents began to have positive attitudes once they started to adjust to the facility (Wilson, 1997). Staff in

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this study, however, did not describe positive aspects of living in long-term care but, instead, described the negative aspects of long-term care as they felt the residents experienced them. Although Kahn described residents making the best out of their living situations, staff in this study talked about how residents had to learn to conform in order to survive. Although the staff seem to have an in-depth understanding of residents' experiences living in long-term care homes, the potential positive aspects of living in long-term care may not always be recognized by staff. Why this occurs has yet to be determined, but it may be that the staff's perceptions of the overwhelming negative effects in long-term care overshadow the positive aspects. By focusing solely on the negative effects, the resilience and capacity of individuals, however, to create positive aspects of potentially negative circumstances is overlooked.

What is also evidenced from the discussions of the staff in the present study and in other research (Dupuis & Wiersma, 2006) is that staff perceptions of "quality care" for residents does not simply include physical care for residents' bodies, but indicates that staff would like to be present for residents in meaningful ways (Dupuis & Wiersma, 2007). While the focus of the staff's work is to care for the body, staff develop relationships with residents, and these relationships form the contextual frame through which staff view residents. This, of course, is not to suggest that there are not conflicts between staff and residents or that there is the possibility for abuse, but many staff develop close relationships with residents (Foner, 1995). Developing relationships with residents is considered part of long-term care work (Foner) and of caring (Schirm et al., 2000).

Other research that has examined staff perceptions of caring in long-term care have reported various qualities of care (Schirm et al., 2000). Schirm et al. found that staff felt that being a formal care provider in long-term care was more than just a job and was about an inner, indefinable quality. Caring, as described by nurses in this study, identified compassion, gentleness, patience, and personalized care as essential characteristics of caring (Schirm et al.). These studies would suggest that in order for staff to feel that they are caring well for residents, they must be able to meet the psychosocial needs of residents as well as the physical needs. As evidenced by the present study, the staff seem to have an in-depth understanding of residents' experiences but may not have the resources to provide appropriate emotional support, the main resources being time and staff.

Various models of care for long-term care homes have been proposed, focussing on improving the quality of care and quality of life of residents through various means. Some of these alternative models of care include the personhood approach to care (Kitwood, 1997), the Eden Alternative (Thomas, 1996), and the Gentlecare approach (Jones, 1999). Adopting various approaches to care has been advocated to decrease the negative effects of institutionalization and to "transform nursing homes from impersonal institutions to safe, caring homes and communities" (Lopez, 2006, p. 56). Lopez termed these approaches "culture change management". What Lopez found was that culture change management cannot address structural problems of inadequate staffing. Indeed, the staff at Ridgemount discussed the low ratio of staff to residents, generally inhibiting their abilities and time to develop meaningful relationships with residents. Lopez suggested that culture change management may actually become part of the problem that focuses attention away from structural problems and encourages managers to blame frontline staff instead. In Lopez's study, the positive features of such a managerial approach could not address the problem of the lack of time staff had to complete the number of tasks in the proper way required.

> In the eyes of management, the primary obstacle to the creation of a caring community was not understaffing, or low wages, or an authoritarian attendance policy. Perhaps because there was not much they could do about these issues, managers preferred not to see them. It was, perhaps understandably, easier to believe that the main problem was the work culture of the aides … top staff preferred the idea that too many of the aides saw the work as "just a job"; top management was concerned … that a "core group" of aides with "bad attitudes" was "controlling" the other aides. … Culture change, in this formulation, no longer meant that management should engage in self-criticism, but served as a convenient device for blaming aides for the structural problems of the nursing home system.(Lopez, 2006, pp. 75–76).

The complicity of staff in conforming to institutional structures has not been examined in-depth in the literature specific to the long-term care environment. Ethically, how do staff reconcile the desire to care for residents yet also conform to the structures of the institution? What are the emotional impacts on staff when they must be a part of a system that creates residents as bed-and-body work (Gubrium, 1975)? There are myriad day-to-day circumstances in which staff not only conform, but also resist, the structures that construct residents as bodies. Staff are part of a system that creates residents as bed-and-body work (Gubrium) but they also wish to be present in meaningful ways for residents (Dupuis & Wiersma, 2007).

It is in these day-to-day circumstances that "microethics" become relevant (Nikku & Eriksson, 2006). The concept of microethics focuses on people's behaviour in

everyday settings, focussing on specific situations, the contextual nature of settings, and understanding attitudes and values of human actors (Nikku & Eriksson). Thus, further research needs to focus on microethical analyses of long-term care settings and the ethical dilemmas that staff face in their day-to-day work as they care for residents. In addition, these potential ethical dilemmas in which staff are placed must lead to further awareness of, and action on how to support, staff in self-reflective practice and how to encourage staff to provide emotional support for each other throughout this process so that they maintain their emotional health.

This study was based in only one facility, and the findings should be interpreted accordingly. Given that the structure of long-term care homes is similar across Ontario due to funding and regulations, these findings may be transferable to other facilities with similar structures, as well as to other facilities premised on similar medical approaches and ideologies. The findings of this study were based on a broad range of staff including nurses, personal support workers, recreation staff, and management. It may be interesting to focus more in-depth on each of these specific groups to examine similarities and differences in how staff view the experiences of residents in long-term care. In addition, it would be interesting to examine whether staff views are commensurate with how residents describe their own experiences. Finally, the views of staff toward residents with dementia should be further explored, as staff perceptions of the experiences of residents with dementia may be quite different from staff perceptions found in this study, involving residents without dementia. With an increasing prevalence of dementia, this issue is important to consider in subsequent research.

The disjuncture between the system of long-term care and the ways in which staff want to be able to care for residents is significant. While the systemic issues of long-term care, mainly those of a lack of funding and staff in conjunction with a punitive regulatory system, must be changed to enable staff to care for residents in ways that are meaningful and thoughtful, the numerous ways that current practices and patterns continue to marginalize residents can also be changed. Routinized care, lack of staff, lack of funds, a focus on task completion, and a punitive regulatory system, among other things, are all aspects of long-term care homes that need to be changed in order to allow staff to care meaningfully for residents. To assist residents in the adjustment to long-term care, opportunities should capitalize on staff's obvious awareness and empathy of the residents' experiences, and the time and resources should be made available to allow staff to be present for residents in a compassionate and empathetic manner. Most importantly, the findings of this research challenge us to think of the systemic ways in which issues in long-term care must be addressed to enhance the residents' quality of life and to enable staff to care for residents in appropriate, meaningful ways.

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