Meaning-making dynamics within and across workgroups: an inquiry into the creation and movement of usable knowledge in a long-term care facility in Ontario

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ABSTRACT

Meaning-making dynamics within and across workgroups: an inquiry into the creation and movement of usable knowledge in a long-term care facility in Ontario

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This dissertation reports the results of a qualitative investigation of the meaning-making patterns that occur in a group of caregivers in a long-term care home. The research design included an ethnographic component to reveal the overall meaning-making dynamic in the site, and a case study focusing on a specific improvement initiative. Data was gathered over a three month period through observation, interviews, and documents. Data analysis included the creation of analytic memos, categorizing and theming, and the development of a meaning-making map to depict systematic interactions. The findings suggest that research participants have developed systemic patterns of meaning making that allow them to create experiences of coherence, purpose, identity, and competence. Eight meaning-making themes emerge from the analysis to reveal a workplace where emphasis is placed on immediate concerns and priorities, and where long-term planning and change are problematic. Caregivers begin each day by creating a coherent picture of their workplace, and they engage in brief, pragmatic interactions throughout the day to maintain their shared understanding of the unfolding context around them. Reflection upon the themes allows for the construction of a meaning-making map, which shows how knowledge of the floor (the residents who live on the floor, the staff who work there, the procedures for carrying out the work, and the physical layout and location of key resources)

allows staff to accomplish tasks, and how it simultaneously limits their ability to improve the efficiency and effectiveness of the work and the quality of life of residents. This study confirms previous research and policy reports that describe Canada's long-term care workplaces as highly stressed. The study also supports the contention that strategies to implement a one-way transfer of external knowledge into frontline practices will confront stubborn barriers, and that knowledge moves through processes of exchange—through relationships and interactions—rather than transfer. This inquiry extends the work of organizational researchers and theorists who have attempted to reveal the dynamics of collective learning and sensemaking in workgroups. The practical implications of this study include the importance of using existing interaction patterns as a vehicle for introducing new ideas and practices into long-term care homes, and the advisability of considering whether current long-term care staffing levels are adequate.

ACKNOWLEDGEMENTS

It should be no surprise that my dissertation, which views learning and knowing as social phenomena, owes its existence not just to the author, but to a large number of people with whom I have worked and studied and talked over the past several years.

This intellectual journey began in 1998, when I began to make changes to my life that eventually allowed me to undertake this program of graduate studies. My sister Gail was a rock during this time, and my mother was, as always, a joyful inspiration.

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supervise a reading course for me, and who introduced me to the extraordinary thinking of Walter Fisher.

Several people happily conspired to introduce me to the world of long-term care organizations and the current interest among health services researchers in the flow of knowledge between caregivers, researchers and policy makers. I am grateful to Deirdre Luesby for bringing me into the fascinating world of knowledge networks in healthcare. Dr. Larry Chambers was instrumental in helping me to find a research site. Dr. Aura Kagan, head of the Aphasia Institute in Toronto, introduced me to the fascinating group of researchers and clinicians who are bringing new, social-based approaches to the treatment of stroke victims. I also want to thank Dr. Paul Stolee for his fellowship, good cheer, and incisive thinking, as together we made sense of an emerging knowledge network, and whose war stories of Ph.D. studies never failed to amuse and terrify me.

Although I am not able to name them in this document, I want to thank the twenty-eight people who agreed to participate in my field study. They are generous and busy people, and they tolerated me, their "shadow," with humour and curiosity.

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DEDICATION

In memory of our fathers...

John Gladwin Conklin

Alfred James Turner

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CHAPTER ONE: INTRODUCTION

EXCERPTS FROM MY FIELD JOURNAL

On my tenth day at the site, I positioned myself in the big hall near the medications cart and started to talk casually with the RPN (registered practical nurse). While we were talking, an HCA (health care aid) approached the RPN and said she wanted to see if Mrs. Kantner could be seated in one of the dining rooms instead of out in the hall. They discussed this at some length. They were talking about one of the two residents I had been chatting with earlier that morning, Mrs. Kantner who always asks me if I will get her a cup of coffee, and Mrs. Giles. Mrs. Kantner is seated in the hall because she is confused and she talks so much that she disturbs the other residents. When she is seated at a regular table in the dining hall, she talks and talks, often repeating the same thing over and over, and the other residents complain. Mrs. Giles, on the other hand, is often ill-tempered in the morning, and she too is seated at the little table in the hallway for her breakfast. She can be quite mean to the other residents, I had been told. So these two ladies are seated in the hall, but the HCA felt that it would be better if the talkative Mrs. Kantner went into a room, so the mean Mrs. Giles could be alone at the little table.

The RPN listened, and after a while she explained that when Mrs. Kantner was in a dining room, the others complained. She nodded her head a few times, as if she was remembering something, and then she continued. The inspector from the Ministry of Health often comes to the Lodge, she said, and if she sees something like this—a resident

seated in the hall instead of in a dining room—she will usually insist that the resident be moved into the dining room. The RPN said more than once, "Our residents are human beings, not furniture." She said that the Ministry sends an inspector who takes a quick look around, makes quick interpretations, and then asks for changes—even though the changes do not really make sense. She concluded, "We have to make it work. And this is what we decided to do. We know the Ministry won't like it, but it is best for everybody."

The HCA appeared partly persuaded, but she still thought that moving Mrs. Kantner into the dining room might be a better solution. The RPN suggested that the HCA take it up with the RN (registered nurse), and the HCA walked away. The RPN turned to me and said, "I am not going to decide this one, so she can go to the higher up."

This exchange reminded the RPN of another situation, which she then described to me. There is a male resident in the Lodge who has an extremely big outdoor wheelchair. The Ministry expects all residents to be seated at a table in the dining room during meals. The Lodge's staff had been letting this resident eat off a tray attached to his wheelchair, but during an inspection the Ministry said this was not permitted. So the Lodge had to have a special table installed for him, and because of the height of his wheelchair the table had to be fastened to a wall. Now this man must sit facing the wall, with his back to everybody else, so he can eat at a table. The Ministry presumably wanted the man included in the events of the room, but their rule actually served to isolate him. "The Ministry rule seems humane on the surface, but it doesn't make sense when you try to make it work," the RPN said.

The RPN sighed and continued to work with the medications on her cart. After a moment she said, "The residents want lots of attention in the morning. They are like kids. They want some attention. And if one resident is seen talking to a staffperson, other residents will gather around, to be included. Like in a family."

On my eleventh day at the site, I noticed how quiet it was at the west end. I walked down the hall to the east end, where a memorial service was now in progress. I stood in the hall for a few minutes, and then decided to go back down the main hall in the vicinity of the RPN who still had her medication cart in the hall.

It was quiet—the residents had finished breakfast, and lots of people were now in the chapel for the service. Two residents were sitting in the central area; the lady who calls me "Joe" all the time had fallen asleep at her table in the middle of the big hall.

The RPN said to me, "Quiet at last." She told me that it was not always this quiet at this hour. A few minutes later one of the HCAs walked by me and also commented on how quiet it was.

While standing there, I witnessed an impromptu huddle in the big hall. It involved the regular RN, the RPN, an HCA, the temporary ward clerk, and a new RN who was being oriented. They were not all engaged in the same conversation—there were as many as three conversations going on at once. In one, the temporary ward clerk was asking what she should do next. The RN and the PCA discussed one of the residents in French. But the main conversation, the one that I paid attention to, involved the RN and RPN, with the orientating RN on the periphery.

The RN commented on what a difficult and hectic morning it had been, and the RPN agreed. The RN said "I am going to try to bring some stability." Then she said, "I see what you have to deal with, all this instability." The solution appeared to be to phone the regular Ward Clerk to get some information. The Ward Clerk had been away for about a week, on sick leave. She had come in one day but was sent home again. The RN and RPN talked about needing to get certain reports or forms from the Ward Clerk's computer. They needed to find out how to access them. The RN said she was going to phone the Ward Clerk. The RPN said she was, too, but she wouldn't bother now that the RN was going to do it. The RN repeated that she would phone the ward clerk. The RPN said to let her know if something came up and she needed the RPN to make the call.

A few minutes later, in the chart room, the RPN told me that people have been accessing the Ward Clerk's systems in order to find material that they need. The RPN said that the Ward Clerk was going to be upset when she returned to work, because "She has her systems, that one." I took this to mean that the Ward Clerk is fussy, and will not like finding that things have been changed or that people have been using her computer.

As we left the chart room the RPN said, "I like how they designate me as the chief. I'm not the chief. Go talk to the RN."

One of the ceiling alarm lights was flashing. The RPN noticed this and said, "Is anyone going to get that one? ...Maybe I'm going to get that one." She walked up the hall and went into the room where the alarm originated.

On my thirtieth day at the site, the morning report session was brief and orderly. First, the two RPNs, Colleen and Chantal, led the review of residents, with Colleen reading out her report for the east end, and then Chantal reading her report for the west

end. Colleen read her report in the usual way. She said the name of a resident, then noted one or two details—slept soundly, no bowel movement, restless, etc. At one point she paused and said, "Okay, I am going to take Mrs. Jacobs today, and when I am finished Mrs. Jacobs I am going to take Mrs. O'Hara." Chantal began her report in French, reading the name of a resident and saying, "Rien d' spéciale..." Then, when the words in the binder changed to English, she began to speak in English, saying "Nothing special." When Chantal finished her report, Colleen went to the Agenda binder and said that Mrs. Zedrick was having a family conference that day. Then she looked around the room and said, "That's it."

The night nurse came back into the room at this point and said, "Do you need anything from me?" Colleen said "No, we're fine." The night nurse smiled and said goodbye, and left the floor.

However, today the members of the day shift continued to sit at the table and talk. Two of the HCAs, Janice and Dominique, wanted to know how to chart a specific situation. Together they formulated their question, with Janice beginning to describe the situation, then Dominique jumping in to add some more information, then Janice taking over again. Every now and then Colleen would interject with a question or suggestion. They were talking about the following situation. On this floor many of the residents were both lucid and mobile, but some were in the early stages of Alzheimer's and you could not rely on them being able to answer accurately a question about their recent activities. More specifically, some residents went to the bathroom by themselves, but it was impossible for the HCAs to tell later on if the resident had had a bowel movement or not. This was important for the HCAs, because they were expected to keep track of and chart

all resident bowel movements during their shifts. Dominique mentioned the name of a specific resident, and then phrased her question.

"How are we supposed to chart this? Can we put in a question mark? Can we leave it blank? Should we write 'no' or put in a zero?"

Colleen tried to answer their questions, but as she made suggestions the HCAs offered more examples that brought further complications to the issue. Finally, Colleen said, "You need to ask the RN how she wants you to handle this."

At that moment Susan, the RN, came back into the room. The HCAs again posed the question to Susan, who closed the door and joined them at the table. Susan at first said that the HCAs had to find out when the resident typically had a bowel movement, and then they had to try to be on hand at that moment. Dominique explained how difficult this could be by mentioning the name of a specific resident. Susan expressed surprise that this resident went to the toilet by herself. Dominique, supported by Janice and Colleen, said that this resident did indeed go to the toilet by herself. Dominique went on to say that when she saw that this resident was on the toilet, she would try to stay nearby, and would sometimes take the resident some tissues or ask her if she was okay. But nevertheless, when the resident came off the toilet, there was often no evidence of a bowel movement—and the resident may have flushed the toilet, so there was no way of knowing for sure.

Susan continued to insist that they must try to be on hand. She suggested that they talk to family members and ask when the resident had gone to the bathroom in the past—in the morning, or after lunch, or whenever. The HCAs continued to press their

point, that they could try to find out, but they would not necessarily succeed, and that left them with the charting problem.

Susan then began to talk about the charting issue. She said that they could not leave it blank, and they could not put in a question mark. Janice suggested that they should mark in a zero, but after considering this for a moment she and Susan agreed that this would not necessarily be an accurate code. Susan, in talking about the issue with the team, and in suggesting answers and then considering whether the suggestions would work, arrived at a solution. The essential problem, she said, was to chart the situation in a way that would be acceptable to the people who entered the Minimum Data Set (MDS) codes into the computer system. Susan said that when this sort of situation arose, the HCA should take note of it, and should mark in zeros, but should also bring the situation to the attention of the RPN who was working on that part of the floor. Dominique played an active role in devising this solution, saying several times that this is not an HCA role, but is rather an RPN role. The RPN could then examine the resident, checking for physical symptoms of constipation. All of this would need to be charted, as well, in narrative form, and this charting would be the responsibility of the RPN. They talked about this for a few minutes, agreeing on how the HCA would monitor and note the situation for a few days, and then bring it to the RPN, who would then do an examination and do the appropriate charting. The two RPNs listened to this and did not contribute. After discussing this way of handling the situation for about two minutes, the conversation ended.

The report session began to come to an end. Colleen said to Dominique, "Tomorrow you will need to get Mrs. Christie and Mrs. Newman ready for 9 AM, so they

can be in the photos with you." Janice teased Dominique about being chosen to be in the photographs for the annual report, and Colleen said "Dom still has some of that honeymoon glow on her." They teased her for a moment. Then it came out that on the following day Dominique would be the only experienced HCA on the floor, and she would be working with three temporary on-call people. Dominique moaned theatrically. She said, "I will be working alone." Susan said, "You won't be working alone! There will be three other people here." Janice asked Susan and then Colleen, "Do you want me to come in?" Dominique interjected, "Don't offer to come in on your day off." Then Janice said with a smile, "Hey, I will come in if I can get Saturday off." Susan gave her an arch look, and the conversation ended. The HCAs and RPNs left the chartroom to begin work on their tasks.

The interactions and exchanges between these RNs, RPNs, and HCAs serve to bring a shared reality into being – they are constructing this organization, a long-term care home, through their interactions and words. Their meaning making creates a coherent and shared account of the people and events within the River Lodge, a long-term care home in Ontario. They negotiate a purpose for their work, to provide care to residents in a congenial environment, and while doing this they must make sense of the well-intentioned interventions of others, of the rules and standards that sometimes appear to be based on only a shallow understanding of how life is lived and work is accomplished in this home. They create identities for themselves, as skilled and compassionate caregivers who have both a strong focus on their tasks and a caring commitment to their fellow workers and to the elderly residents they serve. And they

create and sustain their individual and collective expertise, their regimes of competence that are needed to carry out the work of a long-term care home.

I begin with these excerpts from my journal to give the reader a taste of the ongoing flow of overlapping conversations in this workplace (which is also a home)—of the confusion, interpretation, conflict, and collaboration that occurs, and the continuing effort to bring sense and meaning to the experiences of the people who work there.

Before continuing, I will step back and explain the origins of this inquiry.

THE ORIGINS OF THIS INQUIRY

My interest in the subject of meaning making in workgroups grew slowly over the course of my career as a consultant on projects intended to introduce new technology into workplaces. I recall an instance in the mid-1980s when I was invited to observe a technical demonstration for a group of forklift operators in a Toronto warehouse. At the time I was responsible for creating training curricula and documentation to support new radio-linked computer technology being used in warehouses and factories. At the demonstration, I saw the operators (most of whom were men in their 40s) watch with apparent confusion as computers were attached to their forklifts. At around that time, I began to wonder if the basic premise upon which my practice was based—that it is feasible for a group of external expert developers to create knowledge in a development laboratory, and then transfer that knowledge to a group of workers engaged in a busy practice—might be fundamentally flawed.

During the 1990s, I began to experiment with more inclusive and interactive ways of transferring new knowledge into workplaces. I noticed that when the people who were

expected to accept and use a new technology had the chance to discuss, and perhaps even contribute to the design of the technology, they were more likely to cooperate with its implementation, and were more successful in absorbing the technology into their practice. I began to advocate for more interactive methods to produce technical requirements and specifications (Conklin, 1993), and augmented my consulting approach with a variety of facilitation and collaborative work techniques.

Eventually, I began to notice a pattern of social interaction, a meaning-making dynamic, occurring within all practice contexts. Most projects whose purpose was to introduce changes into organizations made the assumption that workplace practices were a *tabula rasa;* the frontline practice was expected to passively accept whatever new processes and technologies external experts wanted to introduce. It seemed to me that this assumption was flawed. A workplace practice was the site of a rich and ongoing meaning-making dynamic that could not be changed on the whim of a manager or an external change agent. Moreover, it became apparent to me that a project to introduce significant technical or process changes into an organization would occasion numerous perspectives and viewpoints, and it would be difficult to argue that one viewpoint—that of the sponsors of the change—was invariably correct and that all other viewpoints were incorrect.

In other words, I moved from a simplistic view that organizational change was a matter of transferring new technology and knowledge from one social group to another, to a more complex view that saw organizational change as a turbulent process where knowledge and action were contested among participants with varying degrees of power.

At around that time, in 2002, I decided to pursue these issues in an academic setting. I enrolled in the M.A. program in Human Systems Intervention offered by the Applied Human Sciences Department at Concordia University. This exposed me to the academic literature on human relations, organizational behaviour, and process consulting; it also allowed me to experience in a reflective manner, through the unique experiential design of the program, the power and frustration of working on intellectual tasks within a social collective. I realized that groups working together on a shared task invariably make meaning, and that this meaning-making process might be in the service of the group's primary task, or it might be in the service of making life bearable for group members when facing confusing or pointless tasks.

However, I was surprised at how little work had been done to describe precisely the meaning-making dynamics in workgroups. I noted that Karl Weick's (1995) watershed work on sensemaking was intended as a contribution to a debate that is barely underway. I found that many authors talked about the importance of making meaning in groups, but did not elaborate on how meaning is made or what these meanings entailed. Weisbord's *Productive workplaces: Organizing and managing for dignity, meaning, and community* (1987) is a case in point—despite his use of the word "meaning" in the title, Weisbord neglects to define this term, and does not establish a relationship between productivity and meaning.

My experience and reading were leading me to believe that interactions between members of a workgroup will always be directed toward the creation of meaning, and that these meaning-making processes might represent an essential, constituting flow within the life of a group. Ultimately, the meaning that is made through group

interactions is the group itself—its shared situation, identity, purpose, and capability. This meaning-making process is not the property of hierarchical managers, but rather belongs equally to all of those who participate in the group's interactions.

Through my M.A. at Concordia, I learned that many theorists and researchers agree that all groups make meaning together; however, the precise dynamics of meaning making are not yet fully understood. Some believe that managers or leaders create and distribute meanings within an organization; others believe that all organizational members create meanings, and that the movement of meaning between groups is inevitably problematic. Today, members of many organizations are responding to a call for greater adaptability, improved decision-making and service delivery capacity, and for evidence-based decision making. The implementation of these concepts requires improved understanding of how workgroups make meaning, and of the barriers and facilitators of knowledge flows between groups. I determined to pursue these questions by undertaking an interdisciplinary Ph.D. program through Concordia University's Special Individualized Program.

When I began my Ph.D. studies, I had not pre-determined what sort of research design I would use for my dissertation research, and I had not decided upon the organizational context in which I would conduct the research. I recall thinking that it would be interesting to focus the study on a large sales team, working on a large outsourcing contract or information technology implementation, due to the different disciplinary backgrounds of participants, the time pressures, and the complexity of the subject matter. However, happenstance intervened to present me with a more intriguing alternative.

In 2005 I was introduced to Dr. Larry Chambers, President and Chief Scientist with the Élisabeth-Bruyère Research Institute in Ottawa, and began to work with him on the development of knowledge exchange networks in Ontario. Dr. Chambers pointed out to me that Canada's long-term care sector has been largely ignored by the health services research community, and that little is known about the organizational factors that could contribute to staff productivity and resident satisfaction in long-term care homes. Through Dr. Chambers I also learned of the considerable interest in the health sector in improving the transfer of research and practice-based knowledge to frontline settings, and in facilitating service improvements through collaborative practice (Chambers et al., 2008; Conklin et al., 2007).

Shortly after this I began to work with Dr. Paul Stolee, a faculty member of the University of Waterloo with cross-appointments in the Department of Health Studies & Gerontology and the R.B.J. Schlegel-University of Waterloo Research Institute for Aging. Dr. Stolee and I have been collaborating for the past three years as evaluators of Ontario's Seniors Health Research Transfer Network (Conklin et al., 2007; Conklin & Stolee, 2008). This experience allowed me to become familiar with the fast-growing body of literature on knowledge flows in the health sector, and also to gain first-hand experience with the issues and challenges that Ontario researchers, policy makers, and clinicians are facing as they try to improve the delivery of health services to seniors.

I found the long-term care sector's interest in knowledge transfer to be intriguing and relevant for the inquiry that I was designing. Health service researchers were studying the "transfer" of knowledge from experts (who were thought of as senior policy makers and research scientists) to frontline practices (in long-term care, these practices

would include nurses, health care aids, and various allied health workers such as physiotherapists and dieticians). This reliance on the concept of "transfer" was similar to a view evident in some of the organizational studies literature, suggesting that one role of organizational leaders is to influence and control the meaning making that occurs within the organizational units for which they are responsible.

However, as research findings accumulated, most researchers working on knowledge transfer were acknowledging that knowledge transfer was not a linear, one-way flow of information to the *tabula rasa* of frontline practice, but instead involved a complex, iterative, two-way exchange of knowledge. This reminded me of the debate going on in the fields of technical and environmental communication, which suggested that when an expert group wants to provide information to a generalist audience, it is best to conceive of this communication as a process of exchange rather than transfer (Conklin, 2007; Hart & Conklin, 2006; Waddell, 1995).

Conducting the research in a long-term care setting was therefore attractive for a number of reasons. Almost no work on meaning making had been done in this organizational context, and hence at the very least my study might contribute to an understanding of meaning making by revealing the dynamics in place in the unique world of long-term care. Second, long-term care settings in Ontario are aware of the growing importance of knowledge transfer, and hence many organizations might be willing to act as the site for my inquiry. Third, numerous efforts are underway to introduce change into Ontario's long-term care homes, and thus a study of meaning making in this context would be almost certain to juxtapose the internal meaning-making dynamic of the frontline practice against efforts to introduce change into the practice. Finally, situating

the study in long-term care would make the literature on knowledge transfer in health relevant for the inquiry, and since this literature has been developed independently, with little reference to the broader organizational literature, it could offer an interesting counterpoint to the organizational literature with which I was most familiar.

PURPOSE OF THE INQUIRY

The purpose of the inquiry reported in this dissertation is to study and describe the dynamics of meaning making in a health organization, and to reveal the challenges of sharing and sustaining knowledge within and across workgroup boundaries.

This study focuses on how knowledge is created and sustained within workgroups in a long-term care setting, and how knowledge can be transferred from one workgroup to another. This dissertation is intended to provide a detailed and accurate description of these knowledge processes. The study consisted of two components. In the first component, I observed the problem-solving and knowledge-sharing activities in workgroups in a long-term care facility in Ontario. In the second component, I investigated one specific example of how a new innovation or idea was implemented in the facility.

THE RESEARCH QUESTIONS

I did not test a hypothesis through this inquiry, but rather explored three questions related to knowledge dynamics in workgroups.

I framed my research questions by using the word *knowledge* rather than *meaning*. I used the word *knowledge* for pragmatic reasons: as I introduced my research project to participants and stakeholders, I anticipated that non-academics would be more familiar and comfortable with the word *knowledge* than with the phrase *meaning making*.

By framing my research questions with the word knowledge, I nonetheless continued to focus on meaning making. When we make meaning, we participate in processes of knowing that result in the construction of knowledge. For example, the construction of coherence may involve knowledge of a workgroup's social context and situation; the construction of purpose may involve knowledge of goals and objectives; the construction of identity may involve knowledge of individual and group roles and responsibilities; and the construction of competence may involve knowledge of procedures, tasks, and techniques.

The following key research questions informed this study:

- How is knowledge created, sustained, used, and altered in workgroups in one long-term care facility in Ontario?
- Do workgroup members consider some or all of this knowledge to be usable—that is, do they believe that this knowledge contributes to the performance of the workgroup's task? What constitutes "usable knowledge" for workgroup members?
- Do workgroup members believe that usable knowledge results in changes to their work? If so, how do they describe the way in which these changes occur?

THE STUDY'S CONTRIBUTION TO OUR UNDERSTANDING OF THESE QUESTIONS

The study will help theorists, researchers, policy makers, and practitioners working in health organizations who are trying to understand how managers and caregivers solve problems, share their knowledge, and implement changes. The study

should contribute to our understanding of evidence-based decision making, inter-professional collaborative practice, and knowledge transfer.

This research makes processes of meaning making visible in one long-term care organization, so that one can discern the situated knowledge dynamics within and between groups. Gaining a better understanding of these dynamics contributes to our understanding of organizational learning and organizational change, and helps organization members to better understand the factors that contribute to effective knowledge exchange within health care environments.

This inquiry is situated in the long-term care segment of Canada's health system. Researchers and policy makers in Canada's health system are currently interested in two factors that are intimately related to my research: evidence-based decision making, and inter-professional collaborative practice. The interest in evidence-based decision making has resulted in increasing emphasis on topics such as knowledge transfer, knowledge exchange, knowledge networks, and knowledge translation. The Canadian Health Services Research Foundation (CHSRF), for example, is exploring the potential of "...networks that aim to share knowledge and promote a culture of innovation by means of building links between health system managers, policy makers and researchers" (CHSRF 2005).

A recent systematic review of the literature on the diffusion of innovations in health organizations calls for new research on specific local settings that could bring to light factors that contribute to the adoption of innovations (Greenhalgh et al., 2004). These authors also call for research on how a local context interacts with a specific knowledge transfer program. They suggest that this research should be reported in

detailed descriptive reports that adequately represent the unique features of the local settings being studied. One specific question that they say needs further investigation is "How can we improve the absorptive capacity of service organizations for new knowledge? In particular, what is the detailed process by which ideas are captured from outside, circulated internally, adapted, reframed, implemented, and routinized in a service organization, and how might this process be systematically enhanced" (p. 618)? My study helps to fill the gaps identified by these authors.

Canadian interest in inter-professional collaborative practice has led to an effort to create evidence of the benefits of inter-professional practice, and to create pre- and post-licensure curricula to develop the collaborative abilities of health care professionals and workers. Recent reports and studies have argued that health service delivery can be improved by changing the way health care providers are organized to deliver service (Advisory Committee on Health Services, 1996; Epp, 1996; Health Council of Canada, 2006; Romanow, 2002; Subcommittee on Primary Health Care, 1996). The Health Council of Canada recently called for a new focus: "doctors, nurse practitioners and other professionals need team training to learn to work effectively together" (Health Council of Canada, 2005. p. 39). Evidence-based decision making and inter-professional collaborative practice are both fundamentally concerned with how people work in teams to solve problems, and how knowledge circulates within and beyond team boundaries—both of these areas form part of the inquiry reported on in this dissertation.

The subject of this inquiry is also of interest outside of the health sector. Private and public sector organizations have recognized a need to replace the stable bureaucratic structures of the past with more agile and adaptive organizations that can respond rapidly

to new circumstances. In contemporary organizations, intelligence and power are distributed among organizational members in ways that no longer parallel the organization's pyramid of authority.

This implies that the meaning-making capacity of organizations has become increasingly important at the same time that it has changed. Today's adaptive organization relies on the intelligence and initiative of all organization members, not just on those at the top of the hierarchy. The adaptive organization will be able to sense the need for change, communicate this need throughout the organization, devise a change strategy, and then rapidly implement the strategy. Moreover, these organizations have also recognized a need to adopt more collaborative work practices that call on the distributed intelligence of organization members. Both of these emerging needs require an increased awareness of how meaning-making dynamics can help to mobilize or impede effective action.

To devise ways of improving knowledge-sharing and adaptive capacity, we must first understand the situated meaning-making dynamics that occur in our workplaces. I am not aware of any research in Canada aimed at filling this gap. The research reported in this dissertation provides a clear and detailed description and analysis of the meaning-making dynamic in a specific health context.

ORGANIZATION OF THE DISSERTATION

I begin this dissertation in the present chapter with an explanation of how I came to be interested in the questions explored through my research, and how the research came to be situated in a long-term care home. I also explained how my inquiry will make an original contribution to social science knowledge.

In chapter two, I review the relevant literature from organizational studies and health services research. This review brings to light the basic nature of meaning making in workgroups, and reveals some of the issues and dynamics at work in healthcare organizations. Over the course of this review I also clarify the assumptions that underlie my inquiry.

Chapter three provides a thorough description of my research design and data-gathering methods. The chapter also outlines the coding procedures and analytical methods that I used to organize and interpret the data. The chapter includes an explanation of why these methods were chosen.

Chapter four offers a "thick description" of the research site, and of the people who participated in the study. The chapter provides a detailed description of the long-term care sector in Canada and Ontario, along with a detailed description of the River Lodge (my pseudonym for the institution that hosted the inquiry). Finally, the chapter provides a background description of the Eden Alternative program for reforming the way in which long-term care homes operate, and summarizes the River Lodge's experience in implementing this program.

Chapter five contains a "thick description" of the meaning-making processes that take place on the two levels of the Lodge during the day shift. The chapter begins by providing an overview of the meaning making that occurs on the floors, and then presents five meaning-making profiles to illustrate the patterns of meaning-making that are apparent in the Lodge.

Chapter six presents the eight thematic components of meaning making in the Lodge that emerged from the analysis of the data, and explains the interactions between

these thematic components. This allows for the construction of a theory that can account for the meaning-making dynamic at work in the Lodge. I then discuss this theory in terms of the principal theoretical construct that I derived from the literature: a view of meaning making that consists of the construction of experiences of coherence, purpose, identity and competence. I conclude the chapter by considering how these findings relate to the research questions.

Chapter seven summarizes the major lessons learned from the inquiry, and offers suggestions for future research. The chapter also outlines the limitations of the inquiry, compares my results with views evident in the literature, and outlines the implications of my findings for practice.

CHAPTER TWO: LITERATURE REVIEW

I carried out a literature review for this inquiry that encompassed organizational studies (specifically the seam within organizational studies that derives from a practice-based epistemology, and that focuses on social learning and knowing, leadership as symbolic action, and communicative interaction) and health services research (specifically, the seam focusing on knowledge transfer and exchange, and the relatively sparse literature on organizational issues in long-term care). Given the exploratory and qualitative intent of my inquiry, this literature review was not meant to allow for the development of testable hypotheses. Instead, it was intended to bring to light the basic nature of meaning making in workgroups, to give focus to my on-site data gathering, and to reveal some of the current issues and dynamics at work within healthcare organizations that could have an impact upon the meaning-making processes that I would encounter while carrying out the on-site research.

Because this chapter reviews literature from several disciplines, it shifts its focus from time to time, and the reader may occasionally lose track of my intention. I have therefore included Figure 1 as a reference point that the reader can use to recall the purpose of the various subsections in this chapter.

***Figure 1*: Overview of the Literature Review**

In short, the organizational literature offers a way of seeing the research site as a ground for an ongoing meaning-making process that constructs experiences of coherence, purpose, identity, and competence. The social learning and knowing literature shows how these processes are situated in specific practices, and how they create a sense of stability and adaptability in a practice. The leadership as symbolic action literature helps to reveal the role played by power in these processes, and indicates that the sensegiving role of formal leaders can be mitigated by the sensemaking of other practice members. The communicative interaction literature helps to reveal the inevitability of this meaning-

making dynamic, and to locate meaning making as a form of narrative rationality that is evident in the ongoing interactions that take place between practice members.

The health services literature provides clues about the current state of meaning making in health organizations, and about contextual factors within long-term care that could shape the results of this inquiry. The knowledge transfer and exchange literature suggests that a transfer paradigm is slowly giving ground to an exchange paradigm, which sees meaning making as a contested process grounded in specific organizational contexts. The long-term care literature reveals the extraordinary strains that are currently experienced by people working in nursing homes.

I will begin with a review of the organizational studies literature, by looking at research and theory in relation to social learning, leadership, and communicative interaction. Then I will review the research on knowledge transfer in health organizations, and on organizational issues in long-term care environments.

ORGANIZATIONAL LITERATURE ON MEANING MAKING

To begin, I borrow from the *Oxford English Dictionary* and define meaning making as a process of creating and participating in experiences of coherence and purpose in workgroup settings. Workgroup members make meaning as they seek a balance between ambiguity and uncertainty, on the one hand, and coherence and familiarity, on the other. Moreover, workgroup members make meaning as they link themselves and the group to a worthy purpose. Experiences of ambiguity and coherence relate to *what the group is doing*; experiences of worth and purpose relate to *what the group is for*.

I take as given the notion that through interaction we construct our experience of the real (Berger and Luckman, 1966). I am concerned here with the social, and the social is always first and foremost a construction on the part of people who, through their actions and interactions, constantly enact the social organizations to which they belong. This enactment can be seen as a process of meaning making. People constantly, through their communication, make sense of their social environments, and sustain or change those environments. If we wish to get close to the social, we must get close to this process of meaning making.

A study of meaning making in workgroups will focus on what Berger and Luckmann termed secondary socialization, or our changing membership in socially constructed groupings such as jobs, professions, church congregations, sports teams, clubs, etc. Secondary socialization requires that I enact the roles and beliefs of the subgroups to which I belong. In enacting these roles and beliefs, I can choose to manipulate others by managing their reactions to me. Goffman (1959), in his dramaturgical account of the ways in which we manage the impressions we make on others, suggests that our ongoing, inherently manipulative dramas are the essential, constitutive phenomena of social experience. Conducting interpersonal and intergroup business is a matter of creating and managing impressions rather than speaking frankly and openly about the issues at hand. This is not unlike Argyris's notion of the all-too-common lack of integrity between espoused theories and theories-in-use (Argyris, 1990, 1993, 2004). Unlike Argyris, however, Goffman seems to dismiss suggestions that interactions might be improved and workgroups made more effective by bringing more candour to human relations. He refers to these shifts toward intimacy as an "anti-

dramaturgical social movement" and a "cult of confession" (Goffman, 1959, pp. 204-205).

Together, these views set the boundaries for this chapter. Meaning making is to be understood as the construction of our experiences of social reality. The chapter attempts to derive a theoretical lens for viewing this constituting process within organizations.

Meaning making in turbulent times

Meaning making occurs in a social world that is experienced as real, and as exhibiting tensions toward stability and order, on the one hand, and change and adaptation on the other. Writing in 1964, sociologist Ely Chinoy claimed that "The central problem facing the man on the assembly line—and many other workers too—is ...not one of morality but of meaning" (p. 75). Peter Berger (1964) elaborates on this predicament: "To deal with 'the problem of work'...is to deal with peculiarly modern phenomena. The focus of the 'problem' is the question of 'meaning' (p. 213)." Berger argues that the division of labour has resulted in work forming a rather thin context for human action, and that at the same time people have come to expect that their careers will provide them with a sense of meaningful vocation. That is to say, the narrowly defined jobs of 1964 were unlikely to provide rich contexts in which workers might find fulfillment, but at the same time workers were coming to expect that work should be meaningful and satisfying.

Other researchers and theorists have argued that the predicament of meaning at work has intensified in the intervening decades. Chalofsky (2003) reviews the literature on meaning and spirituality at work and suggests that meaningful work gives rise to a

sense of integration and wholeness related to three themes: a person's sense of self, the way a person experiences the process of working, and the ability to work with a sense of balance between work and the rest of one's life. Hoar and Kirwin-Taylor (2004) report the results of a survey of UK managers, and say that most managers expect their work to provide them with a sense of meaningfulness. Cartwright and Holmes (2006) argue that the contemporary workplace is putting increased demands on employees, while at the same time employees expect to experience a greater sense of purpose and community at work, and the result can be an increase in cynicism. They suggest that experiences of meaning at work can be related to a sense of belonging, purpose, self-efficacy, and task competencies. According to Velasco (2008), the literature on spirituality and meaning at work can be synthesized into a small number of key themes that characterize meaningful work. Among these themes are a sense of commitment and contribution, a sense of community and connection, a sense of personal fulfillment and development, and a sense of purpose and vision.

For the most part, these authors use the term "meaning" to refer to experiences of purpose and significance. There is, however, a second way in which we experience meaning while participating in workgroups. Weick (1995) refers to this when he talks about the importance of stories as vehicles for making sense in organizations: for Weick, narrative sensemaking aims at coherence, reasonableness, and plausibility. In workgroups, where numerous participants give rise to multiple realities, coherence is needed to bring action together as a coordinated whole.

We often hear reports that organizations have changed significantly since 1964. Today we organize ourselves in a different social milieu—the world is said to be flatter,

faster, and more complex. Globalization, outsourcing, and offshoring are terms used to describe changes in how we divide labour and segment jobs, with demand for products and services increasing, competition stiffening, regulatory regimes becoming layered and complex, and the domestic jobs we retain in our factories and offices becoming less routine and more unpredictable. In organization studies, we hear reference to the need for faster and more adaptive organizations, for a shift in management focus from "bricks and mortar," hard capital, and infrastructure toward the intellectual assets and tacit knowledge of the organization; for a need for organizations to focus on sensemaking, learning, and knowing (Bass & Riggio, 2006; Boyzatzis & Kram, 1999; Brass & Krackhardt, 1999; Davenport, 2001; Goleman et al., 2002; Hunt et al., 1999; Lawler III, 2001; Pearce & Manz, 2005; Plas, 1996; Shamir & Ben-Ari, 1999; Taylor et al., 2002).

One aspect of this changed environment has to do with our experience of the changing relationship between expertise and authority. As work becomes more complex, as we focus less on vertical divisions within bureaucracy and more on horizontal layers of expertise (often expressed as occupations, communities of practice, or cross-functional teams), the rational notion of a logical and orderly layering of organizational authority that is congruent with levels of expertise does not adequately describe our experience of organizational life. Subordinates often know more—have more technical, expert knowledge of a specific area, as well as more practical experience—than superiors. Power based on position has been decoupled from power based on expertise (Barley, 1996). However, this new distribution of power is at best problematic. Those occupying hierarchical positions of power are often reluctant to recognize the new forms of

expertise and power that are becoming distributed throughout organizations (Yanow, 2004).

The very nature of contemporary work, then, has necessitated a distribution of power along the lines anticipated by the notion of empowerment—and the point is that this distribution of power is not derived solely from the values characteristic of contemporary life or from research into employee motivation, but also arises from dynamics inherent in the evolving human systems within our workplaces. The network has become both a popular metaphor and a strategy for organizational design, helping us to make sense of our changing use of microprocessor and Internet-based technology, our short-term project and team-based ways of accomplishing tasks, and our gradual shift from command-and-control management hierarchies to human systems whose power is distributed to numerous decision making points (Burke, 2008; Conklin et al., 2007; Gibbons et al., 1994; McLagan & Nel, 1995; Rogers, 2003; Shaw, 2002; Stewart, 2001; Watts, 2003; Weick, 1995).

The result is a rich, confusing, and changing organizational context for the ongoing meaning-making endeavors of participants. Change is rife. Work is changing, as are jobs, technology, marketplaces, power arrangements, and even values. It is no exaggeration to say that we are living through a shift between two organizational paradigms, a shift from a paradigm of "meaning transfer" to a paradigm of "meaning mobilization" (I will explain my choice of these terms over the course of the chapter). It is within this confusing, transient, networked sense of reality that meaning making now occurs.

Meaning making is the construction of a shared reality and context for action, bounded by a shared need for purpose and coherence. But what, precisely, does meaning making look like in specific organizations? Researchers and theorists have answered this question in a variety of ways, most notably by describing processes of social learning and knowing, processes of influencing (or leading) the creation of a shared context for action, and processes of communicative interaction. To organize my discussion of the organizational literature, I will delve separately into these three areas.

Social learning and knowing

Meaning-making processes in groups can be conceived of as processes of social learning that have been described in terms of two distinct conceptual frameworks. One framework for social learning has to do with learning processes in relation to identity and competence in occupational groups or communities of practice. A second distinct framework looks at learning processes in relation to the congruence between values and attitudes within error-correction dynamics in workgroups. In both cases, researchers and theorists are locating learning and knowing in local contexts, and have emphasized the overriding significance of dialogue and conversation as the vehicle for learning. Some researchers have also pointed to the unfolding interaction between conversation and a social repertoire, and suggest that this dynamic is the basis of meaning making and social learning.

Many theorists see meaning making as a social process based on interactions within workgroups that are often described as communities of practice (Brown & Duguid, 1998, 2000; Cummings & van Zee, 2005; Lave & Wenger, 1991; Orr, 1996; Van Maanen & Barley, 1984; Wenger, 1998) or as social groups sharing a common and

distinct culture (Geertz, 1983, 2000; Yanow, 2000). According to these views, learning is integral to the practices of workplace groups, and involves taking on identities of competence within communities of practice. The dynamics of this process is seen as an interplay between participation and reification that affects the stability and adaptability of the community (Brown & Duguid, 2000; Lave & Wenger, 1991; Wenger, 1998), and involves the creation, use, and sustenance of local knowledge (often in the form of cultural or instrumental artifacts and an oral culture of shared narratives) that is conceived of as collective (Boreham, 2004; Cook & Yanow, 1996; Orr, 1996).

To say that learning is integral to a community of practice is to take issue with a view of learning as involving primarily the transfer of knowledge between individuals or groups (Brown & Duguid, 1998, 2001; Easterby-Smith et al., 2000; Perkins, 2003; Raelin, 2000; Schön, 1983; Tsoukas, 2002). Learning is seen here as part of the glue that holds the group together; it unfolds through shared experiences given focus by the group's work. A newcomer to a practice embarks on a journey from the community's periphery to its centre, gradually acquiring both expertise and reputation (Wenger, 1998). Lave and Wenger (1991) have termed this *legitimate peripheral participation*, and consider it to be the main way in which a practice renews and sustains itself. Members of a practice learn to *do* the work of the group and learn to *be* a member of the group—the learning involves both competence and identity, and these two dimensions are as inseparable as the dimensions of a rectangle (Brown and Duguid, 2000; Wenger, 1998; Weick, 1995).

This learning dynamic unfolds through intertwined processes of participation and reification (Wenger, 1998). Participation speaks to the lived, ongoing experience of

belonging to a practice. It is an experience of accomplishing tasks, interacting with colleagues, and engaging in conversation. Reification speaks to the artifacts of community life—the tools, techniques, documents, and objects that are part of the doing of the work. Some point to an ongoing dynamic within systems between stability and adaptation, and social learning theorists occasionally suggest that the dynamic of participation and reification expresses this unfolding tension between stability and change (Bateson, 1979; Blackler & McDonald, 2000; Cook & Yanow, 1996; Schön, 1983; Swan et al., 2002; Van Maanen & Barley, 1984; Watzlawick et al., 1967; Wenger, 1998). The practice takes action and creates artifacts to stabilize and maintain its identity and competence, to make its work more do-able (Hutchins, 1995; Wenger, 1998; Yanow, 2004). At the same time, the practice adapts to changes in its environment through ongoing interaction among members and between insiders and outsiders, and through the turnover of newcomers and oldtimers (Lave and Wenger, 1991; Wenger, 1998).

The result is the collective knowledge of the community, sometimes conceived of not as a finished 'thing' but rather as an ongoing process of knowing and acting. This knowledge is local (Brown & Duguid, 1998, 2002; Colville et al., 1999; Geertz, 1983; Yanow, 2000, 2004). It is a knowing-in-action, a knowing what to do as the work is happening (Schön, 1983). It is tacit, and it flows among members through their ongoing interactions (Gerardi, 2000; Gherardi & Nicolini, 2000; Leonard & Sensiper, 1998; Nonaka & Takeuchi, 1995; Yanow, 2000, 2004). It is a knowing derived from past experiences, expressed through trial and error experimentation, sustained in part through an oral culture of narratives that tell of problems encountered and solved, of situations and the decisions they gave rise to (Orr, 1996).

This view of social learning has been described in relation to the work of claims examiners in an insurance company (Wenger, 1998), and to the work of photocopy repair technicians (Orr, 1996). Orr's ethnography of technician experience demonstrates the significance of narrative accounts for social learning. Experiences are framed as plausible and coherent accounts of effective and ineffective action, which circulate among the members of the practice. Interestingly, management do not share the view that effective learning and knowledge are attributes of the local practice, and conceive of the service documentation that they provide as the sole source of legitimate knowledge about carrying out repairs. The technicians are seen to incorporate the documentation into their work routines, but only as a mediating resource and not as a source of definitive authority. When complex problems are encountered, technicians turn to their community for suggestions on how to proceed.

This view of social learning is also evident in the work of Boreham, who argues that "it makes perfectly good sense to regard competence as an attribute of a group, team or indeed a community" (Boreham, 2004, p. 8). He suggests that effective workgroup learning follows three principles: "*making collective sense of events in the workplace* , *developing and using a collective knowledge base* and *developing a sense of interdependency*" (Boreham, 2004, p. 9). Boreham suggests that people in interaction make sense of ambiguity largely through conversation, which often leads to the formulation of stories. In another paper, Boreham and Morgan (2004) argue that dialogue is the fundamental process of learning, and relational practices—specifically fostering opportunities for creating shared meaning, reconstituting power relationships,

and providing cultural tools to mediate learning —as the way in which collective learning is sustained and accessed over time.

Yanow's (2000) study of flute-making workshops is yet another instance of this social learning perspective. She argues that learning can be observed in the interactions between people and artifacts within a practice. Elsewhere, Cook and Yanow (1996) consider flute-making as providing evidence that organizational learning is a cultural process that allows for cultural maintenance and adaptation. They argue that social learning can be seen in the common practice of members of a cultural community, through their creation, use, and adaptation of meaningful artifacts and language that allow members to carry out their work. Weick and Roberts (1993) find evidence of a "collective mind" in the interactions of members of a flight deck crew on an aircraft carrier. Hutchins (1995), who looks at navigational practice through a cognitive lens, discovers a complex system of cultural artifacts and shared meanings within a computational system that unfolds in action. He points out that although some would argue that the work of a practice is based on central designs that are created and handed down by experts, his observations suggest that expertise is situated in the practice, and that it unfolds in numerous moments of "local design" and interaction.

In an attempt to extend Orr's work to an investigation of meaning making across practice boundaries, Bechky (2003) undertook an ethnography of three occupational groups: design engineers (who design machines and create the initial and redlined drawings), technicians (who create prototypes and final as-built drawings), and assemblers (who build the machines by putting together sub-assemblies and then the completed product). Her study confirms that meaning is constructed within local

contexts, and hence is situated within a specific community that has ongoing interactions and a shared discourse. She also found that the situated nature of knowledge often creates barriers when members of different practice communities attempt to communicate their unique perspectives to each other. She found that knowledge sharing difficulties between the groups arose because their practices use different terminology and communication strategies to describe their work, and they conceptualize the machines in different ways. The process of sharing knowledge appears to be more a matter of transformation than transfer.

This view of practice-based meaning making focuses on social forms, on communities, roles, regimes of competence, systems of identity. It is concerned with the porous boundaries that contain expertise and roles, and how competence grows within and across these boundaries (Brown & Duguid, 1998, 2002; Swan et al., 2002; Williams, 2002). It is also concerned with notions of power, suggesting that hierarchical authority can never be absolute, and that organizations ignore the latent knowledge within communities of practice at their peril (Barley, 1996; Wenger, 1998; Yanow, 2004).

The view of meaning making as learning-in-practice provides relatively few clues about how we might construe *effective* learning. Boreham and Morgan (2004) talk about creating shared meaning, reconstituting power relationships, and providing cultural artifacts to mediate learning—these three factors, then, might be thought of as contexts within which to assess learning, and to seek improvement. Orr's depiction of technician practice in relation to shared narratives may provide other clues—for example, perhaps one might be able to find ways of strengthening the oral culture of a practice, to create more opportunities for interactive problem solving and a freer movement of knowledge.

Recently, Wenger (2000) has suggested that a community of practice might be assessed and nurtured in terms of its learning energy, the mutuality or depth of commitment of its members, and the quality of the repertoire and how people view the repertoire. Similarly, he suggests that practice boundaries can be assessed in terms of the coordination of boundary activity, the transparency or visibility of boundary activity, and the negotiability (i.e. how much influence people have) of boundary activity. Finally, he says that identities can be assessed in terms of the connectedness people experience with others through the shared practice, the expansiveness of the identity or its ability to enable multi-membership that spans boundaries, and the identity's effectiveness in promoting action.

The second framework for social learning that I will consider looks at learning processes in relation to the congruence between values and attitudes within error-correction dynamics in workgroups. The dynamic in this process is based on human intentionality, or purposive behaviour: human beings have intentions and purposes, they take action to accomplish those purposes, and they learn by observing and reflecting on the effectiveness of their actions. This tradition is exemplified in the work of Chris Argyris and Donald Schön—with much of this work, especially that of Argyris, concerned with creating a framework for interventions to improve group cohesion and performance (Argyris, 1990, 1993, 2004; Argyris & Schön, 1978; Schön, 1983).

Argyris and Schön (1978) spell out the dynamics of workplace learning that is situated in the day-to-day activities within an organization. Learning is conceived of as a facet of human interaction. Learning occurs (at least potentially) on three levels, which they term single-loop, double-loop, and deutero-learning. They also see learning as

serving to stabilize or destabilize the alignment between an organization's espoused theory and its theory-in-use. This process of alignment involves a constant working out of a tension between two opposed theories: what they refer to as Model I and Model II. Table 1 summarizes some of the features of these two theories (Argyris & Schön, 1978). Argyris and Schön contend that most people *say* they value a Model II theory, but act according to a Model I theory.

Table 1

Model I and Model II Theories of Action

	Model I	**Model II**
Underlying values	Try to "win," try to avoid losing Avoid creating or expressing negative emotions Be rational	Work on the basis of valid information Make free and informed choices Be internally committed to the choice, and constantly monitor implementations
Strategies for acting on the values	Control your environment and the work tasks by acting unilaterally (persuade, cajole, manipulate, claim jurisdiction, etc.) Protect yourself and others by acting unilaterally (avoid making statements that can be tested, and be defensive by blaming, intellectualizing, stereotyping, etc.)	Work with others to design situations or encounters where participants can inquire about assumptions and behaviour Share control of the task with others Protect yourself by working transparently with others, with the goal of promoting development and growth

Argyris and Schön argue that we act according to a theory-of-action that, whether we are aware of it or not, forms part of our deeply-held values or beliefs about the social world. Many people have been socialized to act according to a Model I theory of action. They attempt to unilaterally control the situations that they find themselves in at work,

and use a variety of political stratagems to gain ascendancy over colleagues. The result is a deeply embedded tendency to be dishonest about risks, mistakes, and failures, and a systemic tendency to collude in maintaining the Model I system. We attempt to avoid embarrassment when things go wrong, and our colleagues will often help us to save face. Moreover, we ensure that this collusion remains a secret. Argyris and Schön refer to these tendencies as the covering up of errors, and the covering up of the cover up.

Argyris is interested in showing how the ineffective Model I values, strategies, and behaviours can form a self-sealing system of interaction that he terms "organizational defensive routines" (Argyris, 1990). These routines prevent teams and organizations from being able to learn from experience. Argyris believes that organizational defensive routines can give rise to double binds: confronting them could damage relationships and increase conflict, because people lack the interpersonal skills to handle difficult situations; ignoring them could prevent performance improvement, because certain situations will be deemed undiscussable.

Argyris also suggests that the tension between Model I and Model II may reflect a shift in management approaches: "The old theory of management is consistent with Model 1 theory-in-use. The new theory of management is consistent with Model II theory-in-use... The point now is that these two theories-in-use are based on different values and require different skills" (Argyris, 1990, p. 66). He is saying that we have developed a new approach to management—a new theory—that is not yet fully implemented in workplace behaviour. The old theory of management, which values unilateral control, is aligned with the older theories of learning described by Dewey (where teachers are experts who manage a classroom made up of docile and obedient

learners), while the new theory of management, which values transparency and participation, is more aligned with the new theory described by Dewey (with its emphasis on open expression and free activity in a class environment based on democratic ideals) (Dewey, 1938).

This Argyris-Schön theory of organizational learning has several notable features. First, it is a theory of learning that at first glance may appear to have little to do with learning as it is generally understood. Their focus is largely on matters of integrity and honesty: learning is seen as a matter of congruence between values and behaviour, intentions and actions, and as an ability to openly discuss errors and mistakes. They are not concerned with an organization's ability to create and access repositories of relevant task-related knowledge; rather, they are concerned with the nature and quality of relationships and interaction—do people trust each other enough to admit mistakes, do they surface and deal with disagreements, are power relationships within a group interfering with open communication?

Secondly, learning for Argyris and Schön is largely a matter of alignment. They look for alignment (or misalignment) between what people say and do, and they claim that one can improve an organization's learning system by creating the capacity to better align a Model II set of values with a congruent set of behaviours. For Argyris, this is largely a matter of developing new skills (Argyris, 1993). The ineffective behaviours must be brought out into the open—"I want to make the undiscussable discussable," Argyris wrote in the preface to one of his books (Argyris, 1990, p. xii)—and then people can learn how to discuss and ultimately correct errors.

Argyris and Schön also view learning as occurring on levels. Learning can focus on the symptoms of problems (single-loop learning), on the root causes of problems (double-loop learning), or on the organization's capacity to learn (deutero-learning). In other words, learning can involve: 1) taking corrective action in response to environmental stimuli, 2) analyzing and taking action based on deeper factors related to the stimuli's occurrence, and 3) analyzing the organization's overall ability to detect and analyze stimuli.

A third feature of this theory is the view that learning is systemic and can be effective or ineffective [Argyris has occasionally termed ineffective learning as the creation of "skilled incompetence" (Argyris, 2000)]. Argyris and Schön suggest that an organization will tend to have a "limited learning system" when Model II espoused theories are related to Model I theories-in-use, or a more effective learning system when Model II espoused theories and theories-in-use have achieved congruence (Argyris & Schön, 1978).

Schön extends this view through his work on reflective practice, where he argues that professional practice—that is, the day-to-day work of professionals such as lawyers, doctors, engineers, architects, social workers, city planners, and others—can be seen as the ongoing creation of a type of knowledge—knowing-in-practice—and that this knowledge is vital to successful practice (Schön, 1983). He rejects the universality of an epistemology of "technical rationality" which suggests that professional knowledge is created by experts using scientific methods, and is transferred to practitioners in educational settings, and is then applied in day-to-day practice. Practitioners do not work in a reality that presents them with prefabricated technical problems that can be resolved

through the rigorous application of professional theory. Instead, the problems of practice tend to be ambiguous and unclear, and the practitioner must begin by framing or constructing a problem that is capable of resolution. Technical knowledge has a role to play in solving well-defined technical problems, but it is considerably less useful in resolving issues where human interests and values are in collision.

In constructing a theory of professional knowledge that lies close to daily practice, he provides an account of tacit knowing that complements the work of Polanyi (1966) and Bohm (1996) (see also Isaacs, 1999). Schön suggests that there are three types of knowledge quite apart from scientific knowledge, each of which is related to human action. He begins by pointing out it is not possible to claim that every human action is based upon some prior thought, yet he acknowledges that thinking seems to be imbued in all of our action. There is kind of thinking-while-acting, and thus a kind of knowledge, that is intimately connected with action— Schön terms this first type of knowledge "knowing-in-action" (Schön, 1983, p.51). Schön suggests that if we can accept this notion of knowing-in-action, then we should also be able to recognize that sometimes we also consciously "think-on-our-feet." He refers to this second type of knowing, which is simultaneous with action, as "reflection-in-action" (Schön, 1983, pp.54-56). Schön describes a third type of knowing whereby professionals resolve ambiguous problems in practice, which he refers to as "reflection-in-practice" (Schön, 1983, p. 60). A professional deals repeatedly with a certain class of situations, and over time creates a personal repertoire of approaches and ideas for responding to these situations. The professional frames the problem in a way that allows for a solution, and then contexts the problem against the repertoire of past experiences. The professional

then reflects on similarities, frames hypotheses, and tests them in ways that provide information but also shape the situation. The process combines exploration, experimentation, and intervention.

Schön's theory situates social learning not within the hierarchical structures of an organization, but rather within a practice. He suggests that knowledge is not to be understood within a hierarchy of expertise, control, and transfer; rather, knowledge is an inherent property of all human action, and it is not possible to contend that scientific knowledge is superior to other forms of knowledge—all have their purpose and role. Although he describes the processes of reflection-in-practice as an individual process engaged in by the individual professional practitioner, his analysis indicates that this process of learning and knowing is essentially social. I say this for two reasons. Schön uses numerous empirical examples of reflection-in-practice to illustrate his theory, and all of his examples involve social interaction between a professional practitioner and at least one other person. Moreover, Schön's notion of reflection-in-practice sees the practitioner engaging in experimentation that draws on a repertoire of past experiences and experiments. Though Schön represents this repertoire as the personal possession of an individual practitioner, other theorists have shown that the repertoire of experiences and techniques is shared by a practice, and forms part of a learning curriculum that is used when newcomers enter into practice situations.

In the organizational learning theory of Argyris and Schön, learning effectiveness is a function of the type of learning system that is in place, and of the congruence between values and actions. Their theory suggests that learning is effective if it promotes Model II attitudes and behaviours, and ineffective if it impedes these attitudes and

behaviours. Effective learning can be brought about by making unhealthy system dynamics visible for discussion and analysis, and by training people in the interpersonal skills needed to deal openly with errors.

Schön's notion of reflective practice adds to this view of effective learning. Learning, he suggests, is a matter of action and reflection. The professional engages in active problem-solving, and reflects on the results of trial-and-error experiments and problem-framing based on past experiences. Over time, the professional becomes increasingly adept at solving the challenges of practice. Within organizations, however, the learning that is inherent in practice becomes constrained. Organizations must balance a need for stability and sustainability with a need for innovation and adaptability. The latter calls for change through learning, and the former calls for stability through stasis. Schön (1983) comments:

> When a member of a bureaucracy embarks on a course of reflective practice, allowing himself to experience confusion and uncertainty, subjecting his frames and theories to conscious criticism and change, he may increase his capacity to contribute to significant organizational learning, but he also becomes, by the same token, a danger to the stable system of rules and procedures within which he is expected to deliver his technical expertise." (p. 328)

The drive to learning that is inherent in reflective practice may be impeded by the drive for stability that is inherent in organizations that follow a Model I theory of action. Learning-in-practice is often situated within a framework of organizational learning, and these two learning processes may impact on each other. In other words, single-loop

learning embedded in an organization's culture may limit the legitimate peripheral participation unfolding in the organization's practices.

Meaning making conceived of as social learning can thus be seen as involving the construction of identities of competence within a practice, and as processes of error detection and correction that seek congruence between intentions and actions. The learning and knowing that occurs within these processes are situated locally, in the workgroup and organization, and are self-contained but open systems. Knowledge is local: it is the collective property of the workgroup as a whole, and is visible in their interactions and their shared repertoire. Knowing is not separate from action, but is a dimension of action. Meaning making is seen as occurring through interaction, conversation, and dialogue. People talk their shared social reality into being, and hold it in place through the cultural artifacts that they create, use, and adapt. Meaning making can be likened to an evolutionary process that brings stability to the group so it can maintain itself over time, and that also brings adaptive ability so it can endure and change when confronted with innovations and turbulence.

Leadership as Symbolic Action

I am exploring the notion that meaning making is an essential, constitutive process in workgroups. As members of a workgroup interact, they create meanings. I am seeking a description of this basic, constituting process by reviewing the literature of organizational studies. The social learning literature has suggested two distinct but related learning processes within workgroups—processes to construct social identity and task competence, and processes to detect and correct errors. The literature also reveals a view of meaning making (seen as social learning) as involving local, situated knowledge

that is the property of the group, and as constituting the group's stability and adaptability over time. Social learning is seen as a vital constituting process within the life of a group.

Bion's (1961) theory of basic assumption groups and work groups indicates that a desire for leadership is characteristic of all groups, and that leadership can centre in more than one person and can serve more than one purpose. He argued that every group can be considered in relation to two dimensions of group life: the work level where group members focus on the organization's primary task, and the basic level where members focus on certain underlying assumptions (dependency, pairing, and fight-flight) that can divert attention from tasks. When a group's task compels members to confront a reality that is likely to provoke high levels of anxiety, group members may shift their attention to the basic assumptions that are at work within the group. This allows group members to attain some relief from the anxiety that they experience when working on tasks. When this happens, the group may focus on trivial issues, not directly related to its primary task, for lengthy periods of time (Stokes, 1994).

For Bion, leadership occurs within both dimensions. The effective leader of a work group would have a clear understanding of the reality with which the group is contending, and the ability to communicate this reality to other members of the group; the leader of a basic assumption group, on the other hand, focuses solely on the basic assumption that is currently at play within the group, thus helping members to distract themselves from their compelling work-related dilemmas (Bion, 1964). When a basic assumption supplants the primary task as a group's main preoccupation, the group loses the ability to think and act effectively (Stokes, 1994).

Applying Bion's theory to caregiving organizations, William Kahn (2005) argues that effective leaders must offer a dual focus on organizational tasks and the organization's relational and emotional environment. A leader focuses on tasks by providing direction to the team, encouraging members to work toward shared goals, and ensuring that infrastructure, systems and processes support the attainment of goals. A leader focuses on the group's emotional life by being aware of disturbances and anxieties that arise in the group, drawing member attention to them, and intervening to ensure that these anxieties do not disrupt task accomplishment.

The work of Bion and those who have applied his theory to the study of workgroups indicates that leadership can be viewed as a complex process that occurs within all groups, and that it is not necessarily restricted to the intentions and actions of a designated leader (such as a manager in an organizational hierarchy). Many recent leadership publications reinforce this social view of leadership, and also show an interesting parallel with the literature on social learning. The literature indicates that there has been a shift in our conception of leaders, away from a conception of managerial control, and toward a conception of leaders as facilitators of the development of capacity and adaptability within groups. Some envisage the shift in terms of a new role for leaders: leaders are in charge of the learning process within groups, and they therefore attempt to control and oversee the meaning making that unfolds within the groups they lead; others focus less on individual leaders and more on leadership as a social process whereby groups search for coherence and purpose.

Like the social learning literature, the leadership literature makes frequent reference to a shift or transformation of power relationships taking place in contemporary

organizations (Davenport, 2001; Hunt et al., 1999; Kouzes & Posner, 2005; Lawler III, 2001; Pearce & Manz, 2005; Plas, 1996). The argument is that due to increasing ambiguity and complexity in workplaces, a command-and-control management style is no longer effective. Organizations can no longer achieve adequate performance levels if employees are subservient and docile; instead, employees are called upon to be innovative and adaptive problem solvers. To help create these types of organizations, managers are called upon to develop leadership competencies described by words such as mentor, coach, collaboration, empowerment, participation, and democracy.

The conception of leaders as experts who provide answers to vexing organizational questions is giving way to a conception of leaders as encouraging collaboration and inquiry (Perkins, 2003). Many authors argue that a leader's primary role is to set direction and mobilize action during times of destabilizing change (Bass, 1997; Bryman, 2004; Chemers, 1997; Fullan, 2005; Jones, 2001; Kouzes & Posner, 2005; Sherman et al., 1999). Leaders attempt to strike a balance between stability and change in their organizations. Some theorists argue that leaders today function as change agents, and that the change processes that they lead are fundamentally processes of learning (Kegan & Lahey, 2001; Kouzes & Posner, 2005). Leaders help followers to move into and through the turbulence and disruption of change, and at times they consciously destabilize organizations in order to initiate processes of change. Adapting through change is seen here as a process of learning, with leaders helping to develop the environmental characteristics (such as trust and a willingness to tolerate risk) that is needed for learning in social contexts. Leaders, then, are conceived of as the facilitators of social learning processes that occur during periods of organizational change.

Some researchers and theorists continue to see leaders as being in charge of meaning-making processes. Those who conceive of leadership in this way may consider organizational meanings as a resource that is managed and allocated by leaders (Pfeffer, 1997). The leader rationally decides on the meanings that are to be encouraged, and then undertakes a process to ensure that workers understand the current organizational reality (Bryman, 2004). Leaders also help followers to understand and support the goals of the organization (Bass & Riggio, 2006), and through their meaning-making roles they impact on a group's emotional state (Goleman et al., 2002). Some argue that leaders play a "sensegiving" (as opposed to sensemaking) role, especially during periods of organizational change (Lüscher & Lewis, 2008; Maitlis, 2005). Maitlis (2005) argues that sensemaking can be studied in relation to four dimensions corresponding to high and low levels of leader and stakeholder involvement. Heifetz and Linsky (2002), in highlighting the hazards of a manipulative approach to leadership, distinguish between technical problems for which there is a known solution, and adaptive problems that call for experimentation and innovation. Ineffective leaders sometimes cloak themselves in technical expertise, and claim to have technical solutions to adaptive problems. Meaning making here becomes a matter of a designated leader engaging in a process of persuasion and manipulation.

Others see this process of meaning making as a participative dialogue rather than as an exercise in persuasion (Heifetz & Linsky, 2002; Kouzes & Posner, 2005). The leader originates the meaning-making process, but the process itself is inclusive. Some suggest that leadership has to do with uncovering and enhancing followers' ability to contribute to worthy goals as people mature and as complex or troubling situations are

confronted (Aviolo & Gardner, 2005; Lipman-Blumen, 2001). Creating a sense of meaning among followers involves the creation of a shared vision and purpose that all members of the group will embrace and adopt.

Smythe and Norton (2007) argue that leadership can be conceived of as a particular process of thought, where the leader focuses his/her thinking upon a specific goal or quest—in a sense, the leader is a follower of the call to change: "Leaders live thinking, experience a resonance of knowing, and are always on the way of change" (p. 65). The thought processes of leaders often take place in the context of a confusing, emergent social milieu in which coherence and certainty are problematic. Boal and Schultz (2007) suggest that leaders use stories and dialogue to influence interaction and to facilitate the construction of shared meanings that can guide the future direction of a group. These authors still view leaders as "doing" this to followers: leaders set the vision, provide rationales, and guide behaviour. Dialogue allows for opportunities to create shared meanings, and storytelling acts as a vehicle for sharing knowledge.

Plowman et al. (2007) see organizations as complex adaptive systems, and argue that leaders enable rather than control the development of the future. Leaders do this by disrupting current ways of behaving, encouraging novel approaches, and making sense of events for organization members. Their argument derives from complexity theory, which is based on principles of emergence and self-organization that see order achieved through manifold interactions that produce unintended outcomes independent from any attempt to impose hierarchical control. Complexity theory, they argue, calls for a rethinking of leadership. Leaders in complex systems enable and allow rather than direct and control;

they facilitate the emergence of a coherent and shared understanding of what is happening in the system, by helping people to make sense of and give meaning to events.

Leaders also use dialogue and collaboration to bring a sense of coherence and certainty to workgroup experience (Fullan, 2005). Leaders help to mitigate the impact of anxiety and uncertainty on people (Kahn, 2005; Lipman-Blumen, 2001). Leadership involves sensemaking in a changing context rather than decision making in a stable, operational environment (Spreitzer and Cummings, 2001). The creation of coherence and the reduction of uncertainty is conceived of as involving the relinquishing of control and power. Leaders must resist the urge to opt for inappropriate technical solutions that have become faddish among managers and exploited by consultants. Instead, they must openly acknowledge their own uncertainty, and reach out to workers to devise and experiment with solutions based on shared experience and knowledge.

There is also a noticeable shift in focus from the leader as a privileged organizational member to leadership as a participative organizational process. In part, this is evident in the ongoing discussion of employee empowerment and participation (Lipman-Blumen, 2001; Bennis, 2001; Kouzes & Posner, 2005). Lawler (1998) argues that the democratization of the workplace has significant implications for our conception of leadership, and that leadership must now be seen as an organizational, rather than an individual, capability. An empowered workforce requires effective relationships, clear communication, a spirit of initiative, and a willingness to engage in respectful conflict. The move to this new form of leadership will not necessarily be smooth. Stewart and Manz (1997) suggest that the move from hierarchical structures to more empowered

project or team-based arrangements may, paradoxically, require the use of hierarchical power in the early stages.

There are thus two different views of participation and empowerment evident in the literature. On the one hand, empowerment is seen as a tool or technique that hierarchical leaders use to enhance employee confidence, motivation, and performance. On the other hand, empowerment is also seen as a shift in power relations and control mechanisms that, once made, cannot be easily rescinded.

Some authors suggest that we need to turn our attention away from individual leaders and toward leadership as a social meaning-making process in which all group members participate. This process is seen to help workgroup members recognize coherence and purpose in their work. Some see this sensemaking process as involving a subtle and symbolic process whereby a leader interacts with followers, and ultimately defines their shared reality (Morgan, 1998; Sherman et al., 1999). Others point out that a leader's epistemological assumptions will shape their behaviour (Tickle et. al., 2005). Leaders who hold to an epistemology of practice are likely to bring followers into collaborative processes that allow all group members to explore adaptive problems and solutions. Leaders who hold to a rationalist epistemology are more likely to believe that it is their job to frame organizational problems and solutions on behalf of followers, and to discourage dissent and alternative meaning-making processes.

Drath and Palus (1994) advocate a constructivist view of leadership as meaning making within a community of practice. Meaning is here seen as a structure of ideas and feelings that allows people to know a version of the world and that places the person in this world. Meaning making "...consists of creation, nurturance, and evolution (or

revolution) of these cognitive and emotional frameworks" (p. 4). Leadership can thus be seen as a social process, in which all group members participate, that frames and creates the shared reality of the group. This view entails separating the notions of power and authority from leadership, allowing one to look at the interplay among power, authority, and leadership as separate but interrelated processes. In this conception of leadership, leaders might best be thought of as those who are able to clearly express the thoughts and feelings that are present in the group. The person with hierarchical authority does not take charge of the meaning-making process, but rather participates in it.

Smircich and Morgan (1982) also conceive of leadership as a social process through which people try to construct a shared sense of reality. They look at the literature on the development of unstructured groups, and suggest that leadership tends to be attributed to people who structure shared experience in ways that others find meaningful. Leaders help to define shared experiences and situations in ways that become a basis for acting—"by mobilizing meaning, articulating and defining what has previously remained implicit or unsaid, by inventing images and meanings that provide a focus for new attention, and by consolidating, confronting, or changing prevailing wisdom..." (p. 258). For Smircich and Morgan, leadership results in the creation of shared points of reference for members.

Ford (1999) argues that those who are responsible for introducing change into organizations must attend first and foremost to the conversations through which organizational reality is constructed. Mitki et al. (2008) report the results of a twelve-year longitudinal study of a change process, and argue that leadership of major change initiatives is a "balancing act" that involves dialogue and learning. The authors suggest

that the turbulent environment in which change takes place gives rise to dissonance which, in turn, triggers sensemaking processes. To promote effective change, leaders encourage ongoing dialogue among people impacted by the change, and the establishment of learning mechanisms to allow participants to make sense of the unfolding situation and develop action strategies to respond to the challenges and opportunities.

O'Neill and Jabri (2007) report the results of a two-year investigation of failed change initiatives, and argue that the failures they investigated are associated with an inability or unwillingness to recognize the importance of legitimizing change through ongoing conversations among organizational members. Conversations can serve to legitimate organizational members' perceptions of their shared reality. The authors write: "Change efforts will be negatively affected when new perceptions are not assimilated into the daily language and conversational practices used in the various groups and sub-groups that make up an organization" (p. 571). They suggest that research into change efforts has focused largely on managerial action or inaction, and has yielded a bewildering array of factors that might contribute to the failure of initiatives; the research has largely ignored the overall social context in which the change is occurring, and instead focuses on the roles and actions of leaders and resistors. As an alternative, they suggest that it may be useful to focus on group-level processes rather than on the actions of hierarchical leaders. They argue that an organization can be viewed as a network of relationships that are expressed through interaction and conversation. Group members, through their conversations, create the social reality that they share. Conversation gives rise to organizational roles, power relationships, goals, and values, and hold these

organizational variables in place. To change the organization, one must therefore change the conversation. This requires more than top managers communicating, through speeches and newsletters, with employees. They argue that leadership of change involves numerous opportunities for group members to interact in ways that allow them to construct new perspectives and meanings congruent with the change. Schweigert (2007) agrees that leadership has less to do with individual character traits and more with the social context, processes, and requirements that give rise to authoritative action. He discusses how people achieve access to power, how they legitimize their ideas and actions, and how people work together to achieve their goals. Leadership development is a form of legitimate peripheral participation within a group of community practitioners.

Parry and Hansen (2007) conceive of leadership as a social process of discourse, separate from individual leaders, that allows for the creation and communication of a vision that moves people to action in support of the vision. They suggest looking at these compelling narratives as leaders—it is the story that people follow, not the individual storytellers. Organizational narratives make sense of the collective identity of organizational members, in part by asserting a shared purpose, and provide guidelines for future action. Compelling organizational narratives, like effective leaders, therefore exert influence over people. Leadership is a social process that involves the collaborative construction of compelling narratives that help people to understand emerging situations and that mobilize action in pursuit of goals.

Pye (2005) also sees leadership as a process of sensemaking. Leading implies movement or transition. Leaders may attempt to ascribe and maintain meaning in relation to their actions—their success or failure may depend on whether the group

accepts these meanings. She sums up leadership by paraphrasing Weick on sensemaking: "it *is* something grounded in identity construction, about which we make *retrospective* sense, *enactive* of sensible environments, undoubtedly *social* and *ongoing*, focused on and extracted by *cues* and most definitely driven by *plausibility* – shaping plausible meaning – *rather than* any notion of *accuracy*" (p. 38). Her research was based on an extensive qualitative study, and suggests that leadership is seen in actions such as listening, conversing, interpreting, and communicating through personal behaviour a sense of the meaning of specific situations. Leadership, she argues, is an ongoing social process of sensemaking that takes place through interactions among organizational members as they collaborate to construct their social world. Citing Weick, she suggests that leadership as sensemaking involves plausibility and coherence: leadership involves explaining and exemplifying meanings in ways that "...transform systems of shared meanings" (p. 46).

Barker (2001) also posits leadership as an ongoing social process. He argues that the conventional view of leadership looks at the attributes and behaviours of individual leaders as they seek to influence followers in pursuit of a goal. He believes that leadership is to be explained in terms of complex interdependent relationships among people in organizations. Leadership emerges as organizational members interact on the basis of their individual values, thereby creating and reinforcing collective values. Leadership is "a process of unfolding" (p. 490) that is "...a process of adaptation and of evolution; it is a process of dynamic exchange and the interchanges of value" (p. 491). Ford and Lawler (2007) suggest that the search for definitive leadership attributes has failed to yield generalizable principles, and the essence of leadership remains elusive.

They argue that leadership might be considered an active, dynamic process that unfolds through time, rather than as something that is done by powerful people to followers, or as something accomplished exclusively by formally appointed managers. They suggest that leadership is "...local to a given place, context, set of processes etc., it is also contingent on the circumstances faced at any given moment in time, and reliant upon individuals' experiences, identities, power relations and inter-subjectivities and is only knowable through those inter-subjectivities (Klugman, 1997)" (p. 422). Leadership involves the social construction of meaning in specific, situated contexts.

Uhl-Bein (2006) suggests that leadership can be viewed in part as a process of social construction that gives rise to approaches, behaviours, attitudes, and values that can promote both order and change. Leadership is to be understood as a collective and dynamic process of unfolding conversations and relationships. Uhl-Bien et al. (2007) extend this view by relating leadership to new insights available through the application of complexity theory to organizational and leadership questions. They see leadership as a "...complex interactive dynamic from which adaptive outcomes (e.g. learning, innovation, and adaptability) emerge" (p. 298). They want to turn the attention of leadership scholars away from concepts of position and authority and toward a dynamic that is emergent and interactive. Leadership, then, is a process that yields outcomes, and leaders are people who participate in and influence the dynamic. The importance of complexity leadership, they suggest, derives from the prevalence of adaptive rather than technical problems in today's organizations, problems that require exploration and innovation. Success in contemporary organizations depends on rapid learning and the sharing of knowledge. They suggest that leadership unfolds through the interactions that

take place within a human system; however, they also say that individual leaders can play enabling roles that help to ensure the success of the dynamic.

This shift in focus from the leader as a powerful causal agent to leadership as a participative social process is evident in the way management education is now perceived. Contemporary leadership theory often focuses on how leaders create and sustain relationships in ways that allow them to influence (rather than control) the behaviour of followers (Boyzatzis & Kram, 1999; Nodoushani and Nodoushani, 1996; Vecchio, 1997). The goal of leadership training is to help leaders become more influential. Interestingly, some authors recommend that development programs be highly experiential, and suggest that learning should be viewed as a process of transformation or planned change (Vroom, 1997; Goleman et al., 2002). Some educators suggest that to learn the new approaches to leadership, learners should be put in charge of their own learning (Mintzberg, 1997; Boyzatzis & Kram, 1999). An epistemology of practice—where knowledge is created by and belongs to the learners who are participating in the development program—holds sway (Taylor et al., 2002). Leadership and learning are here seen as the property of the group, rather than an attribute of privileged individuals—which suggests that leadership is seen as separate from authority and power (Lawler, 2001; Taylor et al., 2002; Fullan, 2005). What is curious about this situation is that the focus on individual, influential leaders implies a rationalist epistemology, while the experiential pedagogy of many development programs derives from an epistemology of practice.

Leadership, then, is a social process that involves organizing and disorganizing, or stabilizing and destabilizing. The effectiveness of leadership can be thought of as the

extent to which the outputs that emerge from the meaning-making process serve as a basis for action—that is, leadership is a social process of meaning making that produces collective knowledge that is more or less actionable. If a project leader convenes a meeting of her implementation team and begins by saying "I want everybody to work smarter, not harder," this attempt at meaning making may be effective if participants are able to link the statement with their own behaviours and are then able to adjust their behaviours accordingly, or it may be ineffective if participants react cynically to the utterance and later mock the project leader behind her back. Though most theorists continue to consider leadership in relation to the role of a designated leader, some are now focusing more on how all group members participate in a shared leadership process.

As a social process of meaning making, leadership exists alongside other social processes—most notably processes of social learning. Leadership can be considered a social process that seeks to create a coherent, shared social reality and sense of purpose, often in relation to a perceived need to bring about change within a human system. Processes of social learning, as I suggested earlier, have been observed and described as having two dimensions: processes of error correction, and processes that construct identities of competence within communities of practice. These three social processes may unfold in an interrelationship, with a capacity for error correction having an impact on the construction of both a coherent and purposeful social reality and identities of competence.

Communicative interaction

The literature on communicative interaction offers three additional insights that are useful to a theory of organizational sensemaking. First, the notion of

metacommunication—the idea that all human action is meaningful, and that messages invariably contain information about both the content of the message and the relationship between communicants—helps to confirm the essential, constituting role of meaning making. Second, the concept of narrative rationality clarifies the nature and importance of an epistemology of practice. Third, the notion of organizing as an interplay between the textual and conversational dimensions of group life highlights more precisely where processes of meaning making might be located and studied within workgroups.

Communication theorists suggest that all communication conveys two distinct types of information: information about a subject matter and information about the relationship between those who are engaged in the interaction (Watzlawick et al., 1967). In communicating relationship information, I assert who I am—my impression of myself. The other replies and either confirms, rejects, or disconfirms my assertion (while making his/her own assertion of identity). In other words, 'A' says "This is who I am." 'B' replies, "This is how I see you." Then 'A' replies, "This is how I see you seeing me." 'B' then replies "This is how I see you seeing me see you." Any of these messages can be met with confirmation, rejection, or disconfirmation. There is a simultaneous process unfolding in the other direction: 'B' is saying, "This is who I am," and 'A' is replying with confirmation, rejection, or disconfirmation. The validation that we seek through these exchanges is vital: "...man is unable to maintain his emotional stability for prolonged periods in communication with himself only" (Watzlawick et al., 1967, p. 85). We crave and need the confirmation of others. Our identities are always being negotiated while we communicate.

This content/relationship structure of communication underlies the competence/identity structure of social learning in practice. As we interact, we necessarily focus on the objects of our shared attention, and we enact our relationship as members of this practice. To the assertion "one cannot *not* communicate" (Watzlawick et al., 1967, p. 49) I would add, *we cannot not make meaning.*

Communication theorists have also suggested that narrative forms of discourse (as opposed to rational discourse) help to reveal how meaning is constructed in virtually all social situations, including those afforded by workgroup practices. Social scientists are increasingly aware of the potential of narrative for organizational studies. Some researchers recommend narrative methodologies as a way to uncover the multiple voices within an organization (Boje, 2001; Czarniawska, 1998). Theorists have suggested that narratives present accounts of human intentions—how they take shape, are altered by circumstance, and ultimately lead to some conclusion (Bruner 1991; Polkingtone, 1988). Narratives necessarily have a point in the sense that a story has a goal, or is attempting to explain something (Gergen, 1999; Schwartzman, 1993). Narrative brings actions and events together into a coherent whole (Gergen, 1999; Polkingtone, 1988). Narratives depict events as unfolding in a linear sequence that explains what happened and that often reveals causal links (Gergen, 1999).

Narrative must be plausible rather than true or accurate, and narrative meaning is negotiated by a community of tellers and receivers (Bruner, 1991). Narrative meaning accrues into a shared stock of knowledge (Bruner, 1991). The connecting, sequencing, plotting function of narrative may serve a human desire to replace ambiguity with coherence—this is the overriding organizational process suggested by Weick when he

talks about sensemaking as a process to replace the ambiguity in information inputs with certainty and thereby promote understanding (Weick, 1969).

Narrative meaning making lends itself to organizational life. Narrative attempts to create order and sense out of the actions and intentions of people unfolding through time. Narrative brings together disparate elements into sensible wholes, but its very nature admits the possibility of diversity and variety—we acknowledge that everybody has their story, and hence an organization will be populated by many tales looking for an audience. Narrative is a form that lends itself to both making sense of the immediate situation and to preserving and communicating lessons from the past. Because narrative allows the teller to join together accounts of being and doing, it promotes both social identity and instrumental action.

Gabriel (2000) argues that storytelling is an important part of an organization's sensemaking apparatus. He believes, however, that organizational stories are not simply a servant to an organization's task regime, but rather that they can serve a variety of purposes—they can entertain, educate, persuade, warn, justify, explain, and reassure. Through stories, organizational members give shape to the reality they experience, and imbue that reality with meaning. Stories can be used to construct individual and collective identities, and assign roles to organizational members. He says that organizational stories may "...support a universe of meanings and values that integrates individuals into their groups, helps them make sense of everyday experiences, and allows them to endure or make light of the hardships and injustices of life" (p. 56). Stories thus can help organization members to cope with the hardships, uncertainty, and arbitrariness

of organizations; they can create identity and coherence, and help to make organizational life bearable.

Fisher's view of narrative rationality brings additional focus to these ideas. He argues that people value at least as often as they reason. Valuing is a form of rational activity that is based on shared values or "good reasons" that are not absolutes, but are rather constantly negotiated through social interaction (Fisher, 1978). Making decisions about beliefs and actions, he suggests, is always intersubjective, and involves a consideration of facts, values, the self, and the social.

To account for the importance of values in social interaction, Fisher (1984a, 1984b) proposes a narrative paradigm to augment the prevailing rational paradigm (see Table 2 for a summary). He suggests that narrative is a universal basis for communicating, learning, and knowing in all cultures. Narratives bring meaning to human experience through a rationale of good reasons and through validation tests of probability and fidelity. Probability has to do with the coherence of a story, and requires that the story be free of contradictions. Fidelity has to do with whether a story seems true in relation to the experience of the listener, and whether it aligns with the listener's values. Fisher does not deny the importance of rational argument for communication, but rather suggests that narrative meaning making is more pervasive.

Table 2

The Rational and Narrative Paradigms

Rational Paradigm	Narrative Paradigm
People are rational Decisions based on inference and argument Argument takes place in contexts established by experts (legal, scientific, etc.) Expertise in the subject matter and in the skills of argument determine rationality The world is a collection of problems that can be solved with rational analysis and argument	People are storytellers Decisions based on values or "good reasons" Values are created through experiential practice that involves history, biography, and culture Stories are deemed rational in terms of their probability (coherence) and fidelity The world is a set of narratives among which we choose

The social learning and leadership literatures make repeated reference to the notion that learning and leading contribute to the stability and adaptability of a workgroup or organization. Communication theory adds to this notion through the conception of an ongoing interplay of talk and texts in organizational life. That the making of meaning in groups is evident in the language of the group, its talk and its texts, draws on a foundation put in place by theorists such as Berger and Luckmann (1966) and their notion of reification, and more recently by Taylor and Van Every (2000) and their notion of a talk-text interplay that both actualizes the organization and renders it problematic. Taylor and Van Every emphasize that processes of organizing can be experienced, observed, and described as processes of communicating that take place among organization members. Elsewhere they argue that

> ...organization emerges in the interplay of two interrelated spaces: the textual-conceptual world of ideas and interpretations and the practical world of an object-oriented conversation directed to action . . . The resulting image of organizational

interaction is of an essentially fluid and open-ended process of organizing, in which inherited positions of strength are exploited creatively by the participants." (Cooren et al., pp. 2-3)

The workgroup in effect talks and writes itself into existence—through its ceaseless, formal and informal conversations about the roles its members play and the work they perform, about clients and bosses, suppliers and colleagues, about problems and issues as well as solutions and innovations. This talk becomes sedimented (or reified) in the form of texts which establish routines, rules, aspirations, intentions, and other fragments of knowledge that help to solidify the community's purpose and identity as well as guide its work. To study meaning making in a work group one must identify, gather, observe, and analyze its texts and its talk.

This text-talk tension is linked to the broader fixed-and-fluid tension in organizational experience. Taylor and Van Every see an interplay between stability and change: "...between two opposite notions of, on the one hand, repetition, regularity, redundance, and, on the other, variety, unpredictability, complexity..." (Taylor and Van Every, 2000, p. 325). They suggest that there are two poles in organizing: "Those poles are text and conversation: text because, in its own way, it fixes a state of the world (sometimes, as in religious or great creative literature, for centuries and even millennia) and lends itself to faithful reproduction; conversation because its outcomes are never quite predictable and, unless rendered by recording into a texted equivalent, are as evanescent as smoke" (Taylor and Van Every, 2000, p. 325). Through the interplay of texts and talk, an organization seeks to establish routines and to create enduring structure, as well as to introduce innovation and change into its manner of thinking and operating.

It is possible, then, that this conception of text/talk might offer a way of looking at the dynamic of the new and the routine, of stability and change, that all organizations experience.

Stacey (2001) views the creation of knowledge as an ongoing communication process, and suggests that knowing and learning in organizations—which occur through interactions between people—are indistinguishable phenomena. The making of meaning and the sharing of knowledge are always local to a specific context. These ongoing interactions have an inherent ordering tendency, resulting in coherent patterns that show signs of both "...continuity and novelty, identity and difference, at the same time" (p. 93). Meaning and coherence emerge from self-organizing patterns of interaction between people that have an essential narrative-like quality. Knowing is local and conversational. Organizational coherence does not arise from an organization's system-like characteristics, with its boundaries and its cohering vision and mission, but instead emerges from numerous, local interactions. He equates knowing with a process of meaning making which continuously creates and transforms shared meanings. This process, he says, must always

> ...emerge in the communicative interaction between people. It emerges as meaning in the ongoing relating between people in the living present. ...Knowledge is, therefore, the thematic patterns organizing the experience of being together. The process of learning is much the same and there does not seem to be much point in trying to distinguish the one from the other. Identity, both individual and collective, evolves and communicative interaction, learning and knowledge creation are essentially the same processes as the evolution of identity.

> From this perspective, it is meaningless to ask whether organizations learn or whether people in organizations learn. It is the same process. It is meaningless to ask how tacit knowledge is transformed into explicit knowledge since unconscious and conscious themes organizing experience are inseparable aspects of the same process. Organizational change, learning and knowledge creation are the same as change in communicative interaction, whether people are conscious of it or not. This perspective suggests that the conversational life of people in an organization is of primary importance. (p. 189)

To improve an organization's capacity to create and share knowledge, one must look at the nature and processes of relating and communicating in organizations. One would want to know if conversational patterns shift and change as circumstances change, or if they appear to be largely repetitive. He suggests that an observer might look for the themes that give stability to organizational interaction and conversation, and whether they evolve or remain stable.

The connection between language and organizing would appear to be central to an understanding of social collectives that form around the performance of tasks. When members of a practice talk about their work, they are both constituting the social group needed to perform the task, and performing the task (describing challenges, brainstorming solutions, sharing insights). The making of meaning, then, is fundamentally social. Gergen suggests that we need to interact with others to create meaning: "The meaning of my words and actions is not fundamentally under my control. I need you in order to mean something" (Gergen, 1999, pp. 145-146). Isaacs (1999) refers to conversation and dialogue as ways of thinking together. To study meaning

making, then, it is not necessary to infer meanings that lie hidden within subjective processes of mind; instead, meaning can be observed in the actions, speech and texts of organizational members.

A summary of meaning making in workgroups

Meaning making is an essential, constituting process in workgroups whereby members negotiate their shared social reality. It can be seen in relation to social processes of learning and leadership, and it serves to incubate a shared sense of identity, competence, coherence, and purpose. Meaning making is local and situated. It is integral to action. Interaction within a workgroup simultaneously contributes to the accomplishment of tasks and the construction of social relationships.

Meaning making occurs in ongoing conversation and dialogue, and becomes stabilized in texts and enduring interpretations. It is a process that stabilizes groups and organizations, and that also introduces the instability that results from internal and external pressures. Meaning making includes processes of error correction that can involve varying degrees of congruence between intentions and actions. The processes of leadership and learning exist in specific organizational contexts that may support or impede the ability to act in ways congruent with intentions.

Meaning making situated in workgroups is often a narrative process. Multiple voices and perspectives are negotiated into coherent accounts that exhibit fidelity to the experiences and accumulated knowledge of members. Through meaning making, people construct plausible social worlds. If this conception of meaning making disallows a correspondence theory of truth, it simultaneously takes hold of a notion of the integrity of

meaning: the plausible social worlds we construct are aligned, when learning is effective, with the "good reasons" of our values.

Meaning making in workgroups can be conceived of as ongoing social learning processes whereby members negotiate their identities of competence, and ongoing leadership processes whereby members negotiate the coherence and purpose of their shared endeavor. We lead lives of significance by creating identities of competence that unfold within coherent social worlds and that are dedicated to worthy goals. We pursue worthy purposes by agreeing on a coherent account of our shared situation and then mobilizing action through social roles organized into regimes of competence.

THE HEALTH SERVICES LITERATURE ON KNOWLEDGE TRANSLATION

Since the field research that I describe in this dissertation occurred in a health context—specifically, in a long-term care home—I believe it worthwhile to review the literature on meaning making in health contexts, and to also look at the literature on long-term care organizations in Canada. Health research related to meaning making has tended to focus on the movement of research knowledge into practice. Meaning is created by specialists (scientists and researchers), and is then transferred into practice sites where it is applied and used. As greater numbers of health services researchers have begun to focus on problems of knowledge transfer, knowledge translation, knowledge exchange, and the movement of scientific evidence into local frontline practices, there is a growing tendency for them to conclude that the movement of knowledge is not a simple linear phenomenon that can be described in terms of discrete, predictable causes and effects.

A review of the relatively scarce research literature on long-term care environments helps to reveal some of the contextual factors that could be at work in the research site. This literature indicates that LTC organizations are characterized by onerous regimes of externally imposed rules and regulations, by command-and-control hierarchies that are reinforced by occupational pecking orders (determined by the relative power of doctors, registered nurses, licenced practical nurses, and health care aids), and by communication flows that tend to marginalize those workers who are closest to the people who live in the homes.

Meaning Making in Healthcare Contexts

Although there is no body of theory and research focusing specifically on social learning or meaning making in health organizations, there is a significant (and growing) body of literature focusing on the issue of knowledge transfer and exchange within health contexts. This interest has arisen in part due to the growing emphasis on evidence-based practice and decision making in health organizations. Numerous studies have indicated that health outcomes could be improved if existing scientific knowledge were to be used more consistently and effectively in frontline clinical settings (Graham et al., 2006; Grol, 2001; McGlynn et al., 2003; Schuster et al., 2003). Over the past decade, there has been a growing realization that to transfer and implement scientific evidence, more needs to be known about the ways in which evidence based on research (as well as on practice) moves from one organizational context into another.

This literature is relevant for the current study for several reasons. First, the theorists and investigators are interested in understanding the ways in which new knowledge might impact the development of enhanced capacity in frontline caregiving

organizations. Though they rarely draw on the insights of organizational scholars in general or social learning theorists in particular, they are essentially concerned with the same issues: how might knowledge circulate between people, and between groups and organizations, in ways that will result in expanded capacity to solve problems and find solutions? Second, while many social learning and leadership scholars base their inquiries on epistemological assumptions deriving from, for example, the educational theories of Dewey (1938), the health researchers generally begin their work within a clear, positivist framework (Kitson et al., 2008). Many health researchers believe that significant medical breakthroughs are achieved by scientists working on controlled experiments in laboratories, and, once their findings are tested and verified, this new knowledge must be transferred to frontline clinicians who are expected to apply it in their interactions with patients. The studies carried out by health services researchers into knowledge transfer follow a clear trajectory, beginning with a view of meaning making as a hierarchical, controllable phenomenon, and moving towards a growing acceptance of the importance of interaction, learning, and facilitation (Kitson, 2001; Kitson et al., 2008).

One British study commented on the prevalence of one-way transfer strategies to move new knowledge into practice, and found that passive approaches to knowledge transfer (such as publishing a journal article or distributing educational material through the mail) are both dominant and largely ineffective (Bero et al., 1998). These authors found that "transfer" strategies do not seem to produce the level of learning needed to bring about significant changes in practice, and call for efforts to devise and implement

new strategies that involve organizational change (based on trial and error) in the implementation sites.

Another study (Shojania & Grimshaw, 2005) lamented the lack of success in implementing evidence-based medicine, and suggested that almost all efforts to transfer new scientific knowledge into clinical settings are based on personal intuition or hearsay stories about what strategies worked best. Rather than accessing evidence that could indicate how best to implement evidence-based medicine, implementation teams have proceeded on the basis of their own hunches. The authors recommend that implementation teams consult the quantitative research evidence about the transfer of knowledge—in other words, to effect the transfer of knowledge from expert to user, implementation teams should search for and absorb expert knowledge on knowledge transfer. These authors examine studies evaluating the relative success of different quality improvement implementation methods, and report that no proven implementation techniques can be identified from this literature. The types of techniques encompassed by their study included education (conferences, workshops, printed materials), reminders or prompts via a computer system, job aids, audit and feedback reports, patient education, clinical team restructurings, and financial incentives. They conclude by criticizing the quality of existing research on knowledge dissemination, and call for "...empirically derived models to inform the decision to select specific implementation strategies, based on clinical features of the quality target, organizational or social context, and relevant attitudes and beliefs of providers and patients" (Shojania & Grimshaw, 2005, p. 148).

One recent Canadian study focused on a review of research about the transfer of medical knowledge, and developed a framework that focuses on *what* should be

transferred, *to whom* it should be transferred, *by whom* it should be transferred, *how* it should be transferred, and *with what effect* (i.e. measurement) it should be transferred (Lavis et. al., 2003). Their focus is on mechanistic processes of knowledge transfer, and their intent is to devise ways of improving the transfer of knowledge from research scientists to frontline clinical staff. They write that the research shows that "...passive processes are ineffective and ... interactive engagement may be most effective, regardless of the audience" (Lavis et. al., 2003, p. 226). They suggest that bringing researchers and decision makers together for an exchange of opinion and knowledge can contribute to a cultural change that might strengthen evidence-based decision making among policy makers. Their use of this insight, however, remains in the service of improving one-way transfer mechanisms.

A recent British evaluation (Russell et. al., 2004) of a technology-mediated knowledge initiative shows additional appreciation for the role of human interaction in the creation and sharing of knowledge. The authors write: "Explicit knowledge is only converted to actionable knowledge when it is linked meaningfully with knowledge and when shared meanings are constructed through social interaction and dialogue" (Russell et. al., 2004, p. 1 of 6). Social interaction, then, is recognized as playing a role in the dissemination of knowledge.

The idea that knowledge exchange in health is a collaborative social process is shared by members of the Canadian Health Services Research Foundation (CHSRF), whose mandate includes facilitating the growth of evidence-based decision making in health by promoting knowledge dissemination through networks. In their *Network Notes* publication (CHSRF, 2005), they talk about "knowledge networks" whose members may

be drawn from a variety of communities of practice. Successful knowledge networks, they say, establish clear goals, have participants from a variety of disciplines, use democratic governance arrangements, include at least some enthusiastic supporters, offer a compelling reason to participate, and are founded on a sustainable infrastructure. The CHSRF authors write: "knowledge networks are organized to maximize the flow of information as well as the creation and transfer of knowledge: they often have a highly developed communications infrastructure that includes face-to-face interactions and ongoing exchanges" (CHSRF, 2005).

Many health researchers and authors are concluding that rather than following a simple, linear flow, knowledge adoption involves social interaction and user engagement, and is more iterative than linear. Logan and Graham (1998) constructed a model now known as the Ottawa Model of Research Use (OMRU), which sees six interconnected elements contributing to the movement of knowledge into a practice: the environment of the practice that is considering adopting the research, potential adopters within the practice, the innovation (or research evidence) that the practice members are considering adopting, strategies for moving the innovation into the practice, the decision to adopt and use the innovation, and the outcomes that are produced through the overall process. The authors insist that the model depicts a dynamic and interactive process, with elements existing in a systemic relationship, influencing and being influenced by each other.

The engagement of and interaction with stakeholders from the implementation site has become a strong theme in the literature. Berta et al. (2005) argue that successful knowledge transfer depends on clear and explicit content and cooperation from the clinical leaders at the implementation site. Kerner et al. (2005) suggest that more

attention be paid to encouraging receivers to be receptive to new knowledge. They suggest that collaborative partnerships between researchers and health care practitioners are needed to promote the knowledge dissemination agenda—a suggestion that finds support elsewhere in the literature (Russell et al., 2004).

Some researchers and theorists are beginning to look at non-linear explanations of knowledge dynamics in the health system. Kitson et al. (2008) argue that implementing new practice guidelines will likely require whole system change that focuses on the organization as a whole as well as individual organizational members. Davis et al. (2003) suggest a health promotion model that emphasizes three factors: increasing knowledge or skills to predispose people to change; promoting favourable conditions to enable the change; and reinforcing the change after implementation. Dopson et al. (2003) argue that the movement of knowledge will not be a smooth, linear process, but will rather be characterized by resistance and opposition deriving from clashing priorities and values. Similarly, Aylward et al. (2003) review the literature on the effectiveness of continuing education in long term care, and conclude that factors within local practice contexts may account for the resistance to transferring new knowledge into a practice. Ginsberg et al. (2007) acknowledge that researchers are turning away from transfer models of knowledge translation, and are looking instead at interaction models. They argue, however, that interaction may be a necessary, but not a sufficient, condition for knowledge translation. At least four other factors will mediate the effects of interaction: stakeholder diversity, actionability of results, finality of study design and methodology, and politicization of results. They also point out that knowledge can be used in different ways (instrumental use might involve translating new knowledge into a procedure, while

conceptual use might involve using knowledge to gain a better understanding of an issue). Dobbins et al. (2002) argue that attempts to move evidence into frontline practices will be impacted by the characteristics of the evidence, organization, cultural environment and the individuals participating in the effort. Recently, Rycroft-Malone (2007) has suggested that knowledge transfer could be dependent almost entirely on local contextual factors (that is, unique factors related to the local context where the knowledge is expected to be implemented), so a general, positivist theory of knowledge transfer may be unattainable.

Others suggest that some of the difficulties revealed through the study of knowledge transfer may be attributable to the assumption that research knowledge is privileged over other forms of knowledge. Nursing researchers, in particular, have argued that a broader definition of evidence and knowledge is needed, to allow us to see knowledge transfer as a process of balancing and negotiating between knowledge and insights derived from different sources (Estabrooks, 1998; Gobbi, 2004; Kitson, 2002; Tarlier, 2005). Estabrooks et al. (2006) argue that given the variety of knowledge sources that can be transferred, and the variety of local practice contexts that must receive and apply this knowledge, we need to be aware of and make use of many different theories of knowledge transfer.

Research into evidence-based decision making in the social services arena reveals another reason why knowledge transfer efforts in health and social services have been problematic. Booth et al. (2003) argue that evidence-based practice can only take hold in contexts that are open to change, and to absorbing and applying new ideas. In social services, however, the reality differs significantly from this ideal:

> A literature review reveals a workforce, poorly equipped by professional education, relying heavily on personal communication and 'gut instinct' to deliver packages of care. A workplace culture of action, not reflection, and the absence of information resources and skills, make social care practitioners less likely to consult research to improve their practice. (p. 191)

Barratt (2003) points out that one significant barrier to knowledge transfer within social services is the fact that most practices rely on an oral culture that values immediate, practical experience more than scientific evidence. Evidence-based practice, she argues, is likely to occur in contexts where workers are organized into teams that are able to solve problems together and share their experience and knowledge. Organizations in which certainty is valued more than adaptability, and where risk-taking is discouraged, are not likely to be open to change based on the importation of new ideas.

Lomas (2004) sums up much recent scholarship on knowledge transfer when he points out that we are dealing with "...a social process in which the evidence sits alongside or is secondary to personal predilection, professional power, and organizational politics as predictors of outcome" (p. 282). He also points out that frontline organizational contexts are characterized by different norms, relationships, layouts, and environments, and that an understanding of evidence-based decision making requires an understanding of specific organizational contexts. For Lomas, knowledge transfer is more a social than a technical process, and requires formal and informal dialogue about the uses and usefulness of research.

This emphasis on the social nature of knowledge transfer is evident in some of the more recent frameworks offered by theorists and researchers. For example, Parent et al.

(2007) take a constructionist view of knowledge transfer, viewing it as "...the dynamic by-product of interactions occurring between actors who are trying to understand, name and act on reality" (p. 84). Knowledge is always local; it is always specific to the given social context, which itself is always a work in progress—is always being constructed and reconstructed by people in interaction. For these authors, knowledge transfer involves the adaptation of new ideas into a social context defined by specific values, cultures, beliefs and activities, and this adaptation often takes the form of devising solutions to problems that the local context deems important. Instead of focusing on a sequential process of transfer, these authors focus on the underlying capacity that makes knowledge transfer possible: a generative, disseminative, absorptive, and adaptive/responsive capacity. When these capacities are present in humans systems, knowledge moves and is acted upon and learning occurs—though this knowledge transfer is a byproduct of interactions, and is not to be seen as the primary object and intent of the actors.

One of the more interesting threads within this literature is the development of the Promoting Action on Research in Health Services (PARiHS) theory, which may afford a lens that could help bring local knowledge dynamics into focus (Harvey et al., 2002; Kitson et al., 1998; Kitson et al., 2008; McCormack et al., 2002; Rycroft-Malone et al., 2002; Rycroft-Malone et al., 2004a; Rycroft-Malone et al., 2004b). This model suggests that successful knowledge transfer will depend on the interplay between three key factors: the level and nature of the knowledge (or evidence, in their terms), the environment or context that is implementing the evidence, and the method of facilitating the implementation process. Essentially, they argue that knowledge transfer will tend to

succeed when the evidence is clear and relevant to the local context, when the local context possesses the characteristics of a learning organization, and when a process of enabling facilitation is used to help practice members to understand, accept, apply, and sustain the new knowledge. They emphasize the importance of the local practice context to the overall process, and point out that the presence or absence of transformational leadership, skilled facilitators, and a receptive and adaptive culture will have significant implications for the transfer process.

Another interesting recent development is the publication of a useful synthesis of the literature on innovation diffusion (Greenhalgh et al., 2004). This synthesis tells us that evidence is often contested and ambiguous, and must be presented to a local context in ways that promote its relevance. Like the proponents of the PARiHS model, these authors argue that the adoption of innovations involves an interaction between the innovation itself, the individual adopters, and the local context in which the adopters are located. This interactive process is not linear, and is impacted by the division of social influence among local participants, the nature of the local network of relationships, and the presence and activity of local opinion leaders, champions, and boundary spanners.

Greenhalgh et al. (2004) also suggest that additional research is needed on specific local settings that could bring to light factors that contribute to the success or failure of new innovations. They call for research on how a local context interacts with a specific knowledge transfer program. This research should be reported in detailed descriptive reports that adequately represent the unique features of the local settings being studied, and should make use of participatory research designs that allow members of the local context to consider the practical implications of the research findings. One

specific question that they say needs further investigation is "How can we improve the absorptive capacity of service organizations for new knowledge? In particular, what is the detailed process by which ideas are captured from outside, circulated internally, adapted, reframed, implemented, and routinized in a service organization, and how might this process be systematically enhanced" (p. 618)?

More recently, Mitton et al. (2007) have presented a review and synthesis of the literature on knowledge transfer and exchange as it relates to policy makers (rather than to frontline clinical practices). Although their review failed to reveal any off-the-shelf, generalizable strategies for implementing knowledge transfer and exchange, they did find that many of the studies attempt to identify the barriers and facilitators to knowledge transfer and exchange. They state that the barriers to knowledge transfer and exchange include mistrust, fear of change, an unsupportive culture, and frequent staff turnover. Facilitators of knowledge transfer and exchange include collaboration, readiness for change, face-to-face communication, and knowledge that is relevant to and tailored for the needs of specific policy maker audiences.

Like Rycroft-Malone (2007), they question the feasibility of arriving at a generalizable, linear theory of knowledge transfer. The activities of policy makers are influenced by numerous factors, and the use of knowledge is always highly contextual. Perhaps more significantly, the decision making process in policy contexts cannot be reduced to a simple, linear transaction with knowledge inputs and decision outputs. They suggest that perhaps what is needed is new research into complex processes by which policy decisions are made. Once the local, situated dynamics of policy makers are better

understood, it might be possible to assess whether evidence-based decision making by policy makers does, or could, occur.

The literature on knowledge transfer in health suggests that a study of local meaning-making processes in a specific health context could help to fill some existing gaps in our current knowledge. Research is needed on the interplay between local factors / processes and programs to implement new evidence or policies that were developed by external agencies. There is also a need for research that can reveal the characteristics of the local context and the precise activities that help to create, sustain, and adapt knowledge to the pressing issues faced by members of the practice.

Research Literature on Long-Term Care

Like other health organizations, LTC facilities experience difficulty in implementing new research findings. Feldman and Kane (2003) have argued that for knowledge transfer to be successful, the new scientific knowledge must be clear and usable, the managers and staff in the frontline practice must understand the evidence and know how to apply it in their daily work routines—indeed, the authors note that "...relevance may trump research sophistication" (p. 199). These authors emphasize that for new knowledge to be applied in LTC settings, organizational leaders must actively support the change and provide the necessary resources (such as training), and incentives must be aligned in ways that support the change. They say that more research related to LTC is certainly needed, but equally important is the need to enhance the capacity of LTC homes to adopt and implement relevant research findings.

These claims are supported by a recent evaluation program that was carried out in Ontario long-term care homes. In 2005 the Ministry of Health and Long Term Care

(MOHLTC) in Ontario launched a Best Practice Guidelines (BPG) Coordinator initiative, which was intended to promote the distribution and use of nursing best practice guidelines (BPGs) in Ontario's long-term care facilities (O-Brien-Pallas et al., 2007a, 2007b). Eight regional coordinators were hired for a 2.5 year term, and in 2006 the Nursing Health Services Research Unit (NHSRU), a collaboration involving the schools of nursing at the University of Toronto and McMaster University, was contracted by MOHLTC to evaluate the success of the BPG Coordinators.

The NHSRU carried out a mixed-methods evaluation of the BPG initiative in eight LTC homes in Ontario, and gathered data through interviews and focus groups; the data was analyzed both quantitatively and qualitatively. The group published two reports, one focusing on process issues and the second focusing on impacts (O-Brien-Pallas et al., 2007a, 2007b).

The first report (O-Brien-Pallas et al., 2007a) identifies barriers that hindered BPG coordinator efforts to bring new knowledge into frontline LTC practices: LTC staff do not have time to take on the extra work involved in adopting new knowledge from external sources; LTC staff currently juggle a complex load of competing priorities, and this makes it difficult to add new tasks and responsibilities to the workload; frontline staff have not been involved sufficiently in the BPG process, and their support and involvement will be essential if new knowledge is to be brought into LTC homes; backfill funding, which would allow staff to attend education sessions while a replacement worker fills in for them in the LTC home, is generally not available; resources are not available to allow staff to work collaboratively on the implementation of new approaches; many homes work with insufficient numbers of staff, and this makes it even more

difficult to take on extra work (BPGs often require adaptation before they will work in the local setting, and this requires extra work from staff); staff sometimes have negative attitudes toward change; MOHLTC and other organizations are trying to introduce numerous changes into LTC homes, and the homes are unable to cope with the rate of change. In their conclusions the authors state that passive ways of distributing new information in LTC sites (such as distributing documents or education materials, or holding sessions where an educator or expert speaks about a topic, with minimal interaction with the audience) are insufficient to bring change into frontline practices.

The second report (O-Brien-Pallas et al., 2007b) confirmed that bringing new knowledge into LTC settings in Ontario is often problematic due to staffing and resource challenges. The authors identify the enablers or supports needed for the effective implementation of new evidence-based practices in LTC homes: support from the home's leadership and management team; support from frontline staff; alignment between local care issues and the content and purpose of specific BPGs; and a general understanding of the importance of BPGs and evidence-based care. They point out that turnover of management and frontline staff can negatively impact a home's ability to integrate new evidence into its practice. Equally important, frontline staff must see that new evidence will benefit residents and is relevant for the challenges and issues that they are contending with, and must be given the time needed to participate in implementation efforts. The authors identify strategies that were found to be effective in introducing BPGs into LTC homes: translating the evidence into user-friendly formats and language; making the information available in other languages (such as French and Mandarin); tailoring the guidelines specifically to LTC homes; training staff in how to apply the

guidelines; providing clear, ongoing communication about the new practices; involving all disciplines in the implementation process; providing access to experts who are familiar with the new practices; and ensuring that leaders demonstrate their support for the changes.

A number of studies have examined quality, effectiveness, and change in LTC facilities in the United States. Banaszak-Holl et al. (2006) found that learning in US nursing homes appears to be stubbornly embedded within local contexts. When a large nursing home chain expands by purchasing new homes, the established homes within the chain do not generally take on new capabilities adopted from the newly acquired homes, and the newly acquired homes do not tend to take on the capabilities and processes of the chain. Although one would imagine that the rationale for some acquisitions is to acquire and share capability, the findings of this study indicate that this tends not to happen.

Some recent studies of LTC settings have argued that the theoretical insights of complexity science are well-suited to the study of LTC organizations. Plsek and Greenhalgh (2001), for example, point out that Newtonian thinking, wherein a problem is dissected into its component parts and analyzed in terms of causes and effects, has had a major influence on problem solving and decision making in medicine. They suggest, however, that this approach is inadequate to explain complex issues such as organizational change in health care, because here we are dealing with complex adaptive systems that consist of individual agents who act in unpredictable ways, and whose behaviour is so closely intertwined that an action taken by one individual will often change the context in which several others are acting. Healthcare organizations have porous boundaries, shifting membership, and agents whose loyalties are divided among

several systems. As the composition of and influences upon complex systems change, the systems themselves adapt and change in ways that are unpredictable and non-linear. Order and innovation emerge naturally from the dynamic that unfolds within these complex systems.

Fraser and Greenhalgh (2001) suggest that learning in healthcare organizations should no longer be thought of exclusively as the transmittal of knowledge through formal educational sessions, but should also be thought of as a particular stance that people take in relation to unfamiliar and uncertain situations. People and groups take on new capability through a transformative process that involves active engagement in which existing experience and knowledge are adapted to emerging circumstances. They suggest that a clinical practice creates a repository of experience and knowledge in the form of stories, that can be accessed and interpreted as one strategy for adapting to new situations.

Colón-Emeric et al. (2006) reported the results of a qualitative study involving five North Carolina nursing homes that indicated that patterns of communication can affect the ability of healthcare personnel to provide effective and innovative care in nursing homes. The authors used complexity science as a lens for looking at a nursing home as consisting of a dynamic and nonlinear set of interactions from which orderly patterns emerge. They contend that long-term care organizations that have open communication systems among people with a variety of mental models (for example, nurses, health care aids, physicians, and administrators) will be more able to adapt effectively when faced with changing situations than organizations with limited communication systems that connect people with similar mental models. The researchers

compared information flows and results in a home with a hierarchical pattern of organizing and limited information flows, with a home characterized by a more open communication environment. The authors conclude that the more closed communication systems were unable to achieve high levels of innovation, while the more open communication systems that involved frontline workers who have diverse views and experiences demonstrated higher levels of innovation. However, the more open system took shape not due to management intentions, but to overcome a problem caused by Registered Nurses (RNs) absenting themselves from clinical problem solving because of the demands of their administrative workload; moreover, turnover was relatively high at this facility, and reassignment was common, and these factors tended to mitigate the system's ability to adapt and innovate. Moreover, staff in the open communication environment felt overwhelmed by requests to provide information as they were trying to complete their tasks. The authors advocate brief and frequent information sharing sessions among interdisciplinary team members.

Anderson et al. (2003) report the results of a study carried out in 164 Texas nursing homes using self-report surveys from directors of nursing and RNs. They argue that their study indicates that traditional, hierarchical management approaches do not lead to improved resident outcomes. They found that where there were more open communications among staff, and a lack of fear about being penalized for speaking frankly during interactions with management, there tended to be a lower use of restraints and reduced disruptive behaviour on the part of residents. Similarly, when organizational leaders focused more on providing constructive feedback to staff, and on helping to

resolve team conflicts and increasing trust among team members, resident outcomes tended to improve.

Anderson et al. (2004) examined nursing home turnover (which they characterize as a serious problem in the United States) by collecting data from 3,449 employees in 164 randomly selected nursing homes in Texas, and linked this data to other data they gathered on facility characteristics, turnover, and resource use. They conclude that turnover in nursing homes depends on the interaction between the organization's climate and its communication practices. Turnover tended to be lower where there were practices to reward meritorious performance, clear organizational goals, a focus on employee welfare, open and accurate communication practices, adequate staffing levels, and continuity in the Director of Care position. Open communication alone did not correlate with reduced turnover; however, open communications and a congenial organizational climate (as described above) did correlate with lower turnover.

Anderson et al. (2005a) suggest that most professional knowledge among frontline workers in nursing homes derives from daily experience rather than scientific research, and frontline workers are rarely involved in discussions of resident care. They report the results of a six month qualitative case study in a long-term care home in North Carolina that sought to investigate the sensemaking patterns among certified nurse assistants (CNAs—in Canada these staff would be referred to by terms such as as personal support workers or health care aids) in nursing homes, by revealing the mental models most characteristic of CNAs. The authors report that the most common mental models were the Golden Rule (do unto others as you would have others do unto you) and Mother Wit (using wisdom gained through the experience of being a mother, which may

imply that CNAs treat residents like children). They suggest that effective sensemaking occurs when the diverse perspectives and interpretations of many different people (including RNs, CNAs, and others) are available to generate solutions and action strategies. The authors conclude that the prevailing CNA mental models are limited, and may occasionally result in inferior care being provided to residents (for example, a resident refusing to eat with a fork is not comparable to the behaviour of a stubborn child, but may rather be the result of how dementia is affecting this individual's brain). They posit two barriers to the development of evidence-based practice in nursing homes: CNAs use unsophisticated mental models that sometimes provide ineffective explanations for resident behaviour; and certified caregivers seldom interact with CNAs in ways that could enrich their mutual interpretation and understanding of resident situations.

Anderson et al. (2005b) draw on complexity science to formulate an argument that human systems such as long-term care facilities will be more adaptive and resilient if the caregiving team (including licensed and unlicensed caregivers) have respectful and effective relationships across disciplinary lines. This will allow for a process of adaptive self-organization to emerge in the human system, where individuals are empowered to adapt to new situations and information without fearing that superiors will criticize or punish them. Self-organization depends on an open flow of appropriate information, good work relationships among members (wherein they trust and depend on each other), and a sufficient level of cognitive diversity among members (the people represent a variety of organizational roles, education levels, cultural affiliation, so as to make new information available when solving problems). The authors are exploring these

assertions through a series of case studies, and state that their findings to date indicate that LTC homes lack the type of interaction needed to promote optimal sensemaking and self-organization. Instead, they have found restricted information flows, poor staff relationships, and limited interaction among staff that display cognitive diversity. They also found significant reliance on the use of formal rules and on processes for enforcing compliance with rules. They suggest that several management reforms might improve performance in LTC settings, including encouraging more interaction between CNAs and nurses.

Some research has also been carried out in relation to the development and use of quality indicators in LTC environments. Kane (2001) argues that USA nursing homes may provide highly competent technical care, but too often provide a poor quality of life for residents. She says that this situation might be improved by instituting a shift in the culture of LTC work environments. Wunderlich and Kohler (2001), in discussing the quality of care in LTC homes in the United States, report that "...a large gap exists between the current state of scientific knowledge and the capacity of most long-term care providers to implement that knowledge" (p. 14).

Yeatts and Cready (2007) report a general desire to implement patient-centered care in LTC homes, and that a common approach to this is to empower employees. They list several different initiatives that have gained popularity since the early 1990s, including a popular approach known as the Eden Alternative. The literature on empowerment in manufacturing settings indicates that when frontline workers are empowered (that is, are given some decision-making responsibility in addition to their task assignments), team performance and job satisfaction tends to improve and turnover

is reduced. The authors report the results of a mixed-methods evaluation of an empowerment program involving CNAs in five Texas nursing homes (their design included a control group, and pre- and post-surveys). To implement empowerment in five test homes, they oriented and trained CNAs and nursing staff, developed improvements for specific procedures, instituted new weekly meetings with an external facilitator, instituted new meetings during shifts; and established a process for nurse management to provide feedback on CNA suggestions. Post-tests were conducted after 16 months, to ensure that effects were sustained over time. Their results indicate that performance underwent a modest improvement, and turnover was in some cases reduced.

Wodchis and Wong (2007) explored the relationship between nurse staffing levels, nursing skill mix, and patient satisfaction. The study used data on patient satisfaction publicly reported between 1999 and 2004, including 750 patients at 30 LTC facilities in Ontario. They linked this patient satisfaction data with Minimum Data Set (MDS) data on nurse staffing and patient clinical data. They found that patient satisfaction tended to rise as unregulated, frontline staff spent more time with residents.

Other quality-related studies attempt to identify how residents assess their own quality of life and care while living in an LTC home. Robichaud et al. (2006) examined how LTC residents assess their own quality of life by carrying out interviews with 27 LTC residents and their families in five nursing homes in Quebec. They found that the three most important quality of life indicators for residents were "...being treated with respect, sympathetic involvement in relationships, and perceived competency through technical (nursing) acts and attitudes" (p. 245).

Arling et al. (2007) created a method for measuring nursing home quality in Minnesota nursing homes. They derived a set of quality indicators from the Minimum Data Set (MDS), and also developed new quality of life and resident satisfaction indicators through interviews with a sample drawn from 14,000 residents. The resulting measures are used in a Nursing Home Report Card in the state, and consist of the thirteen domains indicated in Table 3.

Table 3

Thirteen Indicators of Quality of Life and Satisfaction in Long Term Care

• Autonomy	• Food enjoyment	• Relationships
• Comfort	• Individuality	• Security
• Customer satisfaction	• Meaningful activity	• Spiritual well-being
• Dignity	• Mood	
• Environmental adaptation	• Privacy	

In another report on the Minnesota program, Kane et al. (2007) state that many quality improvements to address reported shortcomings in specific homes can be implemented by making organizational and leadership changes.

William Kahn's work (Kahn, 2001, 2003, 2005) on caregiving organizations, which includes a considerable amount of work in healthcare organizations, suggests that these types of organizations are prone to specific kinds of sensemaking breakdowns. Extending the work of Bion (1961), Kahn argues that a caregiving workplace can function as a *holding environment* in which people who are dealing with complex challenges and are experiencing strong emotions can receive care and support from the organization that employs them. A holding environment allows an organization to

provide nurturing support to organizational members who are contending with difficult challenges, by creating a temporary context where interpretation, or collective sensemaking, can occur.

Kahn argues that holding environments are especially significant for caregiving organizations whose primary task is to provide care to careseekers (Kahn, 2005). In these organizations (he uses LTC facilities as one of his examples), one group of people, caregivers, provides care for another group, careseekers, through the medium of the personal relationships that they establish. Given the nature of the problems that careseekers often seek help with, emotionality tends to be high, which creates anxiety among frontline workers. An effective caregiving organization supports and nurtures caregivers as they cope with the anxiety of working with emotionally volatile careseekers.

Kahn argues that sensemaking disturbances in caregiving organizations are common, and that when sensemaking breaks down the organization is no longer able to nurture and support its frontline caregivers. Given the complexity of caregiving environments, given the number of internal and external influences that affect organizations such as LTC homes, and given the traumatic events (such as the accidental death of a patient) that can occur, stress and anxiety are common.

Kahn is arguing that if a caregiving organization is unable to provide care and support for caregivers, then a dysfunctional dynamic can take shape that amounts to an organizational defensive system protecting caregivers from an overwhelming sense of anxiety that is a by-product of the caregiving task. Over time, the defense system becomes institutionalized into the structures, routines, systems, and processes of the

organization. Tasks are completed, but in ways that do not fully meet the needs of careseekers (as Kahn phrases it, careseekers are taken care of, but are not cared for) (Kahn, 2005). Relationships between caregiver staff are constrained, and communication is limited. The primary task of providing care is supplemented by a covert task of maintaining the defensive system for coping with anxiety. Kahn suggests that it is common for caregiving organizations to experience these breakdowns, and that they often take the form of subgroup "splitting" in ways that allow group members to defend themselves against anxiety. Splitting is the forming of specific relationships (factions, cliques, occupational group loyalties, departmental rivalries, etc.) that serve to distract caregivers from the real source of their anxiety, essentially giving them something else to focus on. However, this splitting of the organization into subgroups negatively impacts the organization's internal communication flows and network of relationships, and undermines the organization's ability to form an effective caregiving system.

SUMMARY OF THE LESSONS DERIVED FROM THE LITERATURE REVIEW

The purpose of this literature review was to bring to light the basic nature of meaning making in workgroups, to give focus to my on-site data gathering, and to reveal some of the current issues and dynamics at work within healthcare organizations that could have an impact upon the meaning-making processes that I would encounter while carrying out the on-site research.

The review of the organizational literature suggests that meaning making is an essential, constituting process in workgroups through which members negotiate their shared social reality. Social processes of learning and leadership help to create a shared sense of identity, competence, coherence, and purpose. Meaning making is active, local

and situated; it contributes to the accomplishment of tasks and the construction of social relationships; it is evident in ongoing conversation and dialogue, and it becomes stabilized in texts and enduring interpretations. Meaning making unfolds as the creation of identity and competence within a practice, and as processes of error correction that can involve varying degrees of congruence between intentions and actions—and the adaptive impulses of a practice can sometimes be at odds with the stabilizing tendencies of an organization. Through meaning making, multiple voices and perspectives are negotiated into coherent accounts that exhibit fidelity to the experiences and accumulated knowledge of members. We lead lives of significance by creating identities of competence that unfold within coherent social worlds and that are dedicated to worthy goals. We pursue worthy purposes by agreeing on a coherent account of our mutual situation and then mobilizing action through social roles organized into regimes of competence.

The literature on knowledge transfer in health suggests that researchers are in the process of changing their conception of how meaning is constructed in health organizations. From a linear, causal view of meaning making, where scientific experts construct meaning that is then transferred into frontline practices where it is applied to specific patient situations, researchers are looking for more interactive and iterative models to explain the creation and use of knowledge in health organizations. Some authors are calling for further research that will reveal the precise dynamics that exist in specific health organizations that could have a bearing on the success or failure to implement new innovations to improve the delivery of health services.

The existing theory and research that focuses specifically on long-term care environments reveals a system that is experiencing significant pressure and strain. Organizations make use of hierarchical arrangements that place barriers between occupational groups, and frontline caregiving staff have little time to participate in efforts to implement new innovations within their practice settings. The literature also indicates that there are insufficient numbers of workers to fill all of the positions in LTC homes, which creates additional strains upon existing workloads. Finally, there are some indications that meaning-making processes in long term care are impeded by occupational and hierarchical barriers, resulting in a situation that may not serve the best interests of LTC residents.

The research that I report in this dissertation is intended to contribute to our general understanding of meaning making in workgroups, and to our knowledge of the specific meaning-making dynamics in long-term care settings. Although the organizational literature does include a small number of empirical, descriptive studies of meaning making in specific contexts (Bechky, 2003; Boreham and Morgan, 2004; Cook and Yanow; 1996; Hutchins, 1995; Orr, 1996; Wenger, 1998; Yanow; 2000; Weick & Roberts, 1993), as of yet there are no (as far as I am aware) detailed, descriptive studies of meaning making focusing on a specific healthcare or long-term care organization. By carrying out an inquiry into the meaning-making dynamics of a specific healthcare organization, we may gain new insights into the factors that help or hinder efforts to implement new innovations that could improve patient care.

CHAPTER THREE: RESEARCH METHODOLOGY

RESEARCH DESIGN

This project attempted to reveal the meaning-making dynamic in workgroups assigned to the day shift on two floors of a long-term care facility in Ontario. The notion of meaning making that I explored is consistent with a constructivist conception of social reality: members of workgroups individually and collectively construct a sense of social reality that is relatively coherent and purposeful, and that includes a set of individual and collective identities that draw upon relevant competencies to undertake required tasks. I was not interested in establishing correlations or causal relationships. Instead, I was interested in bringing to light the full complexity and richness of meaning making in workgroups, to allow for a description of these processes. I was not trying to prove or disprove a hypothesis; I was trying to explore a social phenomenon *in situ*. Consequently, a qualitative design was most appropriate to my purpose (Creswell, 1998; Lincoln & Guba, 1985).

For the purpose of this study, a workgroup was considered to be a group of people who work together regularly to carry out shared responsibilities and to perform common or interdependent tasks. In my specific research context, a workgroup consisted of the people who work together over time on the day shift in a long-term care home.

To conduct this inquiry, I elected to carry out a qualitative study that included an ethnographic component emphasizing participant observation, informal interviews, and document analysis, as well as a case study component that included formal interviews,

focus groups, and document analysis. The ethnographic component was intended to reveal the overall meaning-making dynamic of the site; the case study component was to focus on a specific knowledge-transfer issue that could be contexted against the ethnographic findings.

I selected ethnographic and case study methods because they were well-suited to the nature and purpose of the inquiry. Since my purpose was to reveal, observe and describe meaning-making dynamics as they occurred in their natural setting in the workplace, I needed an exploratory methodology that would permit a direct encounter with the phenomenon being studied (Hopson, 2002). Since I intended to create a "thick description" of the phenomenon, I needed to use methods that would allow me to create a rich, detailed repository of data. Ethnographic methods are well-suited to these purposes (Creswell, 1998; Fetterman, 1998; Hammersley & Atkinson, 1995), and both ethnographic and case study reports are intended to provide a "thick description" of the phenomena being studied (Creswell, 1998; Denzin & Lincoln, 2003; Lincoln & Guba, 1985; Merriam, 1988).

I realized that I would need to treat my inquiry as an "emergent design" (Borman et al., 1986; Johnson, 1975; Lincoln & Guba, 1985). I expected that the research questions might change over time as the data accumulated and I began the analysis. I also expected that the limitations of the site might necessitate that I make alterations to my data gathering strategies. In fact, I did find it necessary to make two changes to the design. First, I abandoned the idea of holding a focus group as a way to gather data for the case study. The workload and pace of work on the floors made a focus group impossible. Second, I added a new category of informant about halfway through the data

gathering period. I term these informants "insiders / outsiders," in that their main role lies outside the research site, but their responsibilities require that they enter the research site from time to time and that they be familiar with the work that occurs on the floors.

ETHICS APPROVAL

I obtained ethics approval from the Ethics Committee of the Department of Applied Human Sciences at Concordia University. Since the River Lodge (the name that I am using for the research site) had a relationship with an academic institution and research institute, I was required to also obtain ethics approval from a second Research Ethics Board in Ontario.

For this second ethics submission, I submitted the required forms and then made a presentation to a multidisciplinary Research Ethics Board, and obtained approval to proceed with the research. This approval stipulated that I must not gather data that might contain confidential medical information about specific residents, and that I would not disclose the identity of participants (all names of staff at the River Lodge used in this dissertation are pseudonyms).

Appendix A contains a copy of the approved Informed Consent Form that I used when recruiting participants for the study.

STUDY PARTICIPANTS

I recruited participants for the inquiry over a week-long period during my first week at the research site, after which I continued to recruit on an ad-hoc basis when new people appeared on the floors who I felt might be able to contribute to the inquiry. One management representative signed an Informed Consent Form to provide institutional approval for the study, and twenty-eight individual participants signed individual

Informed Consent Forms. Of the twenty-eight individuals, four were insider / outsiders, and the rest were full- or part-time employees at the River Lodge (and most of these belonged to one of the three unions that represented people who worked in the Lodge). I thus had 73% of the day shift agree to participate in the study. This number was more than sufficient to allow for the implementation of the research design (on any given day, I was able to locate people who had agreed to participate in the study, and confine my observations to them). I did not attempt to recruit any residents, family members, or volunteers to participate in the study. Over time, most people who came regularly onto the floors knew that I was a researcher (on a few occasions I heard somebody explain that I was studying staff communications). Chapter 5 provides a more detailed description of the research participants.

My stance was that of a participant observer. I was encouraged by the institution's Research Ethics Board, and by the organization's management, to remain in a neutral, observer posture as much as possible. This advice stemmed largely from the fact that I was explicitly instructed not to include any personal medical data in the research. Given the privacy and confidentiality laws governing patient information in the province of Ontario, it was imperative that my data not include information gathered from residents or family members, and that it not include medical information pertaining to specific residents. To honour this commitment, I went only into the public areas of the facility, and into areas designated for use by staff; I did not go into resident rooms, and I gathered and recorded no data from residents. I generally went to a specific public area in the facility, and stood and observed staff interactions for a period of time, after which I went back to a cubicle in a different part of the building to record my notes on a secure

computer that was provided to me by the institution. Although it was inevitable that I would see residents and family members at the research site, and I might interact with them informally, I did not gather data to reveal the extent to which they participate in or contribute to the meaning-making dynamic on the floors.

Nevertheless, I did "participate" in the life of the floors to a certain extent. One day, the facility's chaplain enlisted my help in carrying chairs into a lounge for use during a memorial service. On two occasions, when residents were having a barbecue in the picnic area adjacent to the building, I helped to convey residents in wheelchairs to and from the picnic area. When I saw a resident or staff member looking for somebody, I would tell them where the person was. Staff also integrated me into their day-to-day interactions to a limited extent. I was referred to as "the shadow" on occasion, and staff sometimes remarked to me how boring it must be to stand in a hallway watching things for hours on end. For the most part, however, I merely observed, and did not participate in the activities and tasks that swirled around me throughout the day.

DATA GATHERING

I was at the River Lodge on 33 separate days over a period of 3 months, which amounted to a total of 156 hours spent gathering data. During this time I compiled 192 pages of notes in my field journal. I observed 17 separate morning Report sessions. I also conducted 15 formal interviews, yielding 60 pages of interview transcripts. I also gathered numerous documents relating to the work carried out at the site, amounting to approximately 520 pages of text.

Observations and Creating the Field Notes

During my first week on the site, I focused on recruiting participants, becoming familiar with the overall layout of the floors and the flow of work throughout the day, and identifying specific locations where I might observe staff interactions. I carried a small wallet-like object called "the pocket briefcase," which contained index cards for taking notes. Over time I would also place slips of paper into this wallet, with reminders about questions that I intended to ask participants. After my first week on the site, I settled into a regular routine. I usually began the day by observing the morning report session in the chart room, and then I would spend the rest of the day in the central hallway where most staff interactions occurred (I provide a full description of the physical layout of the floors in the next chapter). I would listen to conversations and observe interactions, and then would slip into a quiet place (an unused lounge, the chart room, or a quiet corner of the hallway where there was a bench or chair) and would spend two or three minutes making cryptic notes on my index cards; then I would resume my observations. I did not make my index-card notes while actually observing events because one participant had advised me that this would be disconcerting for staff, and because the methodological literature suggests that jottings should be carried out in a manner that is comfortable for both participants and the researcher (Emerson et al., 1995). After observing interactions for anywhere from 20 minutes to 3 hours, I would leave the floor and walk to a different location in the building where a small cubicle and computer were provided for my use. Here I would write my detailed field notes.

As recommended by ethnographic methodologists, I wrote my field notes immediately after making observations (Emerson et al., 1995). I made my detailed field

notes in a secure MS Word file, and after completing my notes I would shred the index cards. I took my time while writing these notes, making sure that I remembered as many details as possible, and I took the advice of Emerson et al. (1995) and ensured that I always left the site after no more than three hours and immediately wrote up my notes.

My field journal was organized into a regular format, based on recommendations I found in the literature on ethnographic methods (Fetterman, 1998; Hammersley & Atkinson, 1995; Lincoln & Guba, 1985). Each entry was dated, and began with a straight narrative of what I observed and heard. I included as much detail as I could recall, in sequential order, and refrained from adding commentary or interpretation to this portion of the field notes. After this was a section where I recorded my personal impressions, reactions, emerging interpretations, and concerns. Finally, each daily entry concluded with a record of my reflections on the research design and methods, and included any decisions I came to about changes to the approach (for example, I recorded here my decision to include a new category of informant, the insiders / outsiders, in the data gathering).

Over time, I developed a number of unanticipated practices when inscribing my field notes. I noticed that specific questions were asked by staff on numerous occasions as I observed their work (for example, staff often asked each other about the whereabouts of colleagues). I created a special area in my daily journal to keep track of the questions that repeatedly were asked. In the subsection on Methodological Issues and Decisions, I began to keep track of questions that I wanted to ask staff members when the opportunity arose.

Formal and Informal Interviews

I had intended to conduct brief formal interviews with participants about emergent topics; however, I found that the heavy workload made this impossible. I formed the habit of noting questions that I wanted to ask on a card, and when I was spending time observing a specific participant I would sometimes ask some of these questions. I was able to conduct seven of these brief, informal interviews with staff over the course of the research—where we might step into a vacant room, and I would ask between two and five questions before their duties summoned them away again. I was able to make an audio recording of five of these interviews, and for the other two I made handwritten notes. I included all of this data within the field notes, identifying the data as coming from a "mini interview." In the case of the recorded interviews, I created a verbatim transcript of the interview, and embedded the transcript within the field notes.

I was also able to conduct 15 formal interviews with participants. Generally these interviews were scheduled in advance, and lasted anywhere from 15 minutes to an hour. I recorded these interviews on a digital recorder, and created a verbatim transcript. I provided a written copy of the transcript to the participant, and invited them to make corrections or to add information if they wished.

Selecting the Focus for the Case Study

During my first week on the site, I asked all participants that I recruited for the study if they could think of a suitable focus for the case study portion of the research. Several participants suggested that I use the Eden Alternative.

The Eden Alternative is an approach to providing long-term care to seniors that was developed in the 1990s by an American physician (I provide background on the Eden

Alternative in the next chapter). The River Lodge had been implementing some ideas derived from the Eden Alternative for a number of years, and so far the implementation had met with mixed success. My intention was to use the case study as a way of uncovering information about how knowledge from the external environment might interact with the local meaning-making dynamic. I wanted a relatively well-bounded example of external knowledge (I had originally been thinking in terms of a new standard originating with the Ministry of Health and Long-Term Care, or new practice guidelines emanating from an occupational governing body). The Eden Alternative seemed well-suited to my purpose, since it affected the overall way that care was to be delivered in the Lodge (and hence affected all of the staff who were participating in the study), and it had been underway for a sufficient period of time to allow participants to have accumulated numerous experiences and examples related to its implementation.

I gathered data for the case study largely through interviews and documents. I was also able to observe one Eden implementation meeting, and to examine how specific elements of Eden were visible (or not visible) in the Lodge.

Gathering and Selecting Documents

To gather documents for the document analysis portion of the study, I wanted to find documents that reflected the decisions, interpretations, and solutions that governed work in the Lodge. I also wanted to find documents that offered a conception of work in the larger organization of which the Lodge was part, and documents that illustrated the contested views of the delivery of long-term care in Ontario. I also hoped to find documents related to the Lodge's implementation of the Eden Alternative.

I began by paying attention to the types of documents that were used on a daily basis by participants, and asked for copies of these. These types of documents included schedules, task lists, and records of resident conditions and work that had been carried out on previous shifts.

I then asked an administrative staffperson for copies of job descriptions of participants, and for copies of policies and procedures concerning how incidents should be reported by participants. I obtained copies of job descriptions for Registered Nurses, Registered Practical Nurses, and Health Care Aids, and copies of the various incident reporting policies used in the Lodge.

I visited the organization's intranet, and obtained copies of several online documents. These included the current strategic plan, and progress reports on the strategic plan, along with the organization's last two annual reports. One study participant gave me copies of some inserts she had received in a pay envelope, that contained summary information about the organization's strategic direction.

I gathered several documents from the site pertaining to the Eden Alternative and its implementation. These included an Eden binder that was located in the chart rooms, along with Eden meeting minutes and Eden-related notices on the hallway bulletin boards. I also gathered some additional Eden-related documents that informants told me about (e.g. a CUPE report on the impact of Eden on the workload of unionized staff in LTC homes).

During interviews, informants sometimes referred to documents that they used or were aware of, and whenever possible I asked for copies of these. For example, I was given documents related to the provincial compliance process that LTC homes follow,

and advocacy documents created by industry associations as part of a lobbying effort to influence provincial policy about the way in which LTC homes are regulated. I also obtained more general advocacy documents prepared by associations with a stake in LTC in Ontario, dealing with the challenges facing the long-term care sector in Ontario and Canada.

ASSURING THE TRUSTWORTHINESS OF THE DATA

To assure the trustworthiness of the data I gathered, I relied on Patton's (1990) insistence on ensuring that the researcher has the necessary qualifications for carrying out the study, along with the trustworthiness criteria developed by Lincoln and Guba (1985).

As Patton writes, "The validity and reliability of qualitative data depend to a great extent on the methodological skill, sensitivity, and integrity of the researcher" (p. 11). Before embarking on this inquiry, I completed a two-semester graduate course on research methods which included a practicum in the form of a research study. I carried out an observational and interview study of a cross-functional team of technical communicators at a medical technology company in the United States, using many of the methods that I also used for this dissertation research. The results of this earlier study have been published in a peer-reviewed journal (Conklin, 2007). While designing the study, I received valuable support and advice from two experienced researchers who work at the research institute affiliated with the River Lodge. I have developed a keen interest in qualitative inquiry in general, and was recently guest editor of a special issue of the journal *Technical Communication* on the topic of qualitative research in technical communication (Conklin, 2008).

Lincoln and Guba (1985) suggest that the trustworthiness of a qualitative inquiry can be assessed in relation to the inquiry's credibility, transferability, dependability, and confirmability. For an inquiry to be credible, it must provide an adequate representation of the reality of participants. For an inquiry's results to be transferable, the researcher must provide a "thick description" of the research site and findings, so future readers can determine whether the results might apply also to other organizational contexts. For an inquiry to be judged dependable, the data must display internal coherence. Finally, for an inquiry to be confirmable, the conclusions or theoretical implications of the study must be clearly grounded in the data.

I used a variety of techniques to ensure that my inquiry satisfied these trustworthiness criteria. I gathered data from five distinct sources: observational data recorded in field notes; formal and informal interviews with people who worked at the Lodge; formal interviews with "insiders/outsiders" who are familiar with the Lodge but do not work there; documents gathered from the research site; and documents gathered from the gray literature about LTC homes in Ontario. I tape recorded all formal and most informal interviews, and created verbatim transcripts to ensure accuracy. I observed activity on two floors of the River Lodge, and made sure that I spent time with all of the study participants. I created field notes by jotting down key words and observations while on the floors, and I always typed up my complete field notes in my journal before leaving the research site each day. I continued to gather data from observations, interviews, and documents until certain patterns became prominent, and new patterns were no longer emerging.

I provided interview transcripts to participants so they could look them over and suggest changes. When certain ideas began to become prominent in my notes, I would check with study participants to obtain their feedback, and to ensure that I was correctly hearing and interpreting their comments (for example, when the phrase "knowing the floor" began to strike me as a key concept for the study, I checked with the person who I had first heard use the phrase to obtain her definition, and then I checked with two other participants to see how they reacted to the phrase). These "member checks" have become a standard qualitative technique to ensure that data is trustworthy.

I remained engaged with the site for a period of three months, and visited two floors of the site on both weekdays and weekends, and spent 156 hours gathering data. My field journal included a reflective component where I maintained a record of my overall experience, including possible biases, emotional disturbances, questions, and emerging interpretations.

After the data gathering was complete, I met twice with study participants to review the data and my emerging interpretations, and asked participants for their reactions to my findings; on both occasions the participants validated and supported the findings. I also met with two people familiar with the River Lodge who had not participated in the study, and reviewed my findings with them; once again, they both supported and corroborated the findings and interpretations.

Finally, in writing this dissertation, I have taken care to create a "thick description" of the inquiry, including a detailed description of the research site itself, and a detailed description of the findings and interpretations.

DATA ANALYSIS

The analysis of qualitative data involves the transformation of the gathered data—the observations, interview transcripts, and documents—into a comprehensible account of the phenomenon being studied (Wolcott, 1994). It answers the question that so often vexes qualitative researchers: *what am I going to do with all of this data?* In Wolcott's terms, the analysis of qualitative data might more properly be seen as addressing three distinct objectives: to *describe* clearly and fully the activities that occur in the research context; to *analyze* how things work (or don't work) in the research context, by revealing the systematic interactions between key elements and features; and to *interpret* these descriptions and analyses in order to arrive at a sense of what it all means. Though at the beginning of my inquiry my emphasis was on description, as I worked with the data I found that it was possible to also—using Wolcott's terms—analyze the systemic nature of the Lodge's meaning-making dynamic, and to at least offer some conjectures about what my findings might mean for our overall understanding of meaning making in workgroups.

As is common in qualitative inquiry, I did not draw an absolute line between data gathering and analysis. After I had been gathering data for about five weeks, I began to review my field notes and interview transcripts, and I wrote of my emerging impressions in a series of analytical memos. Over the course of the research period, I wrote 22 analytical memos, which amounted to 85 pages of text. Although I abandoned some of the ideas explored in these memos, others remained important for the findings and interpretations reported in this dissertation.

After the data-gathering phase came to an end, my approach to analyzing the data was derived from the basic coding / unitizing and categorizing / theming procedures described in some of the standard qualitative texts (Creswell, 1998; Hammersley & Atkinson, 1995; Lincoln & Guba, 1985; Merriam, 1988). I then developed a map or visual representation to depict the systematic interactions that occurred among the thematic variables; to do this, I followed the procedures recommended by Argyris (1993) for the creation of an action map to illustrate systemic learning patterns within a human system. I then reflected on whether the map I had created to illustrate the meaning-making dynamic in this specific research context might shed light on the structure of meaning-making dynamics in other workgroups. I describe these steps below.

Coding the Data

My first step in the analytical process was to segregate the data into a set of codes. To prepare for this, I spent two weeks revisiting my original proposal (the intense and hectic nature of the data gathering had left me feeling somewhat disconnected from the original questions I had posed), and re-reading passages from the methodology texts that I had used (particularly Lincoln & Guba, 1985; Merriam, 1988; and Van Maanen, 1988). I also consulted with two experienced qualitative researchers who had no connection with this project, to discuss my proposed next steps and to listen to their feedback.

I then read the data through from beginning to end, making marginal notes and reflecting on the light that the data shed on the research questions. As I did this, I also created PowerPoint slides to use for my first feedback session with the research participants, and I continued to write analytical memos. When I was about one-third of the way through the field notes, I began to create some simple tables to list and

summarize the main incidents that I observed, the questions that are routinely asked on the floors, and my emerging ideas that appeared in the analytical memos and in the "personal log" portion of the field notes. I also created a list of relevant quantities, such as the number of morning Report sessions that I attended, the number of days I was on site, the number of interviews conducted, etc.

After I had completed this first review of the data, I then consolidated the list of questions that I had compiled (I had noted these questions in my field notes at the end of each observation period). After I created the consolidated list, I reviewed the questions and then grouped them into six categories. These questions helped to reveal the focus of much of the routine, daily meaning making that occurred on the floors. Appendix B shows the results of this consolidation.

At this point I began a new set of analytical memos, in which I sought to explore links between what I had observed and heard in the Lodge, and other social phenomena that I was reading about, thinking about, and encountering. For example, I explored in writing some links between meaning-making processes that I had observed in the Lodge, that I was encountering in a consulting engagement in a different healthcare organization, and that I observed in a student cohort that I was working with as an instructor for two graduate courses in human systems intervention. At this point I began to reflect on possible system variables that might be prominent in the Lodge (for example, the prevalence of an oral culture, the tension between a need for stability and adaptability, etc.), and I began to reflect on links between my data and the PARiHS framework (Harvey et al., 2002; Kitson et al., 1998; McCormack et al., 2002; Rycroft-Malone et al., 2002; Rycroft-Malone et al., 2004a; Rycroft-Malone et al., 2004b; Kitson et al., 2008).

I then set aside these reflections, and went through the data a second time. On this iteration I carried out the actual coding (or unitizing) of the data by making notations in the margins of a paper copy, and by creating an index card for each code. As the codes emerged during this reading, I used the back of the index cards to create notes about the meaning of the code—its scope, and the sorts of observations or incidents that fitted the code. This process generated 57 distinct codes.

Then I created a comprehensive code book of the data. This consisted of MS Word files for each code, containing the code name, the code description, the data sources and page references, and a total of the number of codes and number of data sources where they originated. See Appendix C for examples of two codes from my code book.

Then I went through the data for a third time, and located instances of specific codes that I had previously missed. This was especially helpful for codes that had emerged midway through (or later) in the original coding. I did not create any new codes, but I did identify 65 new instances of 19 existing codes in the data. I then updated the computer files with the new references and total counts.

I then created a Coding Inventory Spreadsheet to gain a sense of the relative importance of specific codes in the dataset, and to determine how well-grounded the codes were in the overall dataset. I created columns to hold the following information about each code: number (the numeric identifier of the code), code name, total number of instances of the code, number of different data sources where the code is found, and number of appearances of the code in the field notes, interviews (and I divided the

interviews into three categories—Eden Alternative formal interviews, staff interview, and insider/outsider interviews), and documents.

This inventory revealed the following features of the overall dataset:

- The dataset contained 1,127 instances of the 57 codes
- The average number of instances of each code was 19.8
- On average, each code appeared in 2.9 different data sources
- There were 698 instances associated with the field notes, 109 with the Eden interviews, 10 with the staff interview, 169 with the Insider/Outsider interviews, and 141 with the documents

After entering the data for all of the codes, I then sorted the codes four times (each time using two sorting criteria): by total number of instances of the code, and then by the number of data sources in which the code appears; by the number of data sources in which the code appears, and then by total number of instances of the code (i.e. the reverse of the first sorting criteria); by the total number of times the code appears in the field notes, and then by the total number of times the code appears in all other data sources; and finally, by the total number of times the code appears in all other data sources, and then by the total number of times the code appears in the field notes (i.e. the reverse of the third sorting criteria). I then pulled the top ten codes generated by each of these four sorting criteria, and I created a new column to indicate the number of times the code appeared in a list generated by one of the four sorting criteria (the value for this column would be between 1 and 4 for each code). I sorted this final list, which contained 21 codes, against the values in this new column, so I could scan the list according to the number of times the codes appeared among the top ten of the four sorting methods.

Table 4 is a condensed version of this analysis, showing the strongest codes, how many times each code appears in one of the four priority lists, the total number of times the code appears somewhere in the data, and the number of data sources (field notes, interviews, or documents) in which the code appears.

Table 4

Code Inventory Listing of the Strongest Codes

#	Code Name	Priority List Instances	Total Instances	# of Data Sources
3	Staff are busy	3	47	3
4	People come and go	3	39	3
9	Instability (and stability) and chaos	3	35	3
18	Instances of teamwork or collaboration	3	36	3
26	Constructing and maintaining a shared understanding	3	36	3
30	Factory or family	3	32	3
35	Knowing my floor	3	40	3
8	Specific sensemaking incidents	2	33	1
24	Sharing knowledge with newcomers	2	52	2
27	Ministry rules	2	26	3
28	Instances of hierarchy	2	25	3
40	Tacit care plans	2	30	3
7	On-the-go interactions	1	30	3
10	Here and now	1	20	3
25	Using and not using texts	1	31	3
32	Staff focus on action	1	25	3
36	Newcomers must fit in	1	28	2
48	Resistance to change	1	19	2
49	The Eden idea - pros and cons	1	20	3
50	The Lodge as a change context	1	21	2
51	Facilitators of change	1	18	3

This exercise allowed me to confirm that the codes were firmly grounded in the data. I spent some time looking at the results of the various sorts. When a code was well represented in two or more data sources, I concluded that this code had strong support

from the data. If a code was represented in only one data source, I reflected on whether there might be reasons why this code would emerge only from a single data source.

For example, code number 8 is called "Specific sensemaking incidents." The code book explains this code as follows:

> The data contains numerous specific, identifiable, bounded instances of sensemaking on the floors, and also larger sensemaking processes that continue over many days (e.g. orienting newcomers; implementing Eden). Meaning making, and the movement of knowledge from person to person and from group to group, is a central function of the floors. Without meaning making, the work would be impossible. Sensemaking incidents were observed during every Report session, when the group made sense of the situations that awaited them and set their task priorities and assignments. They were evident throughout each shift, as staff encountered situations that called for consultation and action (a resident slipping out of a wheelchair, a resident wondering where an expected visitor was, the breakdown of a piece of equipment, a discussion over where to place the soiled linen cart). Sensemaking was evident over longer periods of time, as well, in situations such as the ongoing effort to introduce Eden into the Lodge, the puzzlement over the conflict on the second level (which turned out to be related to the inability to integrate newcomers into the floor). Two broad, interrelated dynamics were evident: a dynamic originating externally that involved introducing new knowledge into the floors (Eden, management interventions, Ministry interventions); and an internal dynamic that attempted to share existing knowledge (knowing the floor) with newcomers. Arguably, the former fails

because of the urgency of the latter. It is as though external actors are trying to break in on an existing, urgent conversation, and are both unable to hear what is being said and are unable to be heard by the people they are trying to reach.

This code is strongly grounded in the field notes (with 33 instances), but does not appear in any other data source. Upon reflection, I concluded that it made sense that this code would appear only in the field notes. The code has to do with specific interactions that occur while work is unfolding, and I captured this type of data through my observations, which were recorded in the field notes. I concluded therefore that it was reasonable to retain this code for the subsequent analytical steps.

However, my review of the code inventory spreadsheet also led me to conclude that some codes were insufficiently grounded in the data. I identified four codes that appeared four or fewer times in the overall data sources, and that appeared in only one data source. I examined these weak codes, and compared them to the other stronger codes. I concluded that three of the four codes were really slightly differentiated instances of existing codes, and hence I joined "staff are close" with "informal social exchanges," and I joined "the good worker" and "having the right attitude" with "stories about staff commitment." I removed the remaining weak card, "systemic scenarios and situations," from the codes. This left 53 codes in the code book.

Theming the Data

My next analytical step was to create a smaller set of categories or themes. To do this, I used a clustering technique based on the methods developed by the Institute for Cultural Affairs (Spencer, 1989; Stanfield, 2002). I began by selecting the 21 strongest codes, and I placed their index cards in front of me on a table. I began to pair individual

cards, looking for linkages between the meanings of codes. I began with the most obvious linkages between two codes with similar meanings, and as the process continued I explored more subtle linkages between cards that allowed for the development of an extended or deepened meaning. I continued with this pairing until I had five separate pairs. Then I began to add cards to existing pairs, while also creating new pairs. When this exercise had identified all of the clear links among the cards in front of me, I took an additional ten codes on index cards, and continued with the clustering. I continued until all of the cards fell in clusters. This procedure resulted in eight clusters: two with nine codes, one with eight, one with seven, two with six, one with five, and the smallest with three codes.

I then examined the cluster that contained only three code cards, and considered whether it was truly a separate and integral cluster of meaning, whether these codes really belonged in other clusters, or whether this cluster was an indication that the clustering exercise as a whole had been flawed. I noted that these three codes were derived largely from the non-field note data, and that they were strongly represented in those data sources (the insider/outsider interviews and the documents). I concluded that this was a potentially useful cluster, but that in working with it I must keep in mind its derivation from the perspective of insider/outsiders and from documents rather than from staff perspectives.

I then created a new worksheet in my inventory spreadsheet, and separated the codes into their separate clusters. I created totals for the total number of code instances for the cluster, and for the total number of field note instances and total instances from other (i.e. non-field notes) data sources. I used these totals as a way of considering the

weight of evidence behind each cluster. For example, the average number of data sources for codes in the eight clusters ranged from 2.8 to 3.8. From this I concluded that each cluster was reasonably grounded in a variety of data sources.

Then I began to work on each cluster. Working with one cluster at a time, I read through the code descriptions, and then I created a narrative description for the cluster as a whole (this description consisted of two or three paragraphs), a brief description (of one-to-three sentences), along with a name. At this point I stopped thinking of these aggregations as clusters, and began to consider them as themes. Appendix D summarizes the themes and their associated codes.

I now had MS word files for each theme, with each providing the theme name, a brief description, a longer description, and a list of associated codes with their brief descriptions. I printed these eight theme documents to review. I also created eight condensed theme "cards" that contained only the theme name, brief description, and a list of associated codes. I printed these eight cards, positioned them on a piece of flip chart paper, and began to consider and sketch the interrelationships between the eight themes.

Creating the Meaning-Making System Map

As I examined the themes that emerged from the data, it became evident to me that they pointed not toward a static or inert human system, but rather pointed toward an ongoing system of interactions. It occurred to me that I might use Argyris's (1993) notion of an action map to create a visual representation of the River Lodge's meaning-making dynamic.

I placed a sheet of flip chart paper onto a table, positioned the eight condensed theme cards on the paper, and focused my attention on two cards at a time. I considered

how these two themes might interact with each other in the system. I drew linking arrows, and wrote brief explanations on the paper to explain the interactions. The result of this process was a rather messy sketch with arrows and notations and ideas. Appendix E contains a photograph of this sketch.

On a new piece of paper, I then considered how these interactions might function in a systemic fashion, maintaining the interactions on the floors in a state of adaptive equilibrium. After experimenting with the groupings, I settled on a system map that showed five themes functioning as a meaning-making dynamic internal to the floors, and three other themes interacting with this main cluster. This map is presented and discussed in a later chapter.

I then wrote a narrative to explain the map, and after that I experimented with descriptions of how this map related to the creation of purpose, coherence, identity, and competence on the floors. I found that it was relatively easy to make these connections. I then experimented with descriptions of how the map related to the key dimensions of the PARiHS framework: evidence, context, and facilitation.

Organizing the Eden Interview Data

I also treated the Eden interview data to an additional analytical step. I grouped all responses in relation to the questions. I then clustered the responses to each question into themes, to identify patterns in the way people responded. I used this analysis for my presentation on the implementation of the Eden Alternative in chapter 4.

At this point, I shifted into the fourth chapter of this dissertation. Analytical work continued, but in the context of writing descriptions of the research setting, my findings,

the meaning-making dynamic revealed through the findings, and my conclusions, which can be found in subsequent chapters.

CHAPTER FOUR: THE RESEARCH SETTING—AN ONTARIO LONG TERM CARE HOME

The research setting for this study was the River Lodge, a non-profit LTC home in an urban setting in Ontario, Canada. I will describe the setting by first sketching the broad, external environment that this facility operates within, and then I will describe the Lodge and the people who work there.

THE OVERALL CONTEXT: LONG-TERM CARE IN CANADA AND ONTARIO

Over the past decade, long-term care has received considerable attention from the press and in policy papers produced by government organizations, advocacy groups, labour unions, and associations representing occupational groups and specific interest groups such as the operators of for-profit and non-profit LTC homes. Some of these documents focus on changes in Canada's demographics, and how these changes are likely to impact our health system and our existing LTC infrastructure—including LTC homes that provide accommodation along with personal support and a variety of healthcare services. Other documents focus on the challenges facing the LTC workforce, and on the quality of life of residents in LTC homes.

Seniors currently account for 13% of Canada's population (Canadian Healthcare Association, 2004). Statistics Canada has reported that the number of Canadians over the age of 65 will increase from today's figure of approximately 4.3 million to 5.8 million by 2016, 6.8 million by 2021 and 8.0 million by 2026 (Duffy, 2005). In 2031, seniors will comprise about 25% of Canada's population, and the country will be delivering health

services to over 9 million seniors (Duffy, 2005; National Union of Public and General Employees, 2007). The elderly, aged 80 and over, are said to be the fastest-growing demographic segment in Canada (National Union of Public and General Employees, 2007).

The health needs of this growing segment of Canada's population are becoming complex (MacKnight et al., 2003). Most seniors experience some level and form of disability toward the end of their lives (Canadian Healthcare Association, 2004; National Union of Public and General Employees, 2007). One policy report states:

> The majority of seniors report good health, although they must cope with chronic illnesses. Of seniors living at home, 21 percent of those between 65 and 74 have reported a disability, 28 percent of those between 75 and 85 years reported a disability and over 45 percent of those 85 years and over reported a disability. (Canadian Healthcare Association, 2004, p. 45)

The implication is that Canada's health system will soon be dealing with higher levels of acuity and complexity of health services as seniors claim more of our available healthcare resources.

Many of the disabilities affecting Canadian seniors involve some form of dementia. More than 400,000 Canadians over the age of 65 (or about 8% of Canadian seniors) currently suffer from dementia (Duffy, 2005). As the baby boom generation begins to retire, these numbers are expected to increase significantly—some estimates suggest that the health system will be contending with 750,000 cases of dementia by 2031 (National Union of Public and General Employees, 2007).

These demographic trends suggest that those areas of our health system that provide services to seniors are soon to be facing new demands. In 2002, Canada had approximately 157,500 LTC beds; by 2031, as many as 740,000 LTC beds will be needed (National Union of Public and General Employees, 2007). Most seniors who enter these facilities will be seeking assistance for a range of disabilities that require constant monitoring and care, including cognitive impairment, incontinence, visual impairment, falls, and the types of impairments that often follow a stroke (Canadian Healthcare Association, 2004). For example, incontinence occurs in approximately 20% of seniors, and (as stated above) dementia affects about 8% of seniors (Canadian Healthcare Association, 2004). Moreover, dementia increases with age: it is reported in 1% of Canadians under 65 years, and 35% over 85 years (Canadian Healthcare Association, 2004).

People tend to enter LTC homes because they need support that is not available to them in their current home (Canadian Healthcare Association, 2004). However, the LTC facility is not merely a place where residents receive health services; it is also their home. Once they have been admitted, residents of LTC homes are concerned about the quality of care that they receive, but they also value group activities, friendly relationships with staff and other residents, flexible scheduling, and opportunities to leave the facility to participate in recreational events (Canadian Healthcare Association, 2004).

LTC homes must therefore deliver a wide range of services that provide for a senior's overall quality of health and life. However, LTC homes are not a full or integral part of Canada's health system. Facility-based long-term care is not covered under the Canada Health Act, and nowhere in Canada is it fully insured (Canadian Healthcare

Association, 2004). This means that a senior might receive medical treatment in a hospital and find the service covered under his/her provincial health insurance, but find that the same service in an LTC home must be paid for out of pocket (National Union of Public and General Employees, 2007).

The situation in Ontario is representative of Canada. Over 70,000 people live in LTC homes in Ontario (Smith, 2004). In 2004 there were 577 LTC homes in Ontario, with 70,100 beds. In its 2006 report, Statistics Canada indicated that Ontario's infrastructure had grown to include 644 LTC homes with 81,849 beds (Statistics Canada, 2006).

In 2004 an inquest in Toronto looked into the deaths of two LTC residents who were killed by a fellow resident suffering from dementia (Duffy, 2005). It was reported at the inquest that between 1999 and 2004 11 LTC residents were killed by other residents, and that assault cases in LTC homes rose significantly during that period. This increase in violence was attributed to the increasing numbers of dementia sufferers entering an LTC system that was not adequately prepared for them.

As a result of these reports, in 2004 the Ontario government asked Monique Smith, Parliamentary Assistant to the Minister of Health and Long Term Care, to review the province's LTC system. Her report offers a general profile of the level of care required by residents of LTC homes in Ontario: 80% of residents required mid to heavy care; 86% had some degree of incontinence; 39% required considerable assistance with eating; 72% needed help getting in and out of bed, chairs, and bathtubs; 64% suffered from some level of cognitive impairment such as dementia; and 60% needed help using the toilet (Smith, 2004). One-third of residents were found to suffer from some form of

depression or sadness. Smith's report indicates that many LTC homes placed most of their emphasis on delivering basic care, and offered little in the way of outside activities or volunteerism. Of the 577 homes that existed at the time, only 178 homes had resident councils (which allowed residents a formal vehicle for influencing the activities that occurred within the facility), and only 154 homes had family councils.

Smith (2004) summed up the pressures that were straining the existing LTC infrastructure:

> Changing demographics are placing a greater burden on long-term care facilities. The percentage of the population aged 65 years and over and aged 85 and over both almost doubled between 1961 and 2001. Seniors now enter long term care homes at a more advanced age and with greater health concerns. The number of seniors requiring tube feeding, dialysis and catheters, once rare in these homes, is rising. LTC homes are also receiving residents back sooner from surgery. The average age of a resident in long term care today is 83 years. (p. 8)

The Smith report led to the creation of a new Ontario provincial strategy for long-term care (Government of Ontario News Release, 2004). One aspect of the proposed transformation of long-term care was the fostering of a culture of community in LTC homes. The government intended to do this by requiring that all LTC homes create a Family Council and a Residents' Council, by allowing couples to live together, and by encouraging LTC homes to become more humane and less institutional (Government of Ontario News Release, 2004). In practice, the transformation involved the introduction of a rigorous compliance and inspection regime for LTC homes, and the development of new provincial legislation.

A policy document prepared by CUPE Ontario (2007) in response to the proposed legislation agrees that the existing system must undergo a transformative culture shift, but expresses concerns about the government's emphasis on monitoring and compliance:

> Our members report that they are run off their feet, stretching themselves beyond thin to provide care without enough staff, and blamed when they are unable to do the impossible. The legislation must include a recognition that the homes are both homes and workplaces; that staff should be treated as partners in setting and protecting care standards; that punishable offenses be clearly defined and communicated; that prevention of harm, not just reporting of it, be the goal; and that the culture of fear and reprisal experienced by our members be replaced with respect, democracy and transparency. (p. 11)

The gray literature produced by policy and advocacy groups contains many statements indicating concern about the ability of the existing LTC infrastructure to provide an adequate level of care, and most often this literature relates these concerns to human resource issues. Numerous agencies point to inadequate staffing levels as a root cause of the system's current malaise (Armstrong & Daly, 2004; Canadian Healthcare Association, 2004; Canadian Nurses Association, 2008; Institute for the Future of Aging Services, 2007; National Union of Public and General Employees, 2007). As the Canadian Healthcare Association (2004) asserts: "Adequate human resources are believed to be the foundation on which quality is maintained. An adequate supply of well-prepared health human resources for long-term care facilities is and should be a priority now and in future decades" (p. 70).

Most reports emphasize that the workers who provide service to residents in LTC homes are for the most part skilled and dedicated, and feel a genuine sense of care and compassion toward the residents they serve. Some healthcare workers pursue long-term careers in LTC homes, and indicate that working with the elderly is particularly rewarding (Canadian Healthcare Association, 2004). The National Union of Public and General Employees (2007) claims that most of its members are dedicated to providing care to the elderly, and to do so effectively requires patience, compassion, commitment, and advanced healthcare skills. The problem, they suggest, is not that healthcare workers are not dedicated to doing a good job, but rather that these workers are coping with unreasonably heavy workloads.

Most of the gray literature focuses on problems related to worker shortages. About 55% of nurses working in LTC homes report staff shortages in their facilities that prevent them from completing all of their required work (Canadian Nurses Association, 2008). Jobs in LTC are said to be considered low-status among the nursing professions (Canadian Healthcare Association, 2004). On top of this, caregiving protocols are becoming more demanding, staff are experiencing burnout, and quality and safety are being jeopardized (Canadian Healthcare Association, 2004). While they try to cope with an increasingly demanding workload, staff experience low self-esteem and low morale, and do not feel appreciated or recognized (Canadian Healthcare Association, 2004).

The shortage of skilled workers from several occupational categories in the LTC sector is giving rise to a variety of strains. Staff shortages make it difficult for existing staff to see to all of the needs of residents, and there is a tendency for emotional needs to be set aside while basic needs (such as bathing, dressing, feeding, etc.) are attended to.

Moreover, residents with dementia can often be difficult to work with, and staff regularly complain of violence directed against them (Canadian Healthcare Association, 2004).

Most of the staff who see to the day-to-day needs of residents fall into three occupational categories: Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Health Care Aids (HCAs). A variety of allied health professionals as well as doctors may also be available to provide care to residents. The care that is delivered in LTC settings tends to involve personal interaction rather than advanced technology, and thus the work requires the presence of skilled caregivers in adequate numbers (Canadian Healthcare Association, 2004).

As the complexity of seniors' health problems increases, LTC homes must provide more physical care for each resident, and also more therapies and programs to deal with issues such as complex dementias. Hospitals are transferring patients in need of long-term complex care to LTC homes, in order to free up scarce beds in acute care wards, and a policy shift to provide home care services in community settings has allowed people with fewer care needs to remain in their homes. This means that the ratio of high-needs seniors in LTC homes is increasing; and this places further strain on the existing workforce.

These strains are evident in a variety of ways. Canadians in health occupations miss work due to disability or illness at a rate that is 1.5 times the Canadian average (National Union of Public and General Employees, 2007). The Canadian Nurses Association (2008) reports that absenteeism is higher in LTC than in other healthcare environments, and indicates that LTC nurses tend to experience lower morale, higher turnover, and less healthy work environments. The association also reports that 47% of

nurses suggest that quality issues are attributable to inadequate staffing, that LTC nurses are more likely to report that their health is poor or fair, as compared to nurses working in hospitals (8.5% as compared to 6.4%), and that only 60% of LTC nurses had access to on-the-job training in 2001, while 95% of hospital nurses had access to on-the-job training in the same year (Canadian Nurses Association, 2008).

A 2002 survey commissioned by OPSEU and NUPGE that went to all union members working in LTC indicated that 84% of workers usually or always work alone, and 84% reported that the current workload was resulting in increased levels of stress (National Union of Public and General Employees, 2007). In 2004, CUPE conducted a study of LTC sites in Ontario to investigate the impact of workload on staff ability to complete their tasks. The study authors report that about 18% of staff say they are able to complete tasks in accordance with standards only half of the time, while about 14% say that they are never able to do so (Armstrong & Daly, 2004). The authors conclude that the existing workload for LTC staff is too high, making it impossible to provide a healthy work environment for staff or a congenial home environment for residents. The task that is most often set aside is informal interaction with residents (69.9% of their respondents identified this as the task most frequently not accomplished) (Armstrong & Daly, 2004). Staff also find that they often do not have time to give emotional support to residents (59.8% of the time), and exercising residents is also often ignored (52.3% of the time) (Armstrong & Daly, 2004). Even tasks related to basic needs can remain undone: changing beds, cleaning bathrooms, and bathing are not completed about 20% of the time (Armstrong & Daly, 2004). Perhaps most surprising, feeding residents is not completed 8.5% of the time (Armstrong & Daly, 2004). This study also found that 96.7% of

respondents had experienced a work-related illness or injury at some point during the past five years, and 96.3% reported that a violent incident had taken place in their workplace in the previous three months (National Union of Public and General Employees, 2007).

This grim picture receives at least some corroboration from academic research. Ross, Carswell, and Dalziel (2002a; 2002b) noted that LTC staff must deliver complex and challenging health services, and that the gray literature portrays these workers as overburdened and exhausted. They surmised that staff who are overworked cannot provide high quality complex care. Their study was intended to investigate the existing perceptions about the quality of the work environment in LTC, and the extent of overwork and exhaustion among LTC workers, as a first step toward developing ways of creating healthier LTC workplaces. They used a questionnaire to elicit answers from 275 health providers (including HCAs, RPNs, and RNs, with an average tenure in their current workplace of 12 years) in nine Ontario LTC homes. Their findings—which they describe as "both encouraging and disconcerting" (Ross et al., 2002b, p. 134)—suggest that LTC staff experience high levels of personal accomplishment through their work, while simultaneously experiencing high levels of emotional exhaustion. An orientation to tasks was found to be significantly higher among HCAs than RPNs and RNs (2002a), and they suggest that this routinization of caregiving may depersonalize the work and make it less satisfying. The study also found that participants reported relatively low levels of job autonomy, peer cohesion, and supervisory support (2002a). Emotional exhaustion was found to be significantly higher among HCAs than RNs and RPNs, and they speculate that this could negatively impact the quality of care provided to residents (2002b). The findings also indicate that staff tend to minimize their personal

involvement in the lives of residents, and they suggest that this is because staff are compelled to focus on the completion of tasks rather than personal interaction. At the same time, however, the findings show that staff do not depersonalize the residents (e.g. they do not refer to a resident by his/her medical condition, but rather use the resident's name), and the authors suggest that this implies that the potential remains for a more caring and compassionate delivery of care.

The provincial government has noted that quality of care in LTC homes is often not compliant with standards. Their response has been to introduce new legislation and a rigorous compliance regime that includes unscheduled inspections and a requirement that any unmet standards be corrected within a specified period of time. One of my study respondents provided me with a copy of Ontario's Long-Term Care Program Standards & Criteria (see Appendix F for a summary of this complex inventory of standards and criteria). The compliance program is based on 37 standards that are associated with 454 criteria. For example, standard 1:A deals with "Resident Safeguards: There shall be mechanisms in place to promote & support residents' rights, autonomy and decision-making." This standard is associated with 32 criteria, one of which is criteria A1.2 which states that "Residents/representatives shall be informed of opportunities to participate in their own interdisciplinary care conferences." Similarly, standard 2:B covers "Planning: Each resident's care and services shall be planned with the resident/representative through an interdisciplinary planning process." This standard is associated with 14 criteria, one of which is criteria B2.6 which states that "Each resident's plan of care shall be reviewed and where necessary revised, at least quarterly, by the physician, nursing

staff, the dietitian or food service supervisor, and other care team members as appropriate."

Organizations representing LTC workers and operators, however, have generally responded to the new legislation and compliance regime by expressing concerns that the approach is overly punitive and does not place sufficient emphasis on providing adequate resourcing and on continuous improvement. The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) that represents more than 350 organizations operating non-profit LTC homes in Ontario complains that the new legislation is "...highly detailed, prescriptive and punitive and, if implemented as drafted, will have serious implications for the viability of the not-for-profit long term care sector" (OANHSS, 2007, p. 2).

In July 2007 *The Toronto Star* reported that critics of the government suggest that the most significant change that is needed is to create a standard for the hours of care that a resident receives each day (Welsh, 2007). At present, Ontario has no such standard. Over the past three years, newspaper articles and policy briefs published by advocacy groups suggest that Ontario's current practice runs from 2.04 hours per day to 3 hours per day (Canadian Healthcare Association, 2004; Duffy, 2005; Welsh, 2007). Advocacy groups argue that the standard needs to be set somewhere within a range from 3.25 to 4.55 hours of basic care each day (Canadian Healthcare Association, 2004; Canadian Nurses Association, 2008; CUPE Ontario, 2007).

A final point worth noting is that LTC homes (their services and physical layout) have in the past been designed on the basis of a medical model, which results in layouts and routines that resemble those of a hospital (Canadian Healthcare Association, 2004).

Smith (2004) called for LTC homes to look for ways to provide a more congenial, home-like atmosphere. CUPE Ontario (2007) recognizes that LTC homes are both homes and workplaces, and argues that this fact should be reflected in a regulatory and legislative framework that focuses on comfortable and secure homes for residents and healthy and safe workplaces for staff. The Canadian Healthcare Association (2004) points out that LTC is gradually moving away from the medical model and toward a social model that provides a congenial home for residents, and that delivers care through interprofessional teams responsible for a variety of medical and social programs. The association points out that this move to a social model exists in tension with the medical approach, and suggests that the health service component of LTC must not be overlooked or downplayed.

The River Lodge's external environment is in a tumultuous state. There is talk of inappropriate behaviours (in the form of aggression and assault), worker shortages, a focus on completing basic tasks rather than on meeting the emotional needs of residents, staff burnout, and increasing system pressures (in the form of increasing numbers of seniors with more complex healthcare needs). There is also talk of the need to institute a process of cultural transformation that gives seniors and families more say over the care that is provided, that places more emphasis on providing a home-like environment in LTC homes, and that reorganizes staff into interdisciplinary teams. Staff exhibit signs of a compassionate and caring attitude toward residents, but they focus on the completion of tasks, and are sometimes unable to spend time interacting informally with residents or meeting the emotional needs of residents. Staff are absent from work at relatively high levels, and staff turnover is reported to be high. The external environment exerts pressure

on LTC homes to comply with standards, to institute a cultural transformation, and to provide a healthy workplace—and LTC homes that are already struggling to meet the daily needs of residents are expected to find the resources to participate in this broad program of transformative change.

THE RIVER LODGE'S PHYSICAL ENVIRONMENT

River Lodge is a well-established long-term care home in an urban setting in Ontario. The Lodge is part of a larger healthcare institution, which I will call Valley Health Centre. This larger institution has existed for over 100 years, and occupies several buildings in different locations in the city. Its services include complex continuing care, rehabilitation, long-term care, and palliative care. Valley Health Centre also operates family medical practices, along with a variety of clinics and specialized medical programs. The centre is supported by a foundation that raises funds for its programs, and a research institute that is affiliated with a nearby university.

The centre's main facility occupies half of a city block near the downtown area. This facility is a long, complicated nest of structures and buildings that house the corporate offices, the research institute, some of the clinics, along with a rehabilitation unit, a palliative unit, and one of the LTC facilities. There is also a cafeteria, pharmacy, gift shop, library, and a few other services and amenities. The basement contains a locker room and exercise facility for staff. The centre is in a pleasant neighbourhood. It is a short walk to a variety of shops and restaurants, and there are numerous parks and greenspaces nearby.

Through its services and facilities, the centre maintains 750 in-patient beds, and provides clinical services to more than 6,000 out-patients. The centre has approximately

2,000 employees (about half of whom are full-time) representing eleven healthcare disciplines, and receives support from more than 800 volunteers who collectively contribute more than 60,000 hours of time each year. The centre provides services in both English and French.

The centre has recently embarked on an update of its long-term strategic plan, and as part of this process the centre's management and staff identified some of the challenges that they currently face. These challenges include: (a) the increase in the number of elderly people in the general population, (b) increased complexity of care and emphasis on the management of chronic diseases, (c) the need to constantly integrate new technologies and techniques into the delivery of care, (d) increased pressure on available funds for healthcare, (e) increasing demands for accountability related to service integration and access, (f) increasing demand for community support services rather than institutional care, (g) better informed public with new expectations, (h) more complex family and social environments, and (i) significant difficulty in retaining adequate numbers of skilled staff and volunteers.

The River Lodge is located within this complex, winding facility, occupying two floors in one of the main wings. It has a capacity for 76 beds on its two floors, in both private and semi-private rooms, and during the time of this study there were 71 residents (35 on the first level and 36 on the second). The Lodge's first level provides service to residents whose cognitive functions are largely intact, but who may be experiencing a variety of physical disabilities (many residents on this floor are in wheelchairs). The second level provides services to residents whose cognitive functions are impaired, with the level of impairment ranging from slight to severe. Many residents on the second level

are living with dementia or Alzheimer's disease. The average age of residents in the Lodge is 82 years, and ages range from the mid-40s to 100. Nearly all residents are over 65 years old.

Visitors gain access to the Lodge through one of the building's main entrances. There is no reception area inside this entrance, but signs direct you to the various clinics and programs that are operated from this part of the building. This entrance area has an institutional appearance—hallways extend from the foyer in two directions; a large elevator is located on one wall; sets of doors lead to a staircase, and to two areas where clinics are operated. To reach the Lodge, signs direct you to take the elevator to one of the two levels where the Lodge is housed.

The two levels have nearly identical layouts. The elevator delivers you into a foyer facing what appears to be a nursing station—though in fact this nursing station is never staffed, and merely serves as a location for a telephone that staff can use, and as an entrance way into the locked room where medications are stored. The floor consists of one long, central hallway (which I came to call "the big hall"), and two smaller hallways at each end (the east and west halls). On one of my first visits, I wrote in my field notes that "It looks like a hospital or school, except for the somewhat elaborate, Victorian-style sconces that are attached to the walls up and down the halls (there is also the usual recessed overhead lighting). There are bulletin boards, white boards, and pictures on the walls. You can see red illuminated exit signs here and there. The floor is institutional, salmon-coloured linoleum. The nursing station counter and desk are pink. Most of the walls are covered in a textured blue and gray wallpaper. There is a drop ceiling with foam panels, like the sort you often see in finished residential basements."

The elevator and nursing station are located in the junction of the big hall with the west hall. Some chairs are positioned along the walls, including some armchairs. Sitting on the countertop at the nursing station is a large bird cage that houses a budgie—there are birdcages on both floors. Resident rooms are located in both directions along the west hall, and at one end there is a resident lounge with a television and piano; next to it is a small staff locker room. At the other end of the west hall is a secure doorway (to exit the door you must enter a security code on an electronic lock) leading to some administrative offices, including offices for the Director of Care and administrative assistant. To exit from the floor you can use one of two staircases or the elevator, but to access these exits you must first enter a security code into an electronic lock. This ensures that residents suffering from dementia are unable to leave the facility without an escort.

As you walk down the big hall, starting from the west end and moving toward the junction with the east hall, you pass on the left a room where soiled linens are stored along with other supplies, and then the chart room (both of these have electronic locks on the doors), and on your right you pass the Ward Clerk office. You then pass two resident rooms on your left and right, and then enter the central area that contains one large dining room on the left, attached to a kitchen, and two smaller dining rooms on the right. The large dining room and one of the small dining rooms have large windows looking out onto the hallway, as well as windows looking out onto the parking lots outside. As you keep going, you pass resident rooms on your right and left, as well as two bath/shower rooms. You then arrive at the junction with the east hall. Here there are several more

resident rooms, along with two lounges (on the second level one of the lounges is a chapel), and another room for soiled linens and supplies.

The ceilings of the three hallways are equipped with a series of small lights, with three lights appearing side-by-side every twenty feet or so. In each series, the lights are marked with letters: W, C, or E. There are similar-shaped lights above the doorway of each resident room. These lights, I learned, are used to direct staff toward residents who have pressed a button to indicate that they need assistance from staff. If a resident in the east hallway presses his/her call button, the light outside that resident's room begins to flash, and all of the lights in the three hallways marked with an E begin to flash. If nobody answers the call, after an elapse of time a bell begins to sound. The lights continue to flash and the bell sounds until somebody presses a button in the resident room to indicate that the call has been answered. During the day, these lights were often flashing, and the bells were often ringing.

After being on the site for approximately one week, I came to realize that two physical locations on the floors are of particular significance: the chart rooms and the central portion of the big hall (outside the large dining room). These two areas were the site of considerable interaction, and played specific roles in the work routines of staff.

The core staff for each shift—the RN, RPNs, and HCAs—gathered in the chart room at the beginning and end of each shift, to go through the morning "Report" session as they prepared for the day, and to do their end-of-shift charting. The chart rooms were nearly identical on the two floors. The walls are pale yellow, the floor a blue-gray linoleum. You enter the room by entering a code into an electronic lock (the code was unchanged during my three months on the floors). The room is dominated by two large

tables that are pushed together. Glancing around, you notice that information peppers the walls on white boards and bulletin boards; you see rows of gray binders on two portable carts; and you see more binders, books and forms on the tables and on the built-in shelving to your left. The room brims with information. Figure 2 is my rough sketch of the room's layout.

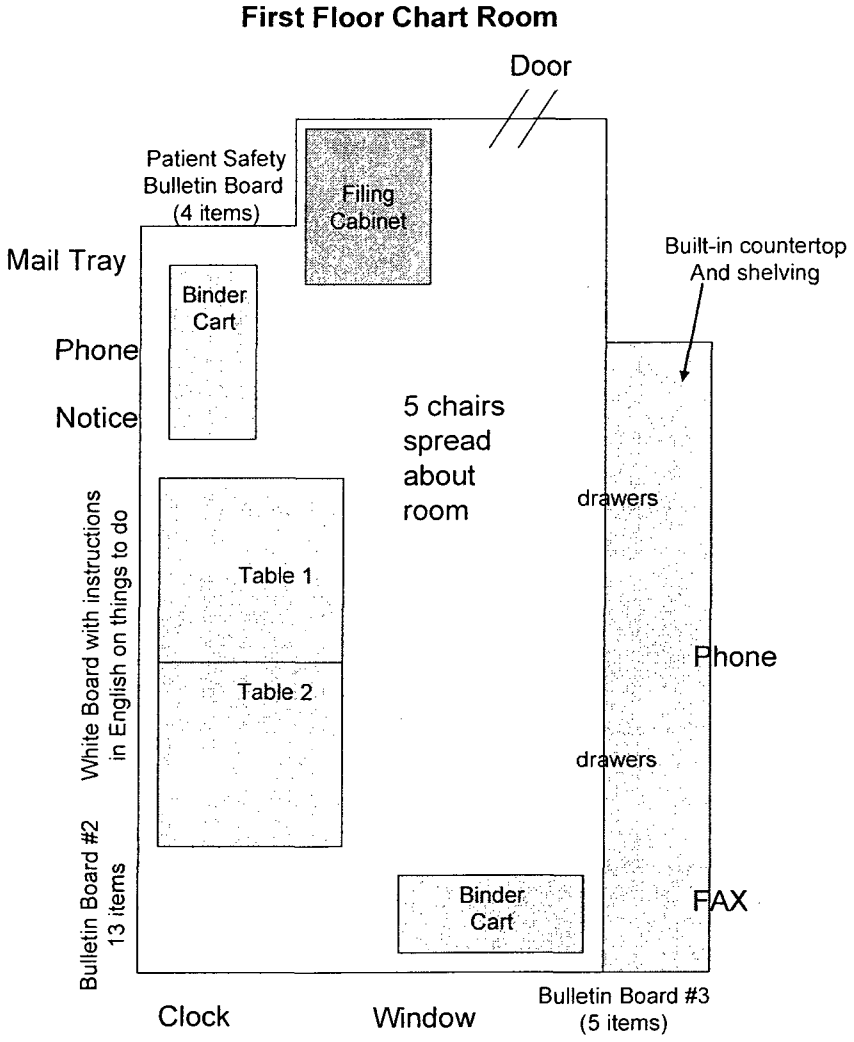

Figure 2. **The Layout of the Chart Room on Level 1**

On my first day in the room, I created the sketch in Figure 1, and made notes about the room's contents. The mail tray (attached to the wall) contained three internal

envelopes. The notice (below the mail tray in Figure 1) was a piece of paper taped to the wall, with the following message: "On June 12, recreation has planned a dairy bar activity. If you are working on that day, please plan to stay until 15:15 hours (and add it on the flow sheet). If this is not possible for you, please let the Director of Care know in advance. Thank you!" The adjacent white board contained eight messages giving directions to staff. For example, one message read: "Please check residents' clothes pockets before sending to laundry." Another message read: "All shifts please complete the MDS checklist." These white board messages remained in place for most of the time that I spent on the floors. Then one day I arrived to find that the white board had been wiped clean. It remained clean for several days, after which new notices began to gradually appear.

The two rows of built-in shelving contain numerous binders, and also a few books and some standard office supplies: stapler, Kleenex, tape, three-hole punch, etc. There were about 45 binders on the shelves, with titles such as : Resource Manual, Dementia Manual, Alzheimer Society Enhancing Care, Restraint Committee, OLD Assignment Sheets, Agenda, Emergency Plans and Procedures, Putting the PIECES Together. There was also a medical dictionary.

The binders on the two portable binder carts (there were about 20 binders on each cart) were arranged on two shelves. The top shelf and about half of the bottom shelf held gray binders labeled with the names of residents who live on the floor. The bottom shelf contained additional binders labeled with the names of doctors, and with other titles such as Interdisciplinary Communication Book.

A variety of other documents are spread out on the two tables. There are two black binders labeled "Report-East" and "Report-West." These binders contain legal-size sheets that list all of the room numbers for either the east or west end of the floor, and that leave room for the RN or RPN on a specific shift to make notes about the resident's behaviour and condition during the shift that just ended. Staff can then use these sheets to share information about a resident's situation as the week progresses. Figure 3, below, illustrates the layout of the legal-size sheets in the Report binders.

Resident	Shift	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
118	Night							
	Day							
	Evening							
120	Night							
	Day							
	Evening							
122	Night							
	Day							
	Evening							

Figure 3. **The Report Binder**

The table also contains a sheet labeled Daily Flow Sheet, which lists employee names and work assignments, and which also lists permanent employees who are on sick leave, vacation, and special assignment. There is also a stack of blank RPN Work Sheets, which gives resident room numbers for either the east or west end of the floor, and has room for the RPN to make notes about the work that is required for a specific shift. Finally, the table contains a small stack of blank papers and some pencils. I later discovered that the HCAs use these blank sheets to make their daily to-do lists, indicating

which residents they are caring for, which residents are to receive baths, and whether any residents are receiving any special attention or participating in a special activity during the shift.

The chart room is where staff can meet and talk in private, and can access information resources that are used to carry out the work of the shift. In contrast, the other area that held special significance for staff was perhaps the most public and accessible area on the floor—the central portion of the big hall, right outside the main dining room. Here one or both of the RPNs would remain stationed for much of the morning, dispensing medications from the medication carts and interacting with staff and residents. I concluded that this was a convenient post from which to dispense medications, because most residents would pass by this spot on their way to and from the dining rooms. It was also a convenient location to hold quick conversations among staff about the daily events on the floor—there were often two or three staff within speaking distance from this location. After the conclusion of the morning Report session, many of the work-related conversations among staff took place in this central location.

THE RIVER LODGE'S SOCIAL SYSTEM

I soon learned that the two floors are home to a complex social system that includes residents as well as full-time, part-time, and temporary staff representing more than seven occupational groups (I saw RNs, RPNs, HCAs, physicians, recreation therapists, physical therapists, equipment technicians, spiritual caregivers, housekeepers, and many people whom I was unable to identify). This social system was beset by a number of issues during the period of my research. The Director of Care for the Lodge, who had been in her position for less than a year, was re-assigned and was replaced by an

Acting Director of Care. One experienced RPN and the Ward Clerk were absent for extended periods due to poor health. A number of experienced workers regularly phoned to say they were ill and unable to work, and thus it was common to find temporary replacement staff on the floors—who were unfamiliar with the tasks, the workflow, and the heavy workload.

I was provided with a staffing sheet for the two floors, and from this I learned that there are six RNs available to work in the Lodge. There is one full-time and one part-time RN for each of the three shifts (the day, evening, and night shift). One RN is expected to be on duty, or available, for each shift (this is a Ministry requirement). The RN on duty is responsible for providing care within the RN scope of practice (which is set by an external licensing body) on both levels. All other staff are expected to provide care on only one of the two levels during their shift; most staff are permanently assigned to one of the two levels, but some staff were observed to work on both floors at different times (I observed one full-time and one part-time RPN working on both floors at different times, though this was rare, and I saw two HCAs regularly work on both floors).

I was provided with a copy of the River Lodge's current job description for RNs. This document states that the RN is expected to provide care that is "evidence-based." The RN interacts with an "interdisciplinary team" and is a "role model and resource" to the staff on the floors. The RN assigns tasks to HCAs and must ensure that HCAs have "adequate knowledge, skills, and information" to do their jobs. Part of the RN leadership responsibilities are to contribute to the "conduct, dissemination and uptake of nursing research." Many of the duties relate to communication and interaction on the floors and with the external environment: developing care plans in collaboration with residents,

family, and members of the interdisciplinary team; educating residents and their families; capturing information in documents as required by governing bodies and the institution; advocating for issues and changes when needed; reporting on safety issues; and serving on committees.

The RN is also responsible for ensuring the adequacy of his/her own knowledge, and for engaging in reflective practice. Reflective practice is a mandated part of maintaining a nursing licence through the College of Nurses of Ontario (2005). Reflective practice involves five steps: complete a self-assessment; obtain peer feedback; create a learning plan; implement the learning plan; and evaluate the learning and application of knowledge in practice.

The RN job description also itemizes the requirements related to collaboration and working with others. The RN is said to engage in "regular interactions" with numerous people including residents, family members, members of the interdisciplinary team, management, students, instructors, and staff from other departments. The work is said to involve "constant standing/moving or considerable heavy physical effort (5-7 hours a day)." The working conditions are described as involving "complex, emotionally charged, stressful interactions/situations" in an "environment where interruptions and need for changing priorities frequently occur." The environment also could bring the RN into contact with "illness/disease situations, toxic chemicals, fumes, dust, biological products/blood and body fluids, and antineoplastic agents of other chemical/medication preparations", and includes a "potential risk of physical and/or mental harm from patients, visitors, material and or equipment."

The Lodge's staffing sheet indicates that there are also 17 RPNs who are available to work, either full-time or part-time, on the two levels. On level 1 there are two full-time and two part-time RPNs for the day shift, and one full-time and one part-time RPN for the evening shift. On level two there are three full-time RPNs and three part-time RPNs for the day shift, and one full-time and one part-time RPN for the evening shift. The night shift on both levels is served by one full-time and two-part time RPNs.

The River Lodge's RPN job description says that the RPN is "a member of the interdisciplinary team." The RPN is required to provide evidence-based, resident-centered care. Unlike the RNs, however, the RPN focus is restricted to residents whose condition is stable. The description of RPN duties and responsibilities places considerable emphasis on communication and collaborative problem solving, and on basing interventions and treatments on evidence. The RPN is to collaborate with the RN and to educate residents and their families. The RPN's work involves documenting assessments and care and workload information in the appropriate documents or online forms. The RPN is a role model and resource for peers, HCAs, and students, and is an advocate for change when needed (including change related to evidence-based nursing practices). RPNs report unsafe practices, contribute to "the conduct, dissemination and uptake of nursing research," and serve on nursing committees. Like RNs, the RPN is expected to maintain skills through reflective practice, and is expected to use "research findings and best available evidence to support practice."

The job description also stipulates significant interaction requirements, including regular interactions with colleagues, interdisciplinary team members, management, residents, family members, students, instructors, and staff from other departments. The

work and working conditions are described in the same language used in the RN job description.

The staffing sheet states that there are 43 HCAs available to work, either full-time or part-time, on the two levels. On level 1 there are four full-time and four part-time HCAs available for the day shift, and one full-time and seven part-time HCAs for the evening shift. On level 2 there are five full-time and eight part-time HCAs for the day shift, and one full-time and nine part-time HCAs for the evening shift. The night shift on both levels is served by two full-time and two part-time HCAs.

The Lodge's job description for an HCA describes the HCA as "a member of the interdisciplinary team" who receives assignments from the RN or RPN and who plays a supportive role in providing care. The listed duties are different from those of the RN and RPN, often focusing on descriptions of specific tasks, but also including several items requiring flexibility and advanced knowledge. For example, the HCA is said to use "current knowledge of the patient/resident's condition at all times within the limits of his/her role." The HCA is expected to recognize changes in resident behaviour and unusual events, and to report these to the RPN or RN. The HCA is also expected to understand and comply "with all relevant policies and procedures, as well as the Nursing philosophy" and to act in an autonomous manner, seeking guidance when needed. The HCA helps to improve the quality of care on the floors, attends staff meetings and educational activities, and participates in the charting activities at the end of each shift. The HCA also is expected to act as a preceptor (or informal instructor who shares practical experience) to students and newly hired HCAs.

The job description states that HCAs will interact regularly with other members of the interdisciplinary team, and with patients, residents, family members, students, and staff from other departments. Interestingly, the HCA job description specifically states that the job does not involve "considerable heavy physical effort" (the job descriptions for RNs and RPNs state that they are expected to face considerable heavy physical effort), despite the fact that the HCA is responsible for providing most of the basic care for residents. Moreover, the HCA job description says nothing about having to contend with emotionally charged and stressful situations, and frequent interruptions.

Over the course of my data gathering on the two floors, I came to realize that the staffing sheet that provides the breakdown of staffing numbers for the floors cannot be taken as a stable and accurate representation of the staff available to work on the two levels. One full-time day shift RPN was present so rarely during the research period that it would seem her employment status must have changed. New HCAs and RPNs arrived frequently who were not on the list, and some people on the list were rarely (if ever) present in the Lodge.

The job descriptions of the three occupational groups that provide most of the care on the floors also give a somewhat idealized view of the way that work is accomplished. Although the job descriptions refer to an interdisciplinary team, much of the work—especially the work of the HCAs—is carried out independently, with only brief moments of interaction. During my three months on the floors, I witnessed no examples of new, evidence-based practices entering into the work of the floors. I did see examples of knowledge and experience being shared among the team, but I also

witnessed specific instances of knowledge and experience being withheld from newcomers to the floors.

The core caregivers for each floor during the day shift are the RN, RPNs, and HCAs. On the first level, the general practice is to have two RPNs and four HCAs for the day shift; on the second level, the general practice is to have two RPNs and five HCAs. The reason for the additional HCA on the second level is that most residents on that level suffer from some form of cognitive impairment, and thus are less autonomous. HCAs have more work to do on the second level, and hence an additional HCA is available during the day. During the day shift, one RN was generally present to provide service on both floors. When the regular, full-time RN was on duty, she would arrive at the start of the shift, and would actively participate in the negotiation of work assignments for the day. She would often act as a problem solver or decision maker when complex situations arose on the floors. When a temporary or part-time RN was called in for a day shift, this person would often arrive after the morning Report session was complete, and would appear to take instructions from the senior RPN on duty.

In practice, the day shift on one or both floors often carry out their duties without a full staff complement, or they have to integrate a newcomer unfamiliar with the floors and, sometimes, unfamiliar with the task regime of LTC. When I inquired about the frequent staff shortages that they experienced, I was told that this was a common occurrence, especially in the summer. Staff call in sick; staff take their summer holidays; and there is a general, overall nursing shortage in Ontario.

The pecking order on the floors was mediated by formal positions, by scope of practice rules, and by experience on the floors. All nursing staff, including the HCAs,

formally reported to the Director of Care. The Director of Care was responsible for overseeing the policies and procedures laid down by the institution (for example, work and shift assignments, vacation, training, etc.) and for progress against the objectives outlined in the strategic plan. However, for clinical situations, responsibility and accountability were determined by the scope of practice rules established by healthcare governing bodies. HCAs had limited autonomy concerning health situations, and were expected to escalate situations to either the RPN or RN. RPNs had autonomy over basic or routine provision of healthcare, and were responsible for dispensing medications. All complex health matters were referred to the RN, who when needed would summon a physician. In practice, however, experience on the floors carried considerable weight in determining who would resolve problems. I often saw temporary RNs consult with and defer to experienced RPNs over procedural matters and situations involving residents. I also often saw temporary RPNs seek advice from experienced HCAs over situations involving residents. Power and decision making within this social system were distributed in a variety of ways, and situations requiring action were resolved through a variety of channels depending on who was present on the floor when the situation presented itself.

Staff in the Lodge contend with a heavy workload. The HCAs each have from six to eight residents to care for during the day, which is a higher ratio than is found elsewhere in the Valley Health Centre and in external chronic care wards. Staff help each resident get up in the morning, help them wash and get dressed, and then escort them to the dining room for their breakfast. If a temporary HCA arrives to work on a shift, and this person is unable to carry a full workload, then somebody else on the shift has to take

on a greater load in order to get the work done. New HCAs, who are either receiving orientation to the floors or who are working their first regular shifts, are often present on the floors. I learned that these HCAs would have received the prescribed college training, and would then enter the workforce through the institution's "buddying" process. A new HCA receives, at most, one day of buddying orientation in the Lodge, and then waits for his/her first call to work an actual shift. This new HCA may not receive a call for several weeks. When they are finally called and arrive for their first shift, the regular HCAs expect the newcomers to be able to do the work with minimal support. This, however, is not what usually happens. The new HCAs cannot absorb all of the facets of the work routine in a single day of buddying, and then retain all of that information until they begin to be called for shifts. As a result, aside from delivering care to residents, the regular staff are also constantly contending with the uncertainty of newcomers.

My analysis on the pages that follow focuses largely on interactions during the day shift among the core nursing group—the RNs, RPNs, and HCAs. However, at any given moment numerous other people were often present on the floors. Housekeepers would be cleaning the rooms and hallways, and occasionally additional housekeeping staff would arrive to carry out periodic maintenance tasks such as changing lightbulbs, waxing floors, and moving furniture. During the day there were usually family members visiting on the floors, especially during mealtimes, and a small number of residents were attended to by professional caregivers who were retained by their families and who were not part of the Lodge's staff. On Wednesdays several physicians usually visited the floors to examine their patients. On most days a recreational therapist would visit one of

the floors, often to lead residents in planned activities, or to escort residents to a rooftop garden for fresh air. At mealtimes several meal helpers would be present to help feed residents who were unable to eat without assistance, and at other times volunteers might be present, helping with tasks such as distributing laundry and walking residents up and down the halls. The Lodge's administrative staff would often come onto the floors, sometimes providing a tour to a family considering the Lodge as a home for a parent or grandparent, and sometimes to obtain information from or provide information to members of the staff. There were also occasionally researchers on the floors—during the three months when I was present on the floors, two other research teams were pointed out to me at different points in time. Although people referred to the Lodge as a "home," I developed the sense that it was more akin to a neighbourhood, with numerous activities and interactions unfolding in the busy public spaces up and down the hallways.

THE DAILY ROUTINE IN THE LODGE

This study focuses on the meaning-making that was apparent during the day shift at the lodge. The day shift, I found, comprises a recurring daily routine. To give a sense of what this routine is like, I am going to describe a typical shift, from beginning to end, on one of the floors. First I will provide a brief summary of the flow of activity through the day shift, and then I will provide more detailed descriptions of the sorts of things that typically occur.

The day begins for the day shift on both levels at approximately 7:15 AM, when the RN, RPNs, and HCAs gather in the chart room for the daily Report session. At this session, the regular staff would greet each other familiarly, and would usually catch up on events in each other's lives (while I was at the Lodge, two HCAs were married, a third

was expecting the birth of a grandchild, another was anticipating a visit from a brother she had not seen in twenty years, and so on). They would determine whether they had adequate staffing to carry out the work for the day, and then would negotiate the daily task assignments. They would usually review the situation of all of the residents on the floor, and also would determine if any special activities were scheduled to occur during the shift. If an unusual medical situation had arisen concerning a resident, the RN and RPNs would occasionally confer and decide on a plan of action. This Report session usually lasted about 30 minutes.

When the session ended, the RPNs would collect their medication carts and would begin to dispense the morning medications, and the HCAs would begin to get the residents up for the day—they would give some residents partial baths at this time, and would help other residents to get dressed. By 8 AM breakfast would start to be served in the dining rooms, so the HCAs would escort the residents to the dining rooms and would get them their meal trays. By then, the meal helpers would have arrived, and they would help to serve the residents and to feed the residents who need help with their breakfast. The halls would be busy places at this time—housekeeping staff would be starting their daily routine of cleaning the rooms, the more mobile residents would be walking up and down the halls, and HCAs could be seen rushing from room to room. The RPNs by then would be dispensing their medications in the central area.

Breakfast would end at around 9:45 AM, and at this point the HCAs would give some residents their baths. Ministry regulations require that all residents receive at least two full baths per week, which means that each HCA on the day shift needs to give two or three full baths each day. HCAs would usually escort residents who are not receiving

a bath into a public area where they could sit and visit with other residents or wait to be taken to an activity, and then would focus their attention on the residents requiring a full bath.

At 10 AM a morning snack would be distributed, though it was usually difficult to discern this as a distinct and separate activity within the busy flow of work that was underway at this time. Juice or coffee and cookies might be available for residents who wanted them. At around this time HCAs would encourage some residents to go to the toilet. HCAs and RPNs would take their morning break and their lunch break during lulls in the busy routine—immediately after breakfast had been served, and just before lunch was to be served. One RPN and half of the HCAs would take a break and then return, and then the other RPN and the remaining HCAs would take their break. On some days I noticed that staff would be unable to take their breaks at the usual time, because of an increased workload.

Lunch would begin to be served at 11:45, and the halls would again be full of HCAs and residents going to and from the dining rooms. By this time the RPNs were usually finished dispensing medications, and they would be helping with the basic care needs of residents. After lunch residents would be taken to the toilet, and some were put down for a nap. Most HCAs worked a 6.5 hour shift, so at around 2 PM the HCAs would do their charting and then get ready to leave. One HCA and the RPNs would remain for another hour, until the evening shift arrived. At the end of the shift they would gather in the chart room to complete their daily charting. They might exchange information with members of the arriving evening shift, and then they would leave the floors.

A typical morning Report session

On my twenty-seventh day of observing activities on the floors, I arrived on the first level a few minutes past 7 AM, and went directly to the chartroom. Two night staff—an RN and an RPN—were finishing their charting, and an HCA from the day shift, Donna, was sitting at the table eating an apple and reading the daily work assignments sheet—she smiled at me and said hello, and then went back to her reading.

The night RN had the Report binders in front of her, along with some other binders. She also had some slips of paper. She looked through the binders, glancing at her slips of paper and at the pages in the binder, and now and then she wrote something down in the Report binder. Occasionally she looked up and asked the night RPN a question, and he responded, and she continued with her work. The night RPN was also turning pages in binders and writing things down. After a while the RPN left, and he did not return to the room. The RN also left, but she returned to the chartroom a few times before finally leaving the floor.

The day shift arrived over a period of about ten minutes. First a part-time HCA named Kelly arrived. She said hello to Donna, and to me she said "Hello, it's you. You're here today!" Then Wendy, the full-time RN, arrived, and she happily announced that this was her final day of work before starting her summer holiday. The three of them immediately became immersed in the conversation about work assignments, which I will describe momentarily. A few minutes later Sharon, an RPN, arrived, saying hello as she came in. Then Jackie, a part-time HCA who had recently been on the floor quite often, arrived, along with another part-time HCA, Sophie, who had just been married. As each person arrived, they joined in the conversation about work assignments.

This conversation began with the two HCAs, Donna and Kelly. Donna said that there were lots of part-time and replacement HCAs on the assignment sheet, and she was having difficulty in working out who the part-timers were replacing on the two floors. She needed to figure this out so she could identify who would be working on the first level that day. Once she had done this, she would be able to determine the work assignments for the shift. This was important because on the first level the HCAs tended to work in two teams—one pair of HCAs looked after the eastern end of the floor, and the other pair of HCAs looked after the western end.

The trouble was that it was not clear who Kelly was replacing. Kelly often worked on this day, a Friday, replacing one of the regular workers who liked to work on weekends, but Kelly was scheduled to be on holidays that day—so in fact another temporary HCA was scheduled to replace Kelly for the day. Kelly could not shed any light on this. She explained that she had just happened to phone the institution with a question about something else, and the person she was talking to just happened to mention that she, Kelly, was scheduled to work that day—so Kelly assumed some sort of mistake had been made, and came into work to ensure that the floor was not short. Donna and Kelly continued to study the sheet and tried to make sense of it.

When Wendy, the RN, arrived she joined in this conversation, and soon she and Donna were trying to agree on an interpretation of the work assignments for the day. The RN appeared frustrated, and then she said in a decisive tone, "All right." She looked at Kelly, Jackie, and Sophie, and asked them where they had been working lately. She wanted to know what floor they had been on, and what part of the floor (east or west). The three HCAs provided this information, and Wendy used this information to make a

decision—the three HCAs would continue to work with the residents they were most familiar with. She took the sheet, wrote down the team assignments, and then showed the sheet to Donna, who nodded in agreement. From the conversation that followed I gathered that Donna had been paired with Sophie, and Kelly was paired with Jackie.

At this point Kelly and Donna talked about a missing HCA, Dave. He had been scheduled to work that day, but had called in sick. "What's wrong with him?" Kelly asked. Donna shrugged and said, "I don't know. He's sick." The RN added, "He won't be back until September." Donna exclaimed "September!" She exchanged a look with the other HCAs. Wendy continued, "I don't think he really wants to work here. But..."

Then the second RPN arrived, a part-time RPN named Lila, and the conversation about work assignments resumed. This time they were trying to determine whether Lila would work on the second level (where she was scheduled to work) or on the first level. The RN said that a different RPN was scheduled to work on the first level, but she had been working on the second level all week, and would probably prefer to remain there. Lila said several times, with a smile on her face, that it didn't matter to her where she worked. The RN then phoned the second floor and spoke to an RPN, asking her if she would like to remain on the second level. The RN hung up the phone and told Lila that she would be staying on the first level. Lila said, "That's great. I like working here." Donna smiled at her and said, "Well that's good, because we like having you here."

At this point the RN went to a corner of the room to talk to the night RN, and the HCAs resumed the conversation about work assignments. Jackie and Sophie, who had been whispering together for the past few minutes, said that they disagreed with the assignments. They wanted to work together, they said. Donna said to Jackie, "Well,

okay, but you need to ask Wendy. She did the assignments." Jackie looked warily at the RN, who was still talking to the night nurse, and said nothing. The four HCAs quietly discussed the assignments. Jackie said to Kelly, "You ain't working with me, honey." Donna said to Kelly, "That means you'll be working with me." Kelly said, "That's fine." I did not see them consult with the RN to confirm that she approved of their decision. The key to the decision appeared to be to persuade the 'senior' HCA, Donna, to go along with this approach, and once that was done the conversation was over.

At this point, the work assignment conversation—which had gone on now for about 15 minutes—came to an end. They then shifted into the actual Report session, which involved reviewing all of the residents on the floor. This was an orderly session, but there was some whispering, and both Sharon and Wendy intervened to ask people to be quiet and pay attention—there were three interventions of this sort during the session. During Report they clustered around the table, with two HCAs and one RPN sitting, and two HCAs, one RPN, and the RN standing. Sharon began by reading the report binder for her part of the floor (the RPNs, like the HCAs, divide the floor between them, with each providing care to half the residents). She would read a resident's name and then would make one or two observations about the resident. Sometimes Donna joined in with additional information about the resident—Jackie also offered information now and then. I gathered that these HCAs had been on the floor quite a lot recently, and they used the session to pool their knowledge about specific situations concerning the residents.

For example, they spent about one minute discussing a resident who no longer rings for assistance when she needs to go to the bathroom, but instead attempts to go to the bathroom by herself. The conversation began with the RPN saying that she wasn't

sure about the resident's recent commode activity. One HCA then observed that the previous day she had found the resident walking along the hallway in a state of partial undress, and had concluded that the resident had been on the toilet and had been unable to properly dress herself afterward. The second HCA offered another observation, to the effect that she had recently gone into that resident's room and had found the resident on the toilet, and had asked, "How long have you been there?" The resident had been unable to answer. The RN observed that until this past week the resident had not minded ringing for assistance, but now she had stopped. They came to no firm conclusion about this, but merely shared these observations. The RPN concluded this review of the resident by saying that the resident would need to be observed.

Sharon also pointed out to Wendy that a resident's rash was quite bad, and she asked the RN to take a look at it during the shift. The RN asked the RPN to explain what she had observed, and Sharon began to reply. Wendy then rolled her eyes and said, "Oh yeah, you told me this already." She shook her head, seemingly exasperated with herself, and Sharon said, "Yes, on Wednesday." The implication was that the RN had been too busy over the past few days and had forgotten about this situation. Wendy said, "OK, I will check her this morning. Put her last on your bath list." This was said to the HCAs who were assigned to that part of the floor. "I will go upstairs to see if the doctor has come, and if not then I will come right back down to check her."

Another situation concerned a resident whose dosage of medication had been changed. After Sharon read this resident's name from the Report binder, the RN interrupted, saying that they were supposed to monitor how the resident responded to the new dosage. Sharon acknowledged this and said she would take the resident for the day

(meaning that she would provide the basic care for the resident, including getting her up, taking her to the dining room, and seeing to her other basic needs), and would keep an eye on her. A fourth example concerned a male resident who had been anxious during the night and had pressed his bell three times. One of the HCAs said, "Didn't he go out yesterday?" The RN replied, "Yeah, he had an eye appointment." They nodded, as if this explained his restlessness.

After Sharon finished going through the residents in her binder, she looked at Lila. Lila said, "Would you like to go over the east side?" Sharon said, "No, that's yours." Lila picked up the other Report binder and went through it. She went into less detail than Sharon, but nonetheless she did highlight a few resident situations.

After Lila finished with her binder, Sharon said "Is there anything in the agenda?" The RN had moved over to the agenda binder and was bent over it, reading. She replied, "I am just looking." She read some things out loud, but the room had erupted into conversations. Sharon said to the HCAs, "Be quiet please. She is reading the agenda." The conversations ended and everyone listened.

The RN said that there was a picnic scheduled for that day. The HCAs wanted to know what this meant. Was it to be outside or inside? How many residents were involved? Sophie pointed out that it was extremely humid, and this wasn't good for some residents. The RN agreed and said that "she"—meaning the recreation coordinator—should really check with them before scheduling something like this. "When it is a barbecue right outside the doors," she said, "we have control over who goes and who doesn't go, but this is not under our control. She should check with us." One HCA said that they might have to stay late because of the picnic. Jackie said she was not staying

after 2:15. Then somebody read out that the picnic was scheduled for 11 AM. The HCAs appeared to conclude that this would not impact their shift times, and the subject was dropped.

During this time there were a number of personal or small conversations, and at times the room was very noisy. In particular, I noticed the night nurse conferring with Wendy, saying a resident's name a few times. The conversation moved back and forth between French and English.

At the end of Report Donna asked Sharon, "Who are you taking?" Sharon replied, "I will take ..." and she said the names of two residents. It was customary for the RPNs to provide basic care to one or two of the residents each day. This helped relieve some of the workload pressure from the HCAs, and also allowed the RPNs to keep a closer eye on the residents with the most serious medical conditions. These assignments were generally agreed upon at the end of each Report session.

Over the course of the session there was some joking about holidays. The RN mentioned three times that this was her final day of work before beginning three weeks of vacation. One part-time HCA said that she would soon be taking six months of holidays. Somebody joked that she must have acquired a new source of income, and another piped in that she had just acquired a husband. They all laughed at that. Then someone said that her husband was working overseas, and what good is a husband overseas? The new bride replied by saying that he has a good contract there. Kelly said a few times that she was supposed to be on holidays today, but had been called in for some reason.

During the formal part of the report session, when the RPNs read from the Report binders, everyone was either sitting at or standing around the tables. This particular

group of workers were all permanent employees (one full-time RN, RPN, and HCA, one part-time RPN, and three part-time HCAs), and they had considerable experience working with each other and with these residents. During the session, one HCA stood directly behind another, with her hands on the shoulder of her seated colleague. Another stood between two seated HCAs, leaning forward slightly to see the pages of the report binder. The RN stood at one end of the two tables, fanning herself with a sheet of paper. An RPN stood beside her, and a little pantomime ensued with the RN fanning the two of them. The group formed a tight cluster.

This contrasted with occasions when newcomers were present (temporary or on-call HCAs who came to fill in for absent permanent staff). Newcomers were treated with minimal (or even no) courtesy. They were often left to stand alone on the periphery of the group. People often did not introduce themselves to newcomers. Little effort was usually made to include newcomers in the conversation.

The general flow of the conversation during this Report session was typical of the seventeen sessions that I observed. Staff would engage in friendly, sociable banter as the team assembled. They would consider whether they had enough staff to complete the tasks assigned to them for the day, and if they were short they would check with the other floor to see if extra staff had arrived there. If not, the RN or an RPN would telephone the staffing office and would ask that another HCA or RPN be called in for the day.

They would then spend time negotiating their specific work assignments. If the shift included regular, permanent staff, this would sometimes be skipped—people would work with their usual teammates, in their usual locations on the floor. However, if a part-time person or a newcomer was present, staff would discuss and negotiate where they

would work, and with whom they would work. The factors that influenced these discussions included preferences concerning teammates, preferences of residents for being looked after by certain staff members, familiarity with residents in different parts of the floor, willingness of permanent staff to act as a "buddy" and "preceptor" for newcomers, and having been present on a certain part of the floor for the previous few days.

The report session itself generally involved the two RPNs carrying out a resident-by-resident review, using the two Report binders (one binder for the eastern part of the floor, and one for the western part) as a way of reviewing each resident's situation over the past few days. Sometimes this review was done in a formal manner, with the HCAs listening while the RPNs took turns going through their binders. Sometimes the review was handled by the RN, with the RPNs listening along with the HCAs. Once, when there was no RN on the floor as of yet, and when both RPNs were part-time staff, the review consisted of the HCAs quietly thumbing through the binders on their own, and making their own notes.

The session usually ended with a review of the daily agenda binder, to determine if any special events were planned for the day. Special events could involve a special recreation activity for residents (such as a picnic or barbecue), training for staff, or a special assignment for one of the staff. Staff were often surprised to learn that special events were to take place, or that they had been given a special assignment for the day. This review of the agenda could sometimes trigger additional conversations. For example, on one occasion when a dairy bar event was scheduled, an HCA said that the daughter of one of the residents had said that she wanted her mother to participate in the

dairy bar, which meant that the resident would have a more active day than usual. In the ensuing conversation, it seemed that some staff interpreted this as meaning that the daughter was forcing staff to make the resident's decision for her. An RPN said, "Well, we can suggest to her that she go, but if she doesn't want to go then we cannot force her."

Throughout the report session there would also be quiet conversations and conferences between two or three people. The Ward Clerk would often enter the room to distribute papers or to make an announcement. Sometimes the recreation coordinator would be present, to explain what was involved in one of the scheduled activities for the day. Sometimes a physician or therapist would put in an appearance. During all of the time that I spent at the site, I never saw a resident admitted to the chartroom, although on three occasions I saw residents standing outside the door, quietly knocking.

Implementing the plans developed during Report

The activities that ensued after the conclusion of the report session were a curious blend of the routine and the surprising. The tasks that had to be carried out were clearly laid down for staff, and after a week or so of observing activities on the floors it was possible to discern the regular flow of activity from hour to hour. At the same time, the residents could bring surprise and variety to the routines of the floor, and the numerous people who would pass through the floor—including visitors, therapists, doctors, spiritual care workers, and researchers—brought variety to the day.

It was evident that staff worked hard. The HCAs spent much of their time inside resident rooms or inside the bathing rooms, and when they did emerge into the hallways they usually walked briskly—sometimes at the pace of a race walker, and sometimes even breaking into a run—to their next task. RPNs spent the first part of the shift

dispensing medications to about 17 residents, and they would be concentrating on this task while also answering questions and providing help for the HCAs, meal helpers, and volunteers. Staff frequently shifted from task to task. Conversations were brief. I often saw staff sighing as they worked. They would frequently interrupt each other, asking for help with a specific task. I often observed staff ask each other for help with moving a resident from a bed to a wheelchair, or from a wheelchair back into bed. On three occasions I witnessed staff approach each other for help in dealing with a resident who was behaving aggressively.

RPNs and HCAs also joked with each other, usually creating humour out of their shared predicament of delivering care with insufficient resources. On one occasion an RPN in the big hall told a few of us that she was having a "The Gods Must Be Crazy" sort of day. She was referring to a popular film of several years ago, and I gathered that what she meant by this image was that odd little things were happening on the floor which served to make her morning somewhat hectic. She was in a good humour (smiling and making little jokes), but she also rolled her eyes or raised her eyebrows a few times after residents spoke to her. I asked her why the day was unusual, and she told me that a new person was being oriented on the floor. The presence of newcomers, I learned, who were unfamiliar with the routines, the people on the floor, and the informal rules of behaviour, could result in unexpected situations.

After the conclusion of the report session, the chartroom would quickly empty. Sometimes an HCA would want advice from the RPN who was working on his/her side of the floor, but usually the entire team moved immediately into working on the initial tasks of the day. At first the floor might seem very quiet. The big hall would be largely

empty. The RPNs would be in the medication room preparing their medication carts, and the HCAs would be in resident rooms. A few residents might have been washed and dressed by the night shift, and they might be having an early breakfast. Otherwise, there would be no sign of activity for a few minutes. Soon, however, the floor would come to life. HCA's would occasionally emerge from a resident room with a bundle of soiled linen, which they would deposit in the soiled linen bins—these were sometimes sitting out in the hallways, and were sometimes kept inside a room with a closed door. The RN might emerge from the chart room and go over to a white board located between the chart room and the supply room, and then write down the daily assignments so everyone visiting the floor would know where the staff were working for the day. This white board was sometimes updated in the morning, and sometimes it would not be updated for two or three days. The regular housekeeping person assigned to the floor would usually be seen pushing her cart from doorway to doorway; she would go inside each room for several minutes, carrying out her cleaning duties. Then the RPNs, first one and then the other, would appear, wheeling a resident to the dining rooms, after which they both returned to the medication room and then pushed their medication carts into the big hall. There they would remain for the next few hours, flipping through their pill binders and dispensing medications. Maintenance staff would often begin to arrive on the floor at this time, sometimes to confer over planned jobs somewhere on the floor, and sometimes to carry out specific tasks—changing lightbulbs, moving furniture, delivering wheelchairs, painting rooms, and so on. The maintenance staff were usually friendly, exchanging jokes with the housekeepers and HCAs.

Voices could be heard from the resident rooms. One morning I heard an HCA calling out from a nearby room, "Fred! Fred! We are having breakfast here! Mr. Smith! Banana! Banana!" This went on for several minutes. Down the long hall I would often hear a brief moment of screeching from a resident who was experiencing some distress and was unable to communicate her meaning with words.

At about 9:45 AM, after breakfast was ending, the HCAs seemed to "park" the residents at various places out in the hallways. HCAs would wheel residents into the central area near the elevators, or into one of the lounges, and leave them there. Soon afterward the HCAs would take their morning break. The breakfast rush was over, and things were often quiet for a while.

At about 9:50 or 10 AM a member of the recreation staff would often arrive, sometimes with some CDs or a DVD. One morning the recreation coordinator called out to the residents sitting in the central area, "Is everybody ready for some music?" One resident said "Oh yes." The recreation director wheeled or led people into the lounge. She would ask them first if they wanted to listen to some music. Most went along with her. A few resisted by saying no, or not yet. The activity might last for about an hour, after which HCAs and the recreation coordinator would wheel or lead residents back to their rooms. The hallways would become very quiet again.

HCAs and the RPNs could often be seen talking to each other, but briefly—quick exchanges about tasks or situations that they had encountered so far that day. One day, for example, two HCAs were talking about a resident's upcoming visit to a beauty salon. One HCA was telling the other how to find the salon, and then told her that the resident

liked to order some take-out food after visiting the salon. The exchange lasted about one minute, and involved the sharing of information related to the performance of a task.

On another occasion, while I was observing from the central area near the elevators, a resident sitting on one of the armchairs in this area was feeling ill, and vomited on the floor. An HCA witnessed this and called out to the RPN and HCAs who were close at hand, reporting the mishap, and an exchange then took place to identify who would clean it up. The situation was not resolved, and the HCAs and RPN went back to their tasks. A moment later a different HCA walked through the central area, noticed the mess on the floor. She fetched a cloth from the supply room and cleaned the mess, and then returned to her tasks.

Every now and then the call lights would flash and, after a few moments, the alarms would begin to sound. Often it would seem that staff took no notice of these signals. Sometimes lights and buzzers would be sounding for the east, west, and central areas, indicating that at least three residents were asking for assistance. I occasionally noticed staff responding to these signals. On one occasion I was standing at the west end of the big hall. I could hear an HCA working with a resident, getting her dressed for the day. It sounded as though the resident was being rather particular about what she wanted to do (she wanted to be washed and dressed in a particular order). The HCA responded pleasantly, but also indicated firmly that she had lots of work to do and needed the resident to cooperate. Meanwhile, a call light for the west hallway began to flash, and a minute or so later the beeper began to sound. After three or four minutes the RPN who was dispensing medications in the centre of the big hall walked down toward me. She remarked to me that the beeper had been going for quite awhile. She looked down the

west hall and saw the source, and then went to the doorway where the HCA was working and said "Can you go and see what Mrs. Jones wants?" The HCA replied, "I can't right now, I'm busy." The RPN went back to the centre of the big hall, and a few minutes later she came back. "I'm going to check on Mrs. Jones," she said. "Thanks," said the HCA. Their tones were matter-of-fact. A few minutes later the RPN came out of Mrs. Jones's room and again paused in the doorway where the HCA was working. "She wanted the bedrail up. The one on the side where she gets into bed." "That's what she wanted?" "Yeah, that was all. I'm just telling you so... so you won't put it down again." The RPN's tone was matter-of fact.

A final example of the exchanges that occur throughout the day concerned a conversation about the death of a resident. It began with an RPN remarking to two HCAs that the other floor had "lost someone" the previous day. There was some confusion about what she meant, and the HCAs quickly established that a resident on the second level had died. The group discussed this quietly for about five minutes, and as they talked another HCA and the temporary RN joined them. The RPN said that the resident died at the end of yesterday's day shift. The HCAs wanted to know who it was, and the RPN told them the resident's name. The HCAs then tried to identify the person, and eventually they agreed that it must be "the little frail man at the far end of the west hall." Everybody in the group participated in the conversation, saying things like: "He went fast." "That was fast." "That is the way to go: fast." "I just fed him." "You won't be feeding him today." The participants in the conversation tried to establish a coherent account of the circumstances surrounding the death (his breathing had been poor all day, a procedure was carried out, his breathing worsened, then it was over), and they laid

emphasis on the indicators of the resident's condition (especially his breathing). There was also some talk about the tasks that would now need to be carried out—the RPN reassured the temporary RN, saying that the upstairs RPN would probably handle most of these tasks.

By 11:10 it was often quiet on the floors, and the HCAs and RPNs would take their lunch break. When they returned to the floor they would begin to take the residents into the dining rooms for their lunch. The three dining rooms would be full of people, residents, HCAs, and meal helpers, and on one of the floors I often saw two residents eating in the hallway outside the kitchen. I asked an RPN why these residents ate in the hallway, and she told me it was because these two residents often caused a fuss if they ate in the dining rooms. One of these residents suffered from dementia, and constantly asked questions or asked people to do things for her. Her requests were ceaseless, and if somebody responded to a request she would almost immediately forget what the person had said and would repeat her request. Residents had expressed frustration with this, and so the staff had decided to have the resident eat her lunch at a table in the hallway, next to the area where the RPNs were distributing medications. The other resident was said to be bad tempered, and she would often criticize other residents, and say things that would result in hurt feelings. The other residents had also complained about this person, and so she too was required to take her meals in the hallway.

Some residents prefer to take their meals in their rooms, but the staff discourage this. The Ministry requires that residents have a home-like experience during mealtime, which means that they are required to take their meals in the dining rooms. Most residents do go into the dining rooms for their meals, but I would usually see some meal

trays being taken along the hallways and into a resident's room. One resident liked to eat by herself in one of the lounges, and staff permitted this.

By 1:15 lunch would generally be finished. Staff would be wheeling the last residents back to their rooms, or into a public area. Visitors who had come to help a relative or friend with lunch might be seen wheeling or walking residents up and down the halls. One afternoon I counted eleven people in the central area near the elevator and in the big hallway at around this time.

Most residents get around in wheelchairs. A few walk with the help of a walker, and a very few are able to walk without assistance (though most of them make use of the handrails that line both sides of the hallways). People pushed the wheelchairs from behind, or sometimes they walked beside the resident holding their hand and pulling them along. They moved very slowly.

Moments of surprise

The floors are also given to moments of surprise, where situations outside the basic task routine attract the attention of residents, staff, and visitors.

One day I was observing events in the big hall. Near me a female resident sat in a wheelchair. Every now and then (once or twice per minute) she stamped her slippered foot on the floor and let out a screech. One hand clutched her neck. She was wearing a blue bathrobe, and she had a look of sadness or perhaps distress on her face. She pushed herself around slightly in the wheelchair, backing into a dining room, and then she came out again, all the while putting on her performance. She was very loud. The RPNs and HCAs were present on the floor, concentrating on their work, and they did not intervene with the resident.

While this was going on, another resident—a tiny, frail-looking woman who often roamed up and down the hallways with the assistance of a walker, and who was known to have a temper—began to make her way slowly down the hall in her walker. As she walked by the resident who was screeching, she muttered something and made a gesture as if she was going to hit the resident who was making the noise. An HCA was standing nearby, and she intervened and prevented the blow from being struck. The tiny, angry resident, unrepentant, continued down the hall toward me, a glower on her face, muttering to herself. The HCA raised her eyebrows and went back to her task. Meanwhile, another female resident was coming toward me in a walker from the other direction. The angry resident saw her and moved to intercept her directly in front of me. The other resident tried to get around this little blockade, but the angry resident moved to block her again. Then the angry resident raised her arm, as if she was going to hit the other lady, and I extended my arm to prevent the blow. The angry resident backed off, but continued to glower and mutter; the other lady now appeared agitated, and pushed her walker back and forth, as if to say "Make way!" The two of them went on their way.

A few minutes later the angry resident returned and went past me again, muttering as she went by the screeching resident. She sat down in one of the easy chairs in the central area—right next to the lady in the walker she had almost hit. They ignored each other. The screeching resident continued to express her distress, and after ten minutes the angry resident got to her feet and came back along the big hall with her walker. She stared with malignancy at the noisy resident, and moved toward her slowly. When the angry resident was within twenty feet of the noisy resident, she began to mutter and nod her head. At this point an HCA came on the scene, and positioned herself in front of the

noisy resident. The angry resident, glowering, continued on her way and went into the dining room.

On another occasion I was standing beside an RPN in the big hall when a resident came down the hall and stopped by the medication cart. The RPN said good morning to her, and then said, "You're not wearing shoes. Where are your shoes?" The resident replied that she didn't know. Another resident walked by, going the other way, and she said, "You left your shoes in the lounge last night. They will still be there, because they weren't going to walk off on their own." At that moment, an HCA came along the hall with a pair of white sneakers. The RPN said, "Here you go, here are your shoes." The RPN and HCA helped her to put her shoes on, and then the HCA ran a hand through the resident's hair. "Nights got her up," she said, shaking her head as though she disapproved of the job they had done. "I'll fix her up after I get her to the table." The two of them continued down the hall to the dining room.

One morning I stood in the central area between two medication carts, and listened to one of the RPNs talk about working in the Lodge. First she talked about the role of planning in the Lodge. She said that in nursing you can try to make plans, but in the end planning doesn't work. A nurse never knows what is going to happen. She explained, "You have to be ready for anything. Planning is good. It is good to do your planning. But then when you start to work, anything can happen, and you have to be ready. You have to be focused on here and now, and you have to deal with the situation that comes along. You have to deal with what is in front of you, not what you have written down in some plan." She concentrated on her task for a few moments, and then she continued. "I love working with old people. They have so much to say. I love

listening to them and hearing their stories." Then she said, "In twenty years of nursing, I have only met one truly bad soul." She told a story about working in a rehabilitation unit, and of encountering a woman who, in the short period of time she was there, hurt many people. But she said that this was the only wicked person she had encountered, and that most others have been decent and good. Then she shared her philosophy of living. She said, "I keep my home stuff at home, and my work stuff at work." She said that she separates things, and as she said this she made little chopping gestures with one hand, indicating separate areas. "I don't let my troubles in one place affect what happens in the other place." She then told another story. "I had one patient who had broken a bone in his lower leg, and that was painful. He was mean to me when I worked with him. But he wasn't really angry with me. He was in pain and was just angry. I had to explain it to him. I said, look, why are you mad at me? I am here to help you. I am here to work with you. I didn't hurt you. I don't want to hurt you, I want to help you. So stop being like this to me. We need to work together on this. And it worked." Then she expanded on this, saying that the same rule—that you do not apply your anger to people who have nothing to do with your problem or your pain—applies to herself. "When I have a problem at home, I can't bring it in here and take it out on the patients." All the while she was working at her medication cart, preparing medications for her residents. She was gesturing, taking a step this way, then a step that way, very animated.

A final example occurred on a day when staff seemed preoccupied and quiet, while some of the residents were unusually active. I observed the following situation in the big hall. An elderly man was wheeling himself up and down the big hall, and he stopped to talk to me now and then. His son had been away at a business convention, and

had just returned to town. The man seemed distraught—he told me he expected to see his wife and son that day, and wondered when they would arrive. He stopped two volunteers who walked by him, asking if they would help him to phone his wife. Both volunteers said they were unable to help him. He seemed frustrated by this. A little later he said to me, "You want to know about the communication system here? It stinks. You writing a report? Don't hesitate. Put it there. You can quote me."

THE EDEN ALTERNATIVE

While I was conducting research at the Lodge, I learned that for several years some members of the management and frontline team had been endeavoring to introduce a new philosophy of long-term care onto the floors. This philosophy, known as the Eden Alternative, calls for the creation of a less institutional and more humane and compassionate environment in LTC homes (Sawyer & Rurak, 2004; Thomas, W.H., 1996). The philosophy was developed by an American physician, Dr. William Thomas, in the 1990s, after he noticed the loneliness and boredom that many LTC residents experience. His philosophy claims to offer a way of eliminating the sense of boredom, helplessness, and loneliness which he says are usually present among the residents of LTC homes.

To bring about these changes, the Eden Alternative offers a plan to transform the prevailing culture of LTC homes from one of hierarchy, task-orientation, and bureaucracy to one of empowerment and autonomy. Eden homes are said to be characterized by the presence of pets, children, and plants. Residents in an Eden home are encouraged to help provide care to their peers, and to perform some tasks to maintain and improve their homes. They also participate in day-to-day decision making.

Caregivers in an Eden home work at a variety of tasks throughout the day, and always focus their efforts on the needs and desires of residents. Eden caregivers are organized into autonomous, empowered teams that handle a wide variety of tasks (more than is allowed for by the scope of practice rules used in the Lodge). Caregivers are expected to place considerable emphasis on interacting in a friendly and informal way with residents, and on helping to dispel the loneliness, boredom, and hopelessness that LTC residents often experience.

The Eden Alternative is not without its critics. A report commissioned by the CUPE Health Care Council states that the philosophy looks good in theory, but that it can produce negative impacts on the work environment in an LTC home (CUPE, 2000). The report argues that in order for the Eden Alternative to be fully and properly implemented, additional resources must be made available to ensure an adequate ratio of staff to residents. Otherwise, staff will find that their workload has increased, and that they are able to spend even less time interacting with residents. The report concludes:

> Most of workers' complaints about the Eden Alternative centre on the issue of understaffing. Often, staffing numbers are not increased in proportion to the new workload, which includes caring for animals, birds, plant and gardens, and the coordination of resident activities with children. The residents' more relaxed schedule also increases the workload. (p. 2)

Over the course of my research, I learned that the Lodge has had a curious experience of implementing the Eden philosophy. Though the implementation has been underway for approximately five years, and receives support from management and many members of the frontline team, little progress has been made.

I had many informal conversations with research participants about Eden, and conducted 14 formal interviews that focused entirely or partly on the Lodge's experience with Eden. I also attended the one meeting of the Lodge's Eden Implementation Committee that took place during my time at the Lodge. I visited those areas of the Lodge that had been improved using the Eden principles, including the rooftop garden and the lounges. I also examined the Eden documentation that is located in the two chartrooms, and on the bulletin boards in the hallways.

Many people at all levels of the organization express support for the Eden philosophy, and say that the creation of a home-like environment in the Lodge is a good idea. When I asked for examples of how Eden is promoting change within the Lodge, I was always pointed to specific, concrete achievements (only one staff member spoke of Eden in terms of a cultural transformation, and one insider/outsider described Eden as a paradigm shift). For example, people pointed to the occasional use of china teacups and ceramic mugs (instead of paper cups) in the dining rooms, and said they liked the use of personal furniture in resident rooms. They described home-like touches such as having TVs in the dining room and lounge, and the new room decorations (such as paint, flooring and curtains) that were being put in place. One person told me that some residents have plants in their rooms, and another said that special activities are offered such as afternoon teas or special breakfasts.

Some people pointed out that the Eden philosophy was more relevant for the first level of the Lodge, where residents are alert and able to make choices for themselves, and less relevant on the second level where most resident are living with some level of cognitive impairment. Curiously, I was also told that Eden was making more headway

on the second level than the first, and this was attributed to the fact that two RPNs on the second level are vocal supporters of Eden, whereas on the first level the most prominent supporters are two of the full-time HCAs.

Although most people said that they liked the focus that Eden brings to the needs of residents, many also indicated that the existing workload is already demanding, and that Eden could require that staff take on additional duties such as washing dishes and looking after pets and plants. Respondents indicated that this could mean that staff would have less time to provide emotional support for residents, and this would be an unfortunate consequence of implementing Eden.

Most of the people I spoke with indicated that the Eden implementation, now in its fifth year, has for the most part been slow and challenging. Several people told me that staff workload makes it difficult and often impossible to provide a type of care that resembles the sorts of things that happen in a home (home-like meals, choosing what time to get up in the morning and what time to have your meals, and so on). Some staff indicated that they would not mind performing tasks such as washing dishes, but they do not have time to take on additional work given the way the work is currently organized. I was told several times that the slow pace of implementation is due partly to the negative attitudes of some staff, and partly to changes in leadership team membership which has resulted in inconsistent support from the top of the hierarchy.

I was also told that the Eden implementation is being led by an Eden Implementation Committee, whose members include representatives from the RPNs, therapists, and management. Although I was told that some HCAs have been appointed to the committee, their workloads and assignments prevent them from attending the

meetings. The committee meets once every two months, and meeting minutes are distributed on both floors. There is an Eden binder with the minutes on each floor, which also contains the ten Eden principles and information about how to implement Eden in a LTC home. Committee members support Eden, though at least one member believes that Eden needs to undergo considerable adaptation to make it relevant for the Lodge. The committee is not always able to move their messages successfully onto the floors. Some people told me that without participation by HCAs it will be very difficult to encourage the adoption of Eden in the Lodge.

People working in the Lodge claim that the biggest barrier to the implementation of Eden is the attitude of staff. As one interview participant put it: "The biggest barrier is attitude. People don't like change." This opinion was shared by several others. One explanation was that many staff members have worked on the floors for a several years, and have always done the same work in the same fashion, and they are not interested in seeing their work routines altered. Some staff specifically say that they do not want to take on new and additional tasks. Change is automatically assumed to mean "more work." Some staff have made it clear that they are not willing to do any additional work, even if that additional work would make the Lodge more pleasant for residents.

Several people also said that formal education sessions are rarely available to staff on the floors, in part because they have to work so hard to get their tasks completed. I heard many times that staff simply do not have the time to consider and act on new information. When something new appears on the floors—a change of some sort—there is said to be an automatic tendency to say "no" to the change and to resist it. Staff say

that they do not have time to talk with lonely residents, and must work hard to finish their tasks within the required timeframe.

Another barrier that people told me about had to do with the large numbers of temporary workers, part-time workers, and newcomers who are on the floors each day. For Eden to become part of the Lodge's culture, these people would all need to be educated about Eden and about how they should operate in an Eden environment. The training and orientation challenge for Eden is thus extensive, and I was told that the Lodge has not found a way to address this.

Some people on the floors believe that the Lodge is genuinely interested in implementing Eden, and is capable of making a change of this sort. Three interview participants told me that senior management, both in the Lodge and in the Valley Health Centre, have shown support for the adoption of a patient-centered philosophy of care; a fourth said that the Eden change is supported by the broader organization. However, two respondents indicated that it is not clear that the organization is prepared to move forward quickly with the change. Others said that despite the espoused support for adopting more humanistic approaches to caregiving, the LTC home is often neglected by the Valley Health Centre. Two people told me that the LTC home is low on the senior management's priorities, as is evident from senior management's lack of knowledge about what is going on in the Lodge. The CEO was recently asked a question about Eden by an employee, and he responded by saying that he is not aware of what is involved in Eden. I was even told that a rumour was circulating to the effect that management was considering selling the Lodge to another organization.

THE LODGE AS A REPRESENTATIVE LTC HOME

Over the course of my research, I attempted to determine whether the River Lodge could be described as a representative LTC home. I did this by identifying people who had experience of several LTC homes in addition to the Lodge, and then asking them how the Lodge compared to other homes. I was always told that the caregiving routines in the Lodge are very similar to the routines used in other LTC homes, because these routines are essentially mandated by the Ministry. For example, most LTC homes follow a routine that is essentially the same as that followed in the Lodge: the day begins with a Report session, and is followed by a regular sequence of tasks. The staff-resident ratios, and the challenges related to completing a difficult list of tasks within a limited timeframe, are said to be similar in all Ontario LTC homes. The type and number of employees who provide basic care—including one RN, a small number of RPNs, and a larger number of HCAs—is representative of LTC homes.

However, I was also told that the Lodge did have some unique characteristics that are attributable to its affiliation with and proximity to a larger healthcare organization. For example, unlike most LTC homes, there is no main entrance to the Lodge; instead, the entrance is shared by other programs run by the Valley Health Centre. The Lodge is not housed within a stand-alone building, but rather occupies two floors of a larger institution. This affiliation with the Valley Health Centre is perceived to bring certain benefits—for example, the Lodge is able to make use of some of the medical facilities and programs within the centre. This means that when a physician requires that some lab work be completed for a resident, the centre's lab technician can come onto the floor and

take the required samples. In other LTC homes, the resident would usually have to be transported to an external lab where the samples would be taken.

The Lodge uses a variety of resources from the Valley Health Centre—the kitchen, for example, and housekeeping and maintenance staff and equipment. There is no facilities manager who is fully dedicated to the Lodge, because this function is related to the entire institution. Perhaps most significantly, the Lodge's meal service is based on a tray system that is highly unusual in LTC. The Lodge occupies two floors within the larger institution, and does not have its own kitchen or dietary service, so food is brought in from the Valley Health Centre's main kitchen. This means that the meal service in the Lodge resembles that of a hospital, and this is not considered to be compliant by the Ministry's regulations. Lodge staff are expected to remove the food from the trays and to serve the residents one course at a time, but this creates problems for staff—there is no room for the trays to be placed, other than in front of the residents at their tables, and so unloading the trays is impossible.

The affiliation with the Valley Health Centre also means that if the Lodge needs to develop and incorporate a policy to remain compliant with Ministry regulations, they are not able to simply enact a policy through their internal discussions and deliberations. Instead, they must submit a request up the centre's organizational hierarchy, and must negotiate a policy statement that complies with Ministry requirements and is also congruent with the centre's policies. In some cases the centre's policies are adapted to the Lodge, so that a larger policy on a subject such as the use of restraints may contain a provision that is developed for and applies only to the Lodge.

CONCLUSION

The environment in which staff of the River Lodge carry out their meaning-making exhibits numerous strains. Heavy workloads combined with a short, 6.5 hour shift create a situation in which staff must hurry through their work in order to get everything done. Staffing shortages give rise to the appearance of new, inexperienced people on the floors in large numbers. The task regime is highly regulated, and is subject to surprise inspections by Ministry officials, and there is little time to spend interacting with residents in ways that can meet their emotional needs. Residents are exhibiting increasingly onerous healthcare needs, and staff are becoming older and less able to handle the heavy physical work that is sometimes required. RNs, RPNs, and HCAs show signs of caring for the residents, but they also feel compelled to focus on completing their tasks. Absenteeism and turnover introduce instability on the floors, and the permanent staff are constantly having to devise makeshift plans for handling their heavy workload when experienced teammates are replaced by inexperienced newcomers.

Some people, especially outsiders, witness the events unfolding in LTC homes like the Lodge, and conclude that staff focus too much on tasks and not enough on the psychosocial needs of residents. These reformers claim that LTC homes need to move away from the current medical model, and adopt a social model of care that allows for the creation of a more home-like environment. In consequence, there is often talk about introducing changes into the environment that will lead to a more home-like experience for residents. HCAs, however, are unable to find the time to participate in these change initiatives, and their tenacious focus on completing their tasks is often labeled "resistance to change" by those who are attempting to introduce reforms.

The result is an environment that is harried and contradictory. HCAs attempt to protect their existing teams and protocols, because they know that today they are able to complete their work, and sometimes have time to interact compassionately with residents; if still more demands are made on them, they worry that they will be unable to spend any time at all on meeting the social and emotional needs of residents. The dilemma is a double bind: if HCAs oppose the cultural reforms that are being proposed, they are labeled as resisters who care only about tasks; if they support the reforms, they are likely to find that they have been given an even heavier workload with more tasks to complete, and will be unable to spend any time interacting with residents.

Together, RNs, RPNs, and HCAs must devise ways of working, and of supporting their work through a meaning-making process, that allow them to function and succeed in this challenging environment.

CHAPTER FIVE: MEANING MAKING IN LONG-TERM CARE

This chapter provides a thorough description of the meaning-making processes that take place on the two levels of the Lodge during the day shift. The chapter begins by providing an overview of the meaning making that occurs on the floors, and then presents five meaning-making profiles to illustrate the patterns of meaning-making that are apparent on the floors.

INQUIRIES AND QUESTIONS—AN OVERVIEW OF MEANING MAKING ON THE FLOORS

When Lodge staff interact with each other in the chart rooms and on the floors, they often begin their interactions with a question. I noticed this tendency on my seventh day of gathering data, and at that point I began to make notes about the types of questions that staff asked each other. When I began to organize and analyze the data, I consolidated my notes about these questions, and grouped them into categories. The types of questions and inquiries that occur on the floors provide a broad view of the uncertainties that trigger group-level meaning making and problem solving.

Staff routinely ask questions of newcomers on the floor to establish the basic identity of people. I often overheard staff members asking a newcomer, "Who are you?" I heard some variant of this question being asked on almost every day when I made observations on the floor. During my first two weeks of conducting the research, I was often stopped in the hallways and asked this question by RNs, RPNs, and HCAs. I heard the question asked of temporary HCAs and RPNs, visitors, maintenance staff, and

therapists. Staff appeared to expect to see unfamiliar faces on the floors during the day shift, but when somebody appeared to lurk in the hallways (as I did) or was wearing hospital clothing (which was the common garb of all members of the day shift), staff would usually ask the newcomer to identify him/herself.

Staff also regularly ask questions about roles and responsibilities. At the beginning of the day they want to know what part of the floor they are working on, and who is to be their partner for the day. They also want to know who their peers are partnered with, and which RN will be supporting their efforts during the shift. They want to know who is looking after specific residents, and who is performing special tasks (such as orienting a newcomer to the team). When special events are planned, such as barbecues or picnics, they want to know how they are expected to contribute to the event, and which residents are participating.

Staff also often inquire into the whereabouts of people and things. I often heard RPNs and HCAs inquire into the whereabouts of the RN. HCAs regularly tried to locate an RPN or the HCA they were paired with for the day. They would often make these inquiries by walking down the big hall and asking the question in a loud voice, not directing the question to any specific person but hoping that somebody—a peer, a resident, or a visitor—might have an answer. They often asked questions about where they could find supplies, tools, or equipment—for example, on more than one occasion I saw staff try to locate nail clippers, lifts, trays, the daily assignment sheet, and care plans.

On occasion, and usually during the report session, staff inquired into the meaning of texts. I heard staff ask for assistance in interpreting the meaning of notations made in the report binder, or in a resident's more detailed care plan. I also heard staff ask for

assistance in identifying the actions that needed to be taken on the basis of specific entries in the binders and charts that they consulted during the morning. I witnessed one situation in which RPNs and an RN consulted several texts to validate a new medication order, which culminated in a discovery that medication order sheets had been incorrectly filed.

Staff also sometimes requested advice from peers or superiors about what action to take in a specific situation, or how to carry out a specific task. I witnessed people asking for instructions on how to fill out a form, and how to chart a resident situation. I also heard staff ask for advice on how to respond to specific resident situations, and how to organize and carry out their work when the floor was shortstaffed.

I also noticed staff ask specific questions in order to obtain facts, information, or explanations that could be helpful for them while trying to complete a task. Staff would ask if a full complement of HCAs were available for the shift, and they would often ask newcomers if they were familiar with the work done on the floor. HCAs would inquire into whether a temporary RPN would be able to handle a full RPN workload. They would ask when a specific task had last been performed, about the status of specific residents, and how to handle resident needs or situations (for example, staff would ask for advice on how to respond to a resident who occasionally became aggressive when receiving care).

These questions indicate that staff vest importance in issues of identity, roles and responsibilities, whereabouts, interpretation, and procedures. They like to know who is on the floors, and who is responsible for the various tasks that must be completed. They want to know where their teammates are, and where resources are located. They seek

help in understanding the meaning of texts and the steps that must be taken to complete a task. They want to know what is going on during their shift, what the team's capabilities are, and how likely it is that the team working the shift will be able to complete its tasks within the allotted time.

The frequency with which these questions are asked also indicates that these can be problematic areas for the Lodge. Identity is not always clear, and roles and responsibilities must frequently be negotiated or clarified. People and resources can be challenging to locate, and the information provided by texts is often difficult to interpret and apply. Some staff are not familiar with the procedures that must be followed on the floor, or with the preferences and idiosyncrasies of specific residents and teammates. These issues and concerns are pointers to meaning-making breakdowns, which trigger and unleash the meaning-making dynamics that allow work to be completed on the floors.

MEANING-MAKING PROFILES

Meaning-making in the Lodge tends to focus on certain recurring problematic areas, and takes the form of particular patterns of interaction and exchange. As a first step toward identifying the systemic nature of meaning-making in the Lodge, I will provide five profiles of the meaning-making dynamics that are apparent on the floors. These profiles are constructed from specific episodes of meaning making, and represent a first step toward identifying a systemic dynamic that sustains itself over time and that allows the RNs, RPNs, and HCAs to construct a shared social reality that permits them to accomplish their tasks.

Meaning making is evident in brief episodes of interaction that can last less than a minute, and it is also evident in longer interactions that occur over a period of 30 minutes. Episodes of meaning making often reveal a larger, enduring enterprise at work on the floors—to cope with staff turnover and the concomitant influx of newcomers, for example, or to make sense of the contradictions that occur as staff attempt to balance the need for regulatory compliance with the need to meet the needs of all residents and to create a work environment in which staff can cope with a heavy workload.

These profiles are intended to complete a qualitative "thick description" of the Lodge. They show the occurrence of meaning-making episodes as they are observed on the floors. After presenting these episodes, the next chapter will describe the individual components of meaning making in the Lodge that emerge from an analysis of the data, and the way these components interact to create an enduring system of meaning making.

Profile 1—The revolving door problem

During the period when I was recruiting participants for the research, I was often asked if my research might help to alleviate the conflict that existed on the floors. Several HCAs alluded to interpersonal conflict and communication challenges. As I continued to gather data in the system, I noticed that these conflicts and tensions generally were attributed to what I came to term the "revolving door" problem: permanent staff who possess considerable tacit knowledge of the floors are often unavailable for work, and they must be replaced by newcomers who are unfamiliar with the floors. The result is additional pressure on staff as they try to complete their tasks, and this pressure was often referred to as "instability" on the floors.

This example of meaning-making on the floors was evident in numerous incidents and interactions that I observed, and also in several formal and informal interviews that I conducted. On one shift on the second level I saw two RPNs talking to an HCA about how to cope with a short-handed situation. The HCA was feeling overwhelmed by the extra work, and one RPN listened to the problems and then gave direct advice: leave Mr. Jones in bed, and go to the dining room and help with the feeding. They reached an agreement about how to handle the work for the next hour, and then returned to their tasks. On another shift I saw a newcomer wheeling a resident down the hall, and an RPN intercepted the newcomer and said that the resident always had her meals in one of the smaller dining rooms. The newcomer changed course and wheeled the resident toward the dining room. The RPN called out to him, "You have to take off your gloves." The newcomer stopped, took off his gloves and deposited them in a waste bin, and then continued with his task. On two occasions I observed members of the core team discussing the way a task had been completed by a newcomer, and agreeing that somebody would have to re-do the task because it had been done improperly. On one occasion I saw a newcomer walk slowly up the big hall, looking from side to side, then turning around and wandering back down the hall. She disappeared from view, and a few minutes later she returned to the big hall, still looking back and forth. I inferred from her behaviour that she was unsure of what she should be doing, and was trying to locate someone who could advise her.

The work on the floors often is experienced as difficult and hectic. One full-time, permanent staff commented on the instability that characterizes the floors, and that it would be desirable to bring a greater level of stability to the workplace. "I am going to

try to bring some stability," she said, and then she continued, "I see what you have to deal with, all this instability." RNs, RPNs, and HCAs associate this instability with the tendency for permanent staff to be absent from the floors, and for their positions to be filled by newcomers who are not familiar with the residents on the floors, with the other workers, and with the workload and work routines. This perceived instability was the occasion for much meaning-making activity over the period when I was gathering data on the floors.

The Lodge experiences constant turnover and absences. People take holidays, call in sick, and go on extended health-related leaves. Though I was unable to access data to systematically show the extent to which core team members are absent from the workplace, I did notice many absences while I was gathering data. Most members of the core team took holidays at some point between early June and early September. Two members of the full-time core team were absent for more than seven days due to poor health, and one member of the part-time core team was absent for more than a month due to poor health. I also witnessed conversations between research participants and people I did not recognize on two occasions, in which the participants welcomed the other person back to the Lodge from what I gathered was an extended absence due to poor health. In total, then, I witnessed at least five instances of health-induced extended leave over the three month period when I conducted the research.

Considerable time is spent transferring knowledge, and talking about transferring knowledge, from permanent staff to replacement staff. Replacement staff often express surprise at the heavy workload, and at how the work routines are organized. Replacement staff often ask to be shown procedures and routines, but sometimes do not

see the value of more in-depth knowledge of the floors—this in-depth knowledge might include a knowledge of resident preferences, of how to balance tasks with psychosocial care, and of the capabilities and preferences of other team members. An orienting nurse once told the person orienting her, "I just need the procedure. I just need to know what to do."

HCAs each have from six to eight residents to care for during the day, which is a higher ratio than found in chronic care. HCAs get the residents up in the morning, ensure that they are cleaned, dressed and fed, and that they are ready for appointments and other activities that take place during the shift. If for some reason an HCA is unable to cope with the workload, then somebody else on the shift must help the HCA to complete the work. An HCA who cannot cope with the workload ends up shifting tasks onto other HCAs, who are already carrying their own heavy workload.

New HCAs have received training over a period of twelve months in a community college. When their job application is accepted by the Valley Health Centre, they are eligible to work in a variety of the centre's programs, including the River Lodge. Before being added to the on-call list of temporary workers, they receive three days of orientation in the centre—this orientation may or may not include one day of orientation in the Lodge. An orienting HCA is assigned a "buddy"—a permanent HCA who is familiar with the floor and the work routines, and who helps the orienting HCA to plan their work for the day and to complete their tasks.

When the new HCA has completed the orientation process and finally arrives for his/her first day of work on a shift at the Lodge, at most they have had exposure to one of the Lodge's floors for a single shift. After their orientation is complete, new HCAs may

wait for several months before they receive their first call to work on a shift, and hence their experiences in the Lodge (if they had a day of orientation in the Lodge) are no longer fresh in their memory. When the new HCA arrives, the core team of permanent staff want the newcomer to be able to handle the workload and to be familiar with the work routine. This, however, is often not the case. New HCAs are usually unfamiliar with the layout of the floors; they do not know the residents; they are not used to the difficult staff-resident ratio that leads to a challenging workload; and they expect members of the core permanent team to be available to support them during the shift.

This, however, is not what happens. New HCAs cannot absorb all of the facets of the work routine in a single day of buddying, and then retain all of that information until they are called in to work on a shift. There is a great deal to know: knowledge of the task routine (the order of doing things, the location of facilities and equipment, the procedures for completing specific tasks, etc.), knowledge of the residents on the floor (their health and condition, how mobile they are, their preferences and idiosyncrasies), and knowledge of the team (the division of responsibilities between team members, and how to accommodate the specific capabilities and preferences of their members over the course of a shift).

The resulting situation functions as a double bind. The Lodge needs to constantly bring newcomers onto both floors in order to complete the work. However, the way in which newcomers are introduced into the workplace, and the way that work is carried out, means that newcomers are not fully prepared for the work. When newcomers come on the floor to work as HCAs, they may be incapable of performing the job, and they rely on the experienced HCAs to support them. The experienced HCAs provide this support,

sometimes grudgingly, and this causes the overall work effort to suffer (the workload is too heavy for the experienced HCA to take on additional tasks). Some experienced HCAs become upset with this situation, and over time become less willing to provide extra support to newcomers. Some experienced HCAs also become less likely to support the existing orientation method, since most newcomers who receive orientation remain incapable of carrying out the work.

This situation was evident on numerous occasions during my research. I often observed report sessions in which newcomers were left to stand alone, off to the side, while the core team prepared itself for the day. Sometimes a member of the core team would provide brief assistance to a newcomer as the rest of the team moved onto the floor to begin work. On occasion a member of the core team would take steps to include a newcomer in the conversation and to ensure that the newcomer understood what was expected. However, I witnessed several occasions when experienced HCAs explicitly refused to provide orientation to a newcomer, and one experienced HCA explained to me that she had provided what she thought was a proper level of support to a newcomer on a specific shift that I observed, but at the end of the shift the newcomer had angrily criticized this HCA for providing inadequate support.

While I was conducting this research, no specific changes to improve this situation were implemented. I did learn, however, that two RPNs sent emails to management after a difficult weekend in which the entire HCA team on one floor consisted of newcomers. These RPNs reported that it is clear that a single day of orientation on the Lodge floors is insufficient to prepare a new HCA for work in this environment. Management responded by sending an email to the training director of the

Valley Health Centre, asking for support in developing a new way to prepare new HCAs for work in the Lodge. Management told me that they were concerned about the impact that this "revolving door" problem was having on staff morale, and they expected that if the problem was not corrected it would lead to additional sick leaves being taken by core team members, and it could result in fewer newcomers being willing to accept on-call assignments at the Lodge. I checked in with the Lodge's Director of Care eight months after completing my field research, and was told that this problem had not yet been resolved.

When members of the Lodge's core team reflect on this problem, they offer different interpretations. Management tend to focus on the attitudes and behaviours of the experienced HCAs. One management team member told me that the HCAs were being worn out by their current workload, and could not find the energy to provide the needed support to newcomers. This manager suggested that HCAs should communicate with each other over the course of each shift in a way that provides a flow of work-related information so that new people can learn, and they should be providing constructive feedback to new HCAs about their job performance. This feedback needs to be documented in a learning plan, so the new HCA knows where they should try to improve. Management believes that the HCAs need to develop a more collaborative and interactive way of doing their work, so they can better support newcomers to the shift. The HCAs, however, do not want to take on a supportive and advisory role in relation to newcomers. They are too busy trying to complete their tasks, and do not have time to become informal trainers and mentors for newcomers. They also refuse to provide feedback about the performance of newcomers. This creates a curious situation.

Newcomers begin their employment with a three month probationary period. They are employed on an on-call basis, and they are often invited to come into a variety of different programs offered through the Valley Health Centre. Management needs feedback about their performance, so they can determine whether the newcomer should be offered a permanent position on the on-call list. Management and the HCAs are unable to agree on who should provide this feedback.

Management representatives told me that they intended to make a number of changes to deal with this dilemma. I was told, for example, that a solution might be to institute an employee appreciation program—and I witnessed the launch of this program when staff on both floors were presented with thank-you cards and a cake to express appreciation for their help with a barbecue event held for residents. I was also told that management was considering teambuilding activities, or conflict management training.

Some HCAs believed that the root of the problem lies with the attitudes and behaviours of the newcomers. One HCA told me that the real problem comes down to the attitude of the newcomer. When the newcomer has "a good attitude," the shift is able to carry out its work in a reasonably effective manner. However, when the newcomer has "a poor attitude" toward the work (the HCA used the example of observing a newcomer "standing around with their hands in their pockets"), the shift struggles to complete its work. This HCA told me that the HCAs on the core team try to be helpful to newcomers. They do this by dividing up the work in a way that provides the newcomer with an easier workload. However, the newcomers are unfamiliar with the work on the Lodge, and they are often unable to see that they have been given the easier tasks to complete. At the end of their first shift, newcomers sometimes complain that they were given an unfair

workload and were taken advantage of. The newcomers also do not like the short, 6.5 hour shift that most HCAs work at the Lodge, and would prefer to work in other Valley Health Centre programs where they are paid for an additional hour. This HCA indicated that one newcomer told her that if she had known about the short shift, she would have turned down the call.

This HCA related a specific story about working with a newcomer who had never before worked at the Lodge. At the start of the day she told the newcomer that they would work as a team. The HCA made this decision because they had an especially heavy workload that day, and it would have taken too long to write out detailed instructions for the newcomer. The HCA said that she worked with the newcomer throughout the day. They would get a resident up together, or the HCA would get the newcomer started on an easy person and then would go and work with a more difficult person. The HCA had thought that the approach had worked as well as could be expected, but at 2 PM, as the shift was ending, the newcomer complained bitterly about the experience. The newcomer felt that she had been overworked and given an unfair load. The HCA said she had had no indication of this until the newcomer began to complain at the end of the day.

Another HCA gave a different explanation for the challenge of integrating newcomers into the practice. This HCA did not talk about the attitude of the newcomers, but rather pointed to the inadequacy of the existing orientation process. The HCA said that she has often oriented newcomers who have just finished their college training, and that most of these newcomers are not adequately prepared to begin work at the Lodge. She suggested that the newcomers should receive three days of on-the-job training. On

the first day, the newcomer would follow an experienced HCA, observing and occasionally assisting. On the second day, the newcomer would do the work, and the experienced HCA would correct, advise and answer questions. On the third day, the newcomer would do the job alone, and would approach the experienced HCA only when help was needed. The HCA said that she has thought about taking this suggestion to the people in charge of orientation, but has not done so yet.

The HCA also described the sorts of things that new people must learn: how to perform a lift in the proper manner, with a teammate; how to locate special instructions at the bedside that provide procedures to use with specific residents; and how to find the diapers that are stored in closets in the resident rooms. These are examples of practices and techniques that are used in the Lodge, but that are not used in other parts of the centre.

This HCA expressed compassion for the newcomers. This is a big problem every summer, she said, especially on weekends when regular staff phone in sick more often. The work is hard, and is different from how work is done elsewhere in the centre. However, newcomers have not been adequately trained, and so are not competent to perform all of the work. The HCA also talked about how the floor might react to having to function short-staffed for a day or a portion of a day. She said that on the first level they must find a way for three HCAs to do the work of four. They have tried to work as a three-person team, but this has proven difficult. She said that she is working on an approach with the RN, but they have not yet had time to complete the development of the approach and implement it.

The meaning-making processes that relate to this revolving-door problem are evident in several ways. The floors have a significant requirement for newcomers to fill in the constant gaps that appear in the team; however, the floors are unable to integrate newcomers into their practice. To integrate newcomers into the practice, the core team members would need to find a way to share insider knowledge with the newcomers. They would need to find a way of interacting with newcomers that allows a dispersion of existing tacit knowledge so that newcomers become steadily more able to carry out the work. This, however, does not happen. Newcomers do not feel that they are learning how to do the work, and believe that they are taken advantage of. Core team members become frustrated at their lack of success in integrating newcomers, and become less prepared to participate in existing orientation procedures. Management blames core team members for their poor communication practices and their unwillingness to help with the orientation; some team members point to the "poor attitude" of newcomers; and some members of management and staff suggest that the fault lies with the inadequacy of the orientation procedures. Interpersonal conflict arises within the teams, and between cliques and occupational groups. Managers wonder if an employee appreciation program might alleviate the problem. HCAs say that RPNs should take over all orientation duties. Some cliques refuse to act as "buddies" for newcomers. Some team members (at least one HCA and one RN) try to invent new methods for carrying out orientation, but they are so busy with their existing workloads that they are unable to complete the design of these new methods.

Profile 2—Talking about texts

Staff make use of texts as part of their regular meaning-making processes, but texts often appear to be problematic. I observed staff searching through documents, complaining about misplaced or inadequate information, and commenting on the inadequacies of existing documentation resources and the need for additional or different documentation. As staff use documents to prepare for their work or complete their tasks, they encounter problems and errors. A conversation then ensues, during which staff share their knowledge about the situation under discussion, and this often results in a solution to the problem or a correction of the error.

After the end of one morning report session, a permanent RPN, Janet, along with an orienting RPN who was assigned to her for the day, stayed behind to consult with Pat, a manager, about a special situation. Janet had read a note in the report binder stating a medication change had been ordered for a resident. However, when she looked in the resident's care plan she could not find the appropriate medication order form. Janet and Pat together poured over the care plan. They focused on the sheets covering the last four or five days. Together they read through some narrative notes that had been left. Then they looked in the portion of the care plan binder that contained medication and treatment orders to see if they could identify recent changes in medication orders. They found some forms dated three months ago, and nothing else. Janet then left the chartroom, and returned about a minute later carrying a pink sheet of paper. This paper was a copy of a medication order that she had retrieved from the medications cart. Using this sheet, the two of them were able to confirm that a medication order had indeed been submitted, and they then searched through the care plan binder once again. This time they found the

sheets they were looking for, located in the wrong order. They opened the binder, moved some sheets around, and then closed the binder. They were smiling at this point. Janet said, "Mystery solved." Pat said, "Well it just didn't make sense, but now it does." Janet and the orienting RPN left the chart room to begin their day.

Another incident involved a manager searching for a required form. We were in the chartroom after a report session, and she was thumbing through a binder. She told me that one of the senior managers had asked for a copy of a checklist used at the resident/family conferences. This conference is an annual meeting involving the Lodge medical staff, the resident, and the resident's family. The manager said that she had never seen this checklist, and she turned the pages looking for an example of the form. She found a sheet dealing with medications, and wondered out loud if that might suffice: "I guess I could send her a copy of this, but I don't know if this is really what she is looking for." Then she said that she knew that the doctors review the Lodge's "Directives of Care" during the annual conference, but, she said, tapping her forehead, "They do it from memory. They don't use a checklist."

During another report session on the second level, a part-time RPN appeared unexpectedly, saying that she had been called in for the shift. Since there were already two full-time RPNs in the chartroom, this came as a surprise. Janet, one of the full-time RPNs, examined the Daily Flow Sheet that described the daily assignments. She said aloud that she had been assigned to a special duty for the day, which must be why a replacement RPN had arrived. Janet said this was the first that she had heard of it. There was then some confusion about who was replacing who, and whether they had sufficient HCAs on the floor for the shift. At this point a newcomer HCA arrived, and she was

immediately questioned about why she was there. The newcomer said that she had been called to work on the first level, but when she went there she was told to trade places with another temporary HCA who had been called in to work on the second level. The RPNs on the first level had told the two newcomers to trade assignments because each of these newcomers were familiar with only one floor of the Lodge, and the RPNs wanted the newcomers to work on the floor they were familiar with. The HCAs on the second level then asked the newcomer to confirm this several times: "You are more familiar with this floor?" The newcomer HCA indicated that this was the case.

As this report session continued, participants discussed the restraints used for certain residents, and attempted to make sense of two recent order forms for new restraints. The two forms had been submitted by the RN on the same day earlier in the week, and one had been filled out completely while the other had not. The restraints involved tables and buckles and straps. In certain seating arrangements, there was a strap that prevented the resident from slipping from a wheelchair, and also a buckled restraint that served to hold the resident in place. In other arrangements, a table served the purpose of the buckled restraint. The change orders were for two new tables and buckles. As they discussed the situation, however, one HCA remembered that a table had been borrowed from one resident for use by another, and that the new orders concerned these two residents—one of whom already had a table. The order should have been for one table (instead of two) and two buckles. The RN was frustrated by this, and said "Can we please try to get our information straight before you ask me to submit an order. It makes me look stupid."

This was followed by a discussion of communication problems on the two floors. The conversation was a cryptic, insider conversation. An RPN, Janet, made a suggestion about using some sort of paperwork to improve communications. Afterward, when most of the team had gone onto the floor to begin work, I asked Janet and Erika, the RN, if they could explain what had just taken place. Janet said that she was suggesting that they create a new Communication Binder. This binder would be used to record significant events on the floor that staff could thumb through as they prepared for their shift. An example of an entry in the Communication Binder would be a note saying that a dining room was closed for the day. Janet explained that the Ward Clerk had just come in and said that the big dining room and one small dining room were to be closed that day. This was the first that any of the staff had heard of this. The decision had been made by the Director of Care and one or two others, but had not been communicated to the floor. The staff were about to get people up and move them into the dining rooms, so it was important that they know that certain dining rooms were closed. Janet explained that the Agenda book is used to cover activities on a specific day, so people tend to look only at what is scheduled for the current day. The Communication Binder would be a running record, and they would thumb through several pages looking for information that was still relevant. Janet said that they had used to have a Communication Binder in the past, but staff had used it to record criticisms—one shift criticizing the work of the previous shift, for example. She said that the new Communication Binder would not be used for that purpose. The examples of poor communication that Janet and Erika referred to were the dining room closures, Janet's special duty, and the order for tables and buckles.

The day shift makes use of a variety of texts and forms to bring stability and continuity to their work. These texts are most clearly evident during the morning report session, when several texts are used to help with the negotiation of daily task assignments and with the review of resident conditions and special activities. However, these texts are often experienced as problematic, and can occasion additional moments of instability. Many texts trigger processes of interactive negotiation and problem solving, as staff try to create a shared understanding of the environment in which they must accomplish their daily tasks.

Profile 3—Pooling knowledge to create shared accounts and to complete the work

I often observed members of the Lodge day shift sharing experience and knowledge in order to create a shared account of a situation, and then use this knowledge to complete a task or to devise a solution to a problem. This often took the form of individual people contributing fragments of information that allowed for the construction of a coherent narrative about a situation on the floors, after which there would be a discussion about how the team should deal with the situation. Sometimes one or more team members would use this process as a way to complete a specific task, and at other times several team members would use this process as a way to create a guideline to govern behaviour in specific contextual situations.

One day, for example, I observed several team members in the chartroom while an Incident Report Form was being filled out. During the shift a resident had fallen out of her bed, and this was a situation that needed to be reported to the centre's patient safety committee on an Incident Report Form. To begin with, an RPN and an RN had a conversation in which they identified and ultimately agreed on the basic facts in the

event. This took place through a somewhat erratic process. The discussion did not cover the incident sequentially from beginning to end, but rather pieced together an account of the incident, with one of them asking questions and the other suggesting answers. The answers came out like this: the resident tried to get herself up; she wanted to go to the bathroom; she had just been changed a little while before; she did this earlier in the week, too; she must have slipped off the sheets; the nurse buzzer was working; the nurse buzzer was in its proper location; all of the equipment was working; the resident had been checked on regularly during the shift. As they stepped through these facts, one person wrote a narrative in the grey binder for that resident, and the other filled out the Incident Report Form. The form was the bigger challenge—it took longer, and after a while a second RPN began to actively collaborate in discussing how the form should be completed. They tried to fit the facts of the case to the options available on the form. One person recommended selecting the "Not Applicable" option a number of times, and said "When in doubt, it's 'Not Applicable. '" While the RN and two RPNs filled out the form, a third RPN and two HCAs related this incident to events concerning the resident that had occurred earlier in the week. This additional information allowed the two RPNs and RN filling out the form to construct an account of the event that satisfied them and that could be transferred to the form.

After another report session, two HCAs, Janice and Dominique, lingered for a few moments and asked for advice on how they should chart a specific situation that had recently arisen on the floor. (I described this incident in the italicized introduction to chapter one. I repeat it here because it is a good example of how shift members pool their knowledge to solve a problem.) Together they formulated their question, with

Janice beginning to describe the situation, then Dominique jumping in to add some more information, then Janice taking over again. Every now and then Colleen would interject with a question or suggestion. They were talking about the following situation. On this floor many of the residents were both lucid and mobile, but some were in the early stages of Alzheimer's and you could not rely on them being able to answer accurately a question about their recent activities. More specifically, some residents went to the bathroom by themselves, but it was impossible for the HCAs to tell later on if the resident had had a bowel movement or not. This was important for the HCAs, because they were expected to keep track of and chart all resident bowel movements during their shifts. Dominique mentioned the name of a specific resident, and then phrased her question.

"How are we supposed to chart this? Can we put in a question mark? Can we leave it blank? Should we write 'no' or put in a zero?"

Colleen tried to answer their questions, but as she made suggestions the HCAs offered more examples that brought further complications to the issue. Finally, Colleen said, "You need to ask the RN how she wants you to handle this."

At that moment Susan, the RN, came back into the room. The HCAs again posed the question to Susan, who closed the door and joined them at the table. Susan at first said that the HCAs had to find out when the resident typically had a bowel movement, and then they had to try to be on hand at that moment. Dominique explained how difficult this could be by mentioning the name of a specific resident. Susan expressed surprise that this resident went to the toilet by herself. Dominique, supported by Janice and Colleen, said that this resident did indeed go to the toilet by herself. Dominique went on to say that when she saw that this resident was on the toilet, she would try to stay

nearby, and would sometimes take the resident some tissues or ask her if she was okay. But nevertheless, when the resident came off the toilet, there was often no evidence of a bowel movement—and the resident may have flushed the toilet, so there was no way of knowing for sure.

Susan continued to insist that they must try to be on hand. She suggested that they talk to family members and ask when the resident had gone to the bathroom in the past—in the morning, or after lunch, or whenever. The HCAs continued to press their point, that they could try to find out, but they would not necessarily succeed, and that left them with the charting problem.

Susan then began to talk about the charting issue. She said that they could not leave it blank, and they could not put in a question mark. Janice suggested that they should mark in a zero, but after considering this for a moment she and Susan agreed that this would not necessarily be an accurate code. Susan, in talking about the issue with the team, and in suggesting answers and then considering whether the suggestions would work, arrived at a solution. The essential problem, she said, was to chart the situation in a way that would be acceptable to the people who entered the Minimum Data Set (MDS) codes into the computer system. Susan said that when this sort of situation arose, the HCA should take note of it, and should mark in zeros, but should also bring the situation to the attention of the RPN who was working on that part of the floor. Dominique played an active role in devising this solution, saying several times that this is not an HCA role, but is rather an RPN role. The RPN could then examine the resident, checking for physical symptoms of constipation. All of this would need to be charted, as well, in narrative form, and this charting would be the responsibility of the RPN. They talked

about this for a few minutes, agreeing on how the HCA would monitor and note the situation for a few days, and then bring it to the RPN, who would then do an examination and do the appropriate charting. The two RPNs listened to this and did not contribute. After discussing this way of handling the situation for about two minutes, the conversation ended.

My field journal contains numerous examples of this type of interaction, where several staff pause briefly during their daily routine, and collaborate to create a shared, acceptable account of a situation or solution to a problem. After staff have engaged in a conversation that leads to the co-creation of a satisfactory narrative or solution, the participants quickly resume their duties.

Profile 4—On-the-go construction and maintenance of a shared reality on the floor

Staff interactions and collaborative meaning making do not always focus merely on the construction of discrete narrative accounts or coherent solutions to specific problems. Each day when I was at the research site I would notice examples of the core team constructing and then maintaining an overall shared sense of the reality on the floor. This tacitly held, shared understanding was used to reach agreement on facts, to locate people and resources at the moment when they were needed, to set priorities, to assign tasks, and to make decisions. Given that team members were present on some days and absent on others, this process also allowed them to collaboratively create shared narratives about the events that had unfolded on the floor over the past few days. The reliance on an informal, collaborative protocol to construct a shared understanding of the floors, and then to update that understanding through quick interactions during the day, allowed for a meaning-making process that is well-adapted to the hectic task routine that

unfolds during the shift. This meaning-making resource was available as long as it was possible to access teammates and to engage in quick conversations about work. I will offer an assortment of examples of this meaning-making process.

It was 2 PM, and HCAs and RPNs were nearing the end of their shift. An HCA noticed a resident, Mrs. Jones, sitting in the central area, where she had been sitting since lunch. Mrs. Jones was holding two bus tickets for the special bus that was supposed to take her to a 1:30 appointment. Nobody had come to escort her to the bus, and she had been left unnoticed in the central area near the elevators. HCAs and an RPN gathered around the resident and discussed what had happened. An HCA recalled that a visitor had appeared on the floor an hour or so earlier. Another HCA pointed out that this visitor had been for Mr. Williams. An HCA then said that somebody had been paid to pick up Mrs. Jones, but this person had not arrived. One HCA in particular seemed concerned about this situation—the HCA who had wheeled Mrs. Jones into the central area and had given her the bus tickets. This HCA stayed with Mrs. Jones for a while, saying that they will rebook the appointment. Then the HCA and a few others left the floor, their shift over.

On two occasions I observed a rapid exchange concerning missing nail clippers, which are used as part of the procedure to groom residents at the start of the day. On one of these occasions, three HCAs were standing close together in the lobby area near the elevator. One HCA said that she could not find her nail clippers. Another said that she thought the HCA at the far end of the hall might have them. The third HCA went to the telephone at the central station, and phoned the other floor. She asked if somebody could bring a pair of nail clippers the next time they came to the floor. After this phone call

ended, the first HCA said, "Never mind. I need them now. I will run downstairs to get a pair."

A few weeks later I observed a situation in which an RPN was stopped by an HCA, who asked, "Do you know where we keep nail clippers? Mrs. MacDonald has a tear in a nail and I need something to fix it." The RPN said, "Can't you use their own clippers?" The HCA said no, and came closer to the RPN and said something in a soft voice. The RPN replied, "Ooooh," in a sympathetic tone. The RPN and HCA walked down the hall together.

One morning I was in the chartroom waiting for the report session to begin. Two HCAs and the RN were seated at the table, making notes and waiting for the rest of the team to arrive. A man came into the room and began to look through some of the binders. The HCAs continued to make their notes, but the RN, who appeared to be looking for something, asked the newcomer, "Are you an RN?" The man said no and continued looking through the binders. One of the HCAs spoke up, and they tried to find out who the man was. She asked him if he was an RPN, and the man did not respond, so the HCA asked the question again in French. The man said, "I don't speak French." The second HCA now joined in, and laughed and said, "Who are you? That is what we want to know." The RN said, "Are you the night shift HCA?" The man nodded. There was a quick moment of laughter in the room as the newcomer was identified. The RN said, "Who was your RN?" The nightshift HCA said something very softly, and then the RN said "Where is she?" The nightshift HCA said something, and the RN quickly left the room.

On another occasion I witnessed a brief exchange between two HCAs. One HCA went into a resident room, and then came back out and walked up to the other HCA who was working at that end of the hall. She asked, "What do you think I should do about Mrs. Booth?" "What about her?" The first HCA explained, "She has been on for ten minutes but nothing is happening. I think I will give her another five and then take her off." The second HCA shook her head and said, "Take her off now." The first replied, "You don't think I should wait?" The second HCA said, "They were giving her too much [medication], so now she is off it for a while." The first HCA then said, "Oh, okay, I'll take her off." In this situation, the first HCA had been away for a few days, whereas the second HCA had worked on the floor for the past few days. The second HCA had information that the first HCA needed. They talk together, asking and answering questions about a specific situation, and this triggered the release of information relevant to the situation. In this case, a care pattern had changed, and this impacted on the appropriate treatment of the resident at that moment. With the new information, the HCA was able to decide on a course of action.

On another occasion, an HCA talked to an RPN about a bandage on a resident's arm. The HCA said that the resident's bandage kept coming off. She said that the RN had said that it should be kept loose, but the trouble was that it kept coming right off. The HCA wasn't sure where to find a new bandage of the proper type. The RPN discussed this with her for a moment, and then found the proper bandage in her medication cart. The HCA and the RPN then went into the resident's room. About ten minutes later, after I had moved down the hall to continue my observations on a different part of the floor, two HCAs walked past me, one of them holding a bandage. The two

HCAs were discussing what should be done about the resident's bandage. One HCA said, "Tell the RN." The other replied, "Yeah, I think I should, but first I should tell the RPN." They then went off in search of the RPN.

On another day I saw an RPN go into the small dining room to give a resident her medication. When she came out she said to the other RPN, who was dispensing medications nearby, "Did Mrs. Smith have her glasses on the weekend." The other RPN replied, "Yes. In fact she had them this morning. I saw them beside her tray this morning." The two RPNs went back into the dining room and searched for the glasses, but didn't find them. The first RPN came out saying, "I'll go search the bib bin." She then went into the meal tray room. The second RPN stayed in the dining room and continued to search around Mrs. Smith's wheelchair. The second RPN then came out of the room, glanced down the hall, and saw another resident coming toward her in a walker. "Found them!" she called. The resident in the walker was wearing the missing glasses. The first RPN said, "How can she see with them?" The second RPN said, "She is always borrowing glasses." The first RPN retrieved the glasses from the resident with the walker, remarking "She is going to be mad at me now." The RPN handed the glasses to her colleague, who first cleaned them before giving them back to Mrs. Smith. They both seemed amused by this event.

On another occasion I was standing in the central area beside a medication cart where an RPN was dispensing medications. I said to the RPN that the dining room seemed unusually busy. She replied, "Yeah, it's crowded. We have a lot of volunteers right now." I was going to ask her about this, but all of a sudden an HCA came down the hall and interrupted us. She said that she was trying to feed Mrs. Jones her breakfast, but

Mrs. Jones was hitting her and was spilling everything. The RPN said, "Don't do anything when she is like that. Stay away from her. I will give her something as soon as I finish this." The HCA seemed unsatisfied with this. "But she is getting it everywhere, on the bed, on her, on her clothes. I am afraid she is going to choke or something." The RPN said, "Okay. I will come right now." The RPN and the HCA walked to the east end.

Over time, these ongoing, often momentary, interactions suggested a pattern. During the morning report session, members of the core team construct a shared understanding of the situation on the floor. They do this by sharing their recent experiences on the floor over the past two or three days, and by reviewing the information in texts that describe the residents' current status and the events that are expected to take place during the shift. Then, as the shift unfolds over the course of the day, they engage in brief, contextual interactions to ask questions and share information—the purpose of which is to maintain a shared understanding of the floor that allows them to complete their tasks.

Profile 5—Making sense of contradictions

Staff occasionally could be seen to attempt to make sense of contradictions and paradoxes that arose on the floors. In particular, regulations imposed by external groups often did not take into account the unique, highly contextual situations that existed in the Lodge, and staff would struggle to find ways of implementing these regulations that were compliant and sensitive to the needs of both residents and staff. Perhaps more significantly, staff must try to make sense of a work environment that is supposed to provide holistic care to residents, meeting their emotional needs as well as their health

needs, but that is based on a workload and task regime that makes it almost impossible to spend time interacting with residents in an informal way.

One day I was observing activity around the medication cart that was positioned outside the big dining room, and started to talk casually with the RPN. (I described this incident in the italicized introduction to chapter one. I repeat it here because it is a good illustration of the contradictions that staff often deal with.) While we were talking, an HCA approached the RPN and said she wanted to see if Mrs. Kantner could be seated in one of the dining rooms instead of out in the hall. They discussed this at some length. They were talking about one of the two residents I had been chatting with earlier that morning, Mrs. Kantner who always asks me if I will get her a cup of coffee, and Mrs. Giles. Mrs. Kantner is seated in the hall because she is confused and she talks so much that she disturbs the other residents. When she is seated at a regular table in the dining hall, she talks and talks, often repeating the same thing over and over, and the other residents complain. Mrs. Giles, on the other hand, is often ill-tempered in the morning, and she too is seated at the little table in the hallway for her breakfast. She can be quite mean to the other residents, I had been told. So these two ladies are seated in the hall, but the HCA felt that it would be better if the talkative Mrs. Kantner went into a room, so the mean Mrs. Giles could be alone at the little table.

The RPN listened, and after a while she explained that when Mrs. Kantner was in a dining room, the others complained. She nodded her head a few times, as if she was remembering something, and then she continued. The inspector from the Ministry of Health often comes to the Lodge, she said, and if she sees something like this—a resident seated in the hall instead of in a dining room—she will usually insist that the resident be

moved into the dining room. The RPN said more than once, "Our residents are human beings, not furniture." She said that the Ministry sends an inspector who takes a quick look around, makes quick interpretations, and then asks for changes—even though the changes do not really make sense. She concluded, "We have to make it work. And this is what we decided to do. We know the Ministry won't like it, but it is best for everybody."

The HCA appeared partly persuaded, but she still thought that moving Mrs. Kantner into the dining room might be a better solution. The RPN suggested that the HCA take it up with the RN (registered nurse), and the HCA walked away. The RPN turned to me and said, "I am not going to decide this one, so she can go to the higher up."

On another occasion I was observing activity in the east hall. Two HCAs were working in resident rooms, and an RPN was dispensing medications nearby. Down the hall I could hear a resident making a fuss in a room. After a few moments an HCA came out of the room and approached the RPN. She said she was having trouble with the resident, and asked for help. The RPN said she would help, but for a few minutes she continued with the medications. Then she went with the HCA into the resident room. A few minutes later the RPN returned and went back to the medications cart. The HCA came out a little later, put some things in the soiled linen cart (which was located inside a room with the word "Supplies" on the door, instead of being out in the hall where it often was). She spoke momentarily to the RPN, saying it was hard to cope with this difficult resident. She said things like, "I don't know why he is doing this?" And, "I don't like to do this but there is only so much you can do..." The RPN comforted and supported her, agreeing with her assessment and her course of action.

A few minutes later the second HCA who was working in this area noticed the soiled linen cart in the supply room, and she wheeled it out in the hall. Work continued, but then the first HCA came out and saw the soiled linen cart in the hall. She said "Who put this here?" And she promptly wheeled it back into the Supply room. The second HCA and the RPN both witnessed this. The RPN and two HCAs then engaged in a discussion. "Is it supposed to go in there?" asked the second HCA. "The Ministry says we have to keep it in there, because of the smell," said the first HCA. "I didn't know that," said the second, "We always kept it out in the hall." "I know," agreed the first, "But the Ministry said we have to keep it in there for the smell." "Yeah," the RPN agreed, "They were concerned about the smell." "I didn't know that," said the second HCA. "Well, some people leave it in there, and some don't," said the RPN, "It doesn't really matter." By this time the two HCA's had gravitated over to the RPN, and the RPN was standing between them. The first HCA said, "We're supposed to wrap up the diapers, too." The RPN agreed, and explained what this meant to the second HCA. The first HCA went back into a resident room to resume her duties, but the second HCA lingered for a few more moments. "We always kept it out in the hall, so it would be in reach," she said to the RPN. "I know," the RPN said, "It's a nuisance to have to keep going in there [the Supply room] when you are getting them [the residents] up." "Yeah," said the HCA. "Some people do it, some people don't. It doesn't really matter," the RPN said. The HCA nodded and went back to work.

On another occasion, on one of my final days at the research site, I was observing activity at the west hall, and an HCA paused in her work to speak with me. After she finished speaking I went into one of the lounges to make detailed notes about the

conversation. Here is what she said. "Did you learn lots? Did you learn lots in your black book? Do you see what we deal with here?" She stepped closer to me, standing about four feet away, leaning toward me slightly, with a distressed look on her face. "We have no staff. We are shortstaffed. That is the problem. That is what we have to deal with here. There are people who sit in their offices and play with their computers. They say they study how the work gets done, and how the work should get done. But they are not here. They are not on the floor. How can they know anything if they are not here. These are people. These are human beings. Not pieces of paper. We can't talk to them. We don't have time. In the old days it was different. But we can't even sit on their beds and talk to them. There is no loving care. We don't have time to listen to them, to talk to them. And the volunteers who come to help, and who have time to talk to them, we have to brush them off. We don't have time to tell the volunteers what we know. We have to keep working. That's all we have time for."

CONCLUSION

Staff working on the day shift in the River Lodge cope with a heavy workload that unfolds in the midst of a social environment that can be emotionally demanding. As they face ambiguity and uncertainty, staff mount inquiries to create a stable and coherent sense of the identities, roles and responsibilities of their colleagues and the residents they serve, and of the work routines and resources that govern their daily tasks. These ongoing inquiries are needed because questions of identity, roles, and duties can often be unclear, and key resources and people can be difficult to locate. Moreover, the textual information that is intended to stabilize and bring continuity to the floors is often difficult

to interpret, and requires negotiation and the pooling of tacitly held information to create shared, satisfactory accounts that allow staff to continue with their work.

Workers on the day shift can be observed to make use of a variety of meaning-making strategies to find answers to their questions. Staff often use texts to solve problems, to understand the development of specific situations or conditions in relation to residents, and to identify required procedures for handling tasks. However, texts are often problematic, and can serve as occasions for interactive sensemaking. A problematic text may bring several shift members together around a puzzle, creating a situation that calls for the pooling of information that is distributed among shift members in order to create a coherent narrative account of a specific situation, or to devise a solution to a specific problem. Over time, it became apparent that interactive, in-the-moment sensemaking is vital to life on the floors. In the morning, during the regular report session, shift members verbally construct a shared understanding of the current situation on the floor, of the events that are to take place that day, and of the current conditions and situations of the residents. As the day progresses, shift members interact briefly with each other, often in the big hallway near the dining rooms, asking each other questions, sharing observations, and commenting on the work they are engaged in and the residents they are working with, and in doing so they maintain and revise this shared understanding to keep it current and relevant for the duration of the shift.

These meaning-making strategies were often observed to focus on specific disruptions to the coherence or stability of the floors. Staff can be seen to struggle to comply with regulations that originate with external regulators, while simultaneously trying to make it possible to handle the arduous daily workload, and to create a

reasonably congenial atmosphere for residents. Staff also cope with what I came to term the "revolving door" problem, which sees the constant arrival of newcomers onto the floors to help complete the work, thus requiring a transfer of tacitly held knowledge from experienced, permanent staff to these newcomers who are unfamiliar with the floors.

Day after day, these patterns of interaction can be seen on the two floors of the Lodge. Like a computer program that is executed every day, the meaning-making dynamic repeats itself. But why does this human system cling to this specific way of making meaning? What is their meaning-making dynamic *for*? This question is the focus of the next chapter.

CHAPTER SIX: DISCUSSION OF FINDINGS

To this point I have reviewed the current state of long-term care in Canada and Ontario, and I have described the specific LTC home in Ontario where I conducted the research—the River Lodge, including its physical layout, its social system, the flow of activities on a typical day, and the continuing effort to bring about a cultural shift in the Lodge over the past five years based on the Eden Alternative. I have also presented the current state of meaning making in the Lodge: I did this by describing the types of questions that staff typically seek to answer, and by reviewing some meaning-making profiles that are present in the data.

I now propose to consider the eight thematic components of meaning-making in the Lodge that emerged from the analysis of the data, and the interactions between these thematic components. This will allow for the construction of a theory that can account for the meaning-making dynamic at work in the Lodge. I will then discuss this theory in terms of the principal theoretical construct that I derived from the literature: a view of meaning making that consists of the construction of experiences of coherence, purpose, identity and competence. I will conclude the chapter by considering how these findings relate to the research questions.

THE COMPONENTS OF MEANING MAKING IN THE LODGE

As the five profiles presented in the previous chapter indicate, the Lodge is home to a rich and complex meaning-making process. The function of this process is to support the actions that occur on the floors. Meaning-making allows work to be accomplished, and it allows the work experience to be sufficiently bearable that the

members of the core teams are able to continue work, day after day. In the Lodge, the meaning-making process can be observed to be well suited to the heavy workload and fast-moving task routine that allows little time for planning and reflection, in which staff invest their energy in carrying out the many tasks that are involved in the delivery of basic care to residents. Meaning-making is less successful when confronted with issues requiring a slower pace, or that require extensive consultation, conversation and reflection—for example, the integration of newcomers into the practice, or supporting the shift from a medical model to a social model of care.

In this chapter, I will describe the eight components of meaning making that emerged from the iterative analysis of the data. These eight components might be viewed as preliminary, separate answers to the question: what are the key characteristics of meaning making in the Lodge? They provide a way of seeing what lies beneath the profiles presented in the previous chapter, an initial and necessary step toward constructing a model depicting the systemic nature of meaning making on the floors.

An Action-Focused Oral Culture

> *All of a sudden Cynthia walked quickly down the floor and interrupted Colleen. She explained that she was trying to feed Mrs. Yager her breakfast, but Mrs. Yager was hitting her and was spilling everything. Colleen said, "Don't do anything when she is like that. Stay away from her. I will give her something as soon as I finish this." Cynthia seemed unsatisfied with this. "But she is getting it everywhere, on the bed, on her, on her clothes. I am*

afraid she is going to choke or something." Colleen sighed and said, "Okay. I will come right now." Colleen and Cynthia walked back to the east hallway.

Excerpt from Field Journal

The Lodge is characterized by a fast-moving task regime supported by an adaptive oral culture, held together by flexible stratagems that attempt to ensure that essential information is available to the staff working on the floor.

Staff focus on the immediate needs of the moment, and they construct a shared understanding of the prevailing situations on the floor that allows them to work effectively within this narrowly-defined context. The context is initially constructed during the report session, and offers a roadmap for carrying out the work during the day; the context is amended and adapted throughout the day, as the work moves forward and occasional surprises are encountered. At any given moment staff focus on a specific task. The work system appears to have been designed, intentionally or not, with this in mind. There is more focus on "texting" (ongoing interpreting that occurs through conversation) than on texts (stable interpretations that are stored in documents). Interactions are fluid and rapid, often happening as people pass each other in the halls. When a puzzling incident takes place, sensemaking clusters rapidly and opportunistically around the incident, and ends as soon as a response is identified. People then disperse back into their tasks.

To adapt to this emergent reality, staff have devised specific stratagems: verbal texting is used to generate interpretations that create a sense of stability, if only momentarily, on the floors; the medication carts act as a hub in the unfolding social

network, with staff and residents seeking out an experienced (in the sense of 'knowing the floor') RPN for advice when others are not available; staff tend to say what they know about a situation that is unfolding, or to announce information that experience tells them may be significant to others (such as the whereabouts of a key person on the floor, or an event concerning a resident that occurred earlier in the week), to ensure that the information has been added to the unfolding oral context and may be available to others if needed; and staff tend to construct and revise what I came to think of as "tacit care plans," verbal do-lists and stratagems for caring for residents that are co-constructed by colleagues and revised through conversation as the shift moves forward. The result is a culture of rapid conversation and oral exchange, focused on the immediate present, and maintained through stratagems that experienced staff acquire through experience with each other and with the floor as a whole.

The Inside-Out Knowledge Exchange Dynamic

The report session began with the regular HCAs questioning the two newcomers about their background, and then giving them their assignments. They asked one man if he had worked at the Lodge before, and he said "Oh yes," nodding in a way that indicated he had been here quite a lot. Sharon seemed relieved and said "That's good" with a meaningful nod. Jackie fetched a worksheet, and she then went over the assignments with the two men. When one of the men did not write anything down, she pointed to a slip of paper in front of him and said, "Write this down." He then wrote

down the room numbers of the people he was to look after. She told him the name of each person, and what he was supposed to do. He asked a few questions when she was finished, and Jackie seemed to think that perhaps he had not picked up on his assignment, so she went over things again—especially who would get a bed bath, who would get a full bath, and who he should start with. He wrote none of this down. Sharon was watching all of this, and when the HCA finished giving him his assignment she reached across the table, took his sheet from him, and she went through it once more, writing down the names of his residents on the sheet beside the numbers. Later, after he had left the room, she remarked to the RPN that he had written down only the room numbers, and she had added peoples' names. Colleen said aloud, "Maybe he doesn't understand how we do things here."

Excerpt from Field Journal

The existing social relationships, workload, and procedures for integrating newcomers create a situation where sharing knowledge and expertise with newcomers is essential for the group's success, but existing methods for sharing knowledge are often disruptive and ineffective. This is the major strain on the system that was observed during the research period, and no resolution was found during that period of time.

The full-time permanent staff and experienced part-time staff have close relationships, and appear to be formed into dyads, cliques or small groups. The people who make up these groups support and like each other, and make common cause in trying

to make the work bearable and worthwhile. Staff are also exceptionally busy. They work a short shift, and the workload is heavy and performance expectations are high—and expectations are becoming more demanding as new Ministry rules are communicated (such as increasing the bathing rule from one to two baths per week, which happened shortly before my research began). Moreover, the floors are often short-handed (I was told that this is a year-round problem that is exacerbated during the summer, when I was present at the research site). Procedures exist to help staff cope with shortages and workload (the floors regularly orient potential new replacement staff, and the floors are able to call upon staff who work elsewhere in the institution to help when shortages arise), but staff generally experience these procedures as ineffective. Newcomers are found to be unprepared to do the work, require considerable time-consuming support and help (which disrupts the work and prevents permanent staff from completing their tasks satisfactorily), and end up feeling frustrated and resentful at the end of their initial shifts (and sometimes announce that they will not return). As a result, newcomers are sometimes supported, and are sometimes not supported by experienced staff.

Wenger's (1998) concept of legitimate peripheral participation, whereby newcomers to a practice are brought into the practice and put on a path toward identities of competent practitioners, is problematic in the Lodge (particularly when applied to HCAs). Occasionally staff volunteered to provide orientation or support to a newcomer, and occasionally they refused. Sharing internal tacit knowledge (about residents, about the floors, and about the task regime) with newcomers is a significant aspect of the meaning-making dynamic on these floors, and is a constant preoccupation of

management and staff. This dynamic, which is evident largely through interactions and conversations, is difficult, and the results are generally disappointing.

Formal and Informal Learning is Inconsistent

"My mandate is to improve the lives of those who live and work in long-term care. And I do this by providing information and training about best practices, in terms of a small practice that could be changed. For example, a continence program. And in each home it depends on the situation in which they find themselves whether they participate. All of the homes want to participate, and they all do to varying degrees, and some are more successful than others, and it just depends on the staff cooperation, really. And even if, as an example, a manager asked me to come and present on documentation, which I did do, and she posted a notice about the training in the hallway, that doesn't mean that people will come. There is not necessarily any way to make them come. It becomes a conflict with unions and priorities. You cannot really force an adult to take education. So if it is paid for and it is an obligation, then they have to come, but if it is just, "How would you like to come?" Then there is no way to coerce them or convince them that they should come.

Excerpt from Insider/Outsider Interview

Formal and informal training and mentoring is essential if the floors are to comply with regulations and rules and to have a capacity to integrate new people and ideas into the milieu. Some instances of informal training of newcomers were observed during the research period among the RPNs and, to a lesser extent, the HCAs; formal training was rare, and seemed to focus on specific compliance and task issues; informal mentoring of existing staff was rarely observed. The focus on getting things done appears to block a focus on creating new capacity and capability.

During the research period of approximately three months, one in-service took place, and staff were observed to participate in formal training on four occasions (this training involved such things as training on how to operate a fire extinguisher and how to use masks and other clothing to protect against the risk of infection). Staff were often unaware that the training was scheduled, and most often appeared to treat the training as a mild nuisance that made it more difficult to complete their daily tasks. Informal training and mentoring, which is mandated for RNs and RPNs in their job descriptions and through their licensing bodies, was rarely seen to occur (the data shows two clear instances of licensed staff providing informal training for non-licensed staff; on both occasions the mentoring concerned a documentation procedure). Informal training of newcomers was problematic: one some occasions, newcomers were shown consideration and were offered support (this was especially true of new RPNs), and on other occasions newcomers were seen to wander uncertainly in the halls, apparently unsure of what they should be doing and ignored by full time staff.

One clear learning process emerged from the interview data. In the existing compliance process, an external compliance advisor identifies deficiencies, an external

best practice coordinator receives information about these deficiencies from the compliance advisor, and the best practice coordinator then attempts to devise an intervention to help increase competency in the designated area. However, although this process was described by three participants, no instances of the process were directly observed; instead, when observing and listening to staff on matters related to compliance, most often it was evident that staff found ways of working around those compliance directives that created social turmoil or that complicated task performance.

Protecting Against the Ramifications of Poorly Designed Change

> *"They are trying to implant the Eden philosophy here. I don't know...I guess it will take a few years before it is going to be really in place. I think they have a committee for Eden. They have meetings once in a while, and they are trying to introduce a little bit of Eden, different ideas. Like the teacups. I find it is a good idea. But we don't have a dishwasher to wash the cups with. So sometimes the cups are going to be in the sink for two days, because we don't have time, I mean the HCAs, to wash them. It is too bad because I like the idea. It is nice, and it is more like home. But I find that we don't have time to wash the dishes. That is another task. I don't mind, but we don't have the time. We are doing a 6.5 hour shift, and it is so busy. It is sad because it would be nice.*
>
> *Excerpt from HCA Interview*

Staff are committed to the status quo, not so much because they see the status quo in a positive light, but rather because they are suspicious of the ways in which planned changes will impact their work. Staff are also committed to specific teammates as trusted partners. Staff get their work done, help each other, and occasionally (when time permits) show a caring attitude toward residents. They protect the status quo because change is perceived as a threat to their ability to get their work done and to provide brief moments of compassionate care.

Staff comments and behaviours provide an indication of staff commitments—commitments to ideas, people, or ways of acting. Staff sometimes evince a commitment to compassionate care, and at other times they evince a commitment to the status quo. Similarly, staff sometimes show consideration toward residents, and at other times they show consideration toward teammates—and these commitments occasionally appear exclusive. Staff were often observed to express themselves forcefully about what floor they wanted to work on, and with which teammate they wanted to be paired; they were never observed to argue over which residents they wanted to be assigned to work with (I was told, however, that some residents express strong preferences for which staff members they wanted to receive care from).

Experienced staff often can be seen to work collaboratively within their occupational practice. Most staff have clear preferences over who they would like to work with and who they would prefer not to work with (sometimes making very direct statements about this), and as the day unfolded staff could periodically be seen seeking help from their "partner" within the occupational practice. This help could involve helping each other with lifts, or helping each other with charting. Occasionally staff

could be seen to work collaboratively across occupational distinctions, as when an RPN seeks information from a HCA, or when a HCA asks an RPN for assistance with a task.

Despite their focus on the work structure and their teammates, staff were occasionally observed to interact with residents in compassionate and caring ways (these interactions were usually brief, as staff hurried from one task to another), and to make statements about residents that indicated a concern for the residents' health and well being. My field journal is full of observations of small, concrete examples of Lodge staff showing care to residents. One RPN arrived one day with some new clothing for one of the residents, which she had purchased with her own money. An RPN on one level and an HCA on the other level both host summer barbecues at their homes for the residents on their floor. I often saw staff interrupt their work to help a resident locate a missing personal article (a pair of shoes, or eyeglasses). I saw staff spontaneously hug residents, smiling at them and sharing a joke. Staff often tried to soothe agitated residents—for example, when residents were frustrated by their difficulty in communicating, or when an anticipated visitor did not arrive, or when an outing had been cancelled. I often saw staff walking along the hallway holding hands with a resident. As I observed HCAs and RPNs carrying out their duties, I often saw them pause briefly to flatten an errant collar on a resident, or to tuck a strand of hair back in place. These acts of care were usually brief, as staff were busy dispensing medications, or serving meals, or bathing residents.

Staff commitments, relationships and interactions are reflected in the extent to which the Lodge is perceived as adaptable to change, and in the extent to which the Lodge can be said to be characterized by specific facilitators of change. The Lodge is generally perceived to be resistant to change, with this resistance grounded in staff

commitments and attitudes—commitments, that is, to the existing regime of procedures and tasks. Cross-disciplinary cooperation and sensemaking is limited when it comes to change, as evident in the lack of HCA participation on the Eden committee.

Instability, Emotionality, and Reluctant Allegiance to the Status Quo

Sandra was walking so quickly as she performed her tasks, she was almost running. She came out of one room carrying a bundle of linens, and hastened down the hall. Then she came by again, carrying a coffee pot, and she poured a cup of coffee for a resident, saying "Promise you won't move while you are drinking this." Then she rushed into the kitchen and came out pushing a cart loaded with trays of food (it was 10:15, late for them to be serving breakfast). She came hurrying out of the dining room with a food tray, which she placed on a cart with finished trays. Then she stopped and noticed the bell that had been sounding, and turned to Danielle and said, "I don't have time to check on that, I am too busy." Danielle said, "The picnic is at ten and we haven't got them all up yet. We're so far behind! If that girl ever gets here I am going to talk to her." Sandra said, "What are you going to say?" Danielle raised her eyebrows and replied, "You don't want to know."

Excerpt from Field Journal

The Lodge sees a constant flow and turnover of people, and frequent absenteeism, which creates high levels of instability and emotionality. Attempts to improve this are not always successful, and this is attributed to a factor called "resistance to change." Though this resistance is attributed to staff attitudes, it appears to have more to do with the heavy workload, the limited information flow, and the worry that change may negatively impact on the workers' sense of purpose and identity.

The Lodge is the site of a constant movement of people onto and off of the floors, in and out of rooms, up and down the hallways. The floors have the feel of a busy neighbourhood, where service providers deliver a variety of services to people who live in the vicinity. This movement of people also includes an ongoing and intense turnover of management and staff. The Director of Care position has changed several times in recent years (including once during my three-month research period), providing a sense of shifting priorities and uncertain direction. Temporary staff are constantly arriving to fill vacant positions, and this necessitates the provision of support and informal training—which are sometimes not forthcoming. This results in a sense of instability on the floors, and periods of high emotional stress.

Instability in this environment is defined as the inability to focus on assigned tasks, and the need to accommodate constant interruption and problem solving (due to the presence of newcomers, who require attention and support, and whose work sometimes needs to be redone). The emotionality on the floors includes the rueful humour of people who are working together on a worthwhile but extremely difficult task, but more often it is expressed in terms of frustration, confusion and anger.

Although it would seem that all staff would want to improve this situation, participants often referred to the high level of "resistance to change" among staff—often attributed to an attitude consisting of a preference for the familiar tasks and procedures and a suspicion of new ways of doing things, and sometimes attributed to a management approach that does not include sufficient consultation with and inclusion of front line staff in change initiatives. The data, however, suggests that the floor's inability to embrace change has more to do with factors stemming from the heavy workload and the staff desire to provide at least a modicum of compassionate care: the Lodge's Eden Alternative initiative presents staff with a double bind which cannot be resolved (a choice between being seen to be caring but unable to provide emotional care, or being seen to be uncaring but able to provide a modicum of emotional care); the current task structure includes fractured documentation processes and collaboration processes which are inadequate to create a flow of information that can enable an environment that is pro-active, reflective, and capable of double-loop learning (learning that focuses on both solving immediate problems and resolving underlying systemic issues), and that instead is well-suited to support an environment that is reactive, intense, and capable of heroic individual action and single-loop learning (learning that focuses exclusively on solving immediate problems without considering root causes) (Argyris and Schön, 1978).

Absorbing External Pressures for Change into an Unruly and Unstable Environment

> *The biggest barrier to the Eden Alternative is attitude. People don't like change. They don't like to be told that what they are doing isn't the way to go. There are some staff who are in little*

cliques and they don't seem to like anything that changes how they go through their daily routine, and they feed off the negativity of each other, so you can never get past this.

Excerpt from Eden Interview

Staff, managers, and regulators attempt to bring order and control to the instability on the floors through mechanisms such as: documentation; decision processes based on hierarchy, scope of practice, or local knowledge of the floor; and sets of standards and rules that are intended to control behaviour. Control often originates in the external environment, and staff absorb these external pressures through their local regimen of practices—which tends to transform pressures for change into a focus on concrete, short-term negotiations and tasks.

A variety of mechanisms and approaches are used to bring coherence and a sense of control to the daily experiences on the floors. These approaches can originate from inside the system and from outside the system. Staff are required to create documentation during and especially at the end of each shift, to update resident care plans and to pass on important information to subsequent shifts in ways that might bring continuity to the work of the teams. Staff were observed carrying out these documentation tasks and using documents, though this was not observed to be their most significant meaning-making strategy.

On occasion staff are seen to take control of a situation or to direct the work of other people, but hierarchy in this environment is complex and changing—there are competing demands from the organizational hierarchy and scope of practice hierarchies, and intimate local knowledge of the floors was seen to be an important mediating factor

in determining who would have input into and control over decisions. Staff for the most part work independently, and thus a clear knowledge of the task environment and how to resolve immediate dilemmas is critical for success (collaborative meaning making is reserved for the most serious matters). It is evident that knowledge of the rules and standards created by legislation, compliance reports, licensing bodies, and the organization are intended to guide and control the work of staff, but staff tend to subordinate the importance of this knowledge to the incessant demands of the work routine, and the need to complete tasks (which relies more on knowing the floor than knowing standards and rules).

The desire to bring coherence and order to this unstable environment also takes the form of pressures to implement changes to the way that work is managed and carried out, with these pressures often originating in sources in the external environment. Some of these pressures take shape as instances of planned change—for example, the overall compliance process which identifies "unmet" standards that must then be addressed within prescribed timelines, the institution's strategic planning process which impacts all departments and occupational groups, and even the Eden Alternative, which originated with a doctor in the United States and which entered the Lodge when two staff attended training on their own initiative and then attempted to introduce the ideas into the Lodge.

These external pressures result in meaning-making dilemmas for the floors, and these dilemmas can be resolved only with the existing tools and practices that are at hand. Eden, for instance, becomes translated into a disparate set of concrete, small-scale projects to introduce "homey touches" into the Lodge—rendering it manageable through a focus on action and the "here and now." Ministry rules, concerning such things as

meals and soiled linen carts, are negotiated on a case-by-case and day-by-day basis by staff, with compliance varying depending on workload, instability, and the desire to balance overall resident wellbeing with the need to work within the prescribed rules.

Threats to Meaning Making

Colleen was surprised to learn, from the Daily Flow Sheet that came in on the fax machine, that she had been assigned to a special duty that day, which was why a replacement RPN had arrived. Colleen said this was the first she had heard of it. There was confusion about who was replacing who, and whether they had enough HCAs on the floor. Then a replacement HCA arrived, and she explained that she had been initially sent to the first level, but when she went there she was advised to switch with another replacement because the other replacement knew the first level whereas she knew the second level. The HCAs asked her to confirm this a number of times. "You are more familiar with this floor?" The replacement HCA said yes each time. There was also some discussion of whether the replacement RPN should work at the east or west end. Judy finally said that she wanted the replacement to work at the east end, because she (Judy) had been working at the west end for the past few days and would continue to work there over the weekend. As they were sorting out these roles (it was the RPNs who were most active in this part of the

discussion), Colleen made an exasperated sound and said that she was going to find out what is happening, and she left the room.

Excerpt from Field Journal

Meaning making is a contested negotiation that often leads to compromises, some of which favour staff while others favour residents. Contradiction, confusion, and conflict are met with attempts to create or maintain a sense of coherence, purpose, identity, and competence.

Staff and management are constantly contending with small and large breakdowns to the meaning-making processes. These breakdowns can be relatively minor (where a person is unsure of how to perform a task, or two people are searching for a third person or a piece of equipment) or major (where people are attempting to make sense of Eden, or of a new Ministry rule). It is common for staff to be unaware of activities taking place in the Lodge—for example, staff were often unaware of special training activities or work assignments that were scheduled for the day, and they were often unaware of scheduled activities (such as maintenance and repair activities) that would impact their work. It was also common for people to be unaware of the consequences that followed upon certain planning activities and other actions—one of the supporters of the Eden Alternative, for example, was unsure if planned activities to communicate the Eden philosophy were carried out, if explanations of Eden were forthcoming when questions about Eden were raised by senior managers, or if a suggestion for a change made by an HCA was incorporated by the team. This latter tendency gives rise to the need that staff have for sharing verbally all information they possess about a resident or a situation, in case somebody else might find this information useful. Staff often have to resolve

contradictory situations—for example, placing the soiled linen bin in a locked room contains the smell and is a caring act, while leaving the bin in the hall is less considerate but makes the work easier.

Meaning making on the two levels of the lodge is somewhat different, and the two levels are perceived differently by members of the system. The second level was the locus for a conflict situation that turned out to be related to the problem in integrating newcomers—the major dilemma that the Lodge faced during the research period. Staff tend to resolve meaning-making breakdowns by bolstering their experience of coherence, purpose, identity, or competence. They pool information to create a coherent account of what is happening on the floors; they express their support for each other, and for residents; they describe themselves as coping heroically with an unreasonable workload; and they shore up the capacity of the shift by drawing on their knowledge of the floors to create, revise and implement their tacit care plans. However, meaning making may always be contested and problematic in this environment, because of a necessary tension between workplace and home. Although some decisions have neutral impacts, others favour either the workers or the residents, and meaning making in this environment is a contested negotiation that seeks to balance the heavy workload against the comfort and well-being of residents.

Knowing the Floor

I notice that the RPN was often interrupted as she distributed the medications, and that she had to constantly remind herself of where she stopped. I said, "Thank goodness for checklists." She

made a rueful face and corrected me, "Thank goodness for knowing my floor."

Excerpt from Field Journal

The central meaning-making dynamic in the Lodge is described by the term "knowing the floor." Through an oral culture that includes the daily construction of shared understandings and strategies, and the construction of narrative accounts and explanations to bring continuity to the work and to cope with specific situations, staff tackle the daily workload, solve immediate problems, and convey important information to their teammates and to the next shift. Knowing the floor consists of intimate familiarity with the residents, the other staff, the work routine, and the physical environment. Knowing the floor is manifest in the ongoing conversation, the search for meaning (coherence, purpose, identity, competence) that provides a ground for action. It is transcribed at the end of each shift, and is recovered at the beginning of each shift, through the report session, where texts are quickly read, assignments negotiated, and action initiated.

Meaning making, and the movement of knowledge from person to person and from group to group, is a central function of the floors. Without meaning making, the work would be impossible. Numerous specific meaning-making processes and events were observed during the research, including momentary episodes to solve a specific problem, and processes of longer duration that involved solving a vexing problem on the floors or introducing a new culture and identity onto the floors.

The local meaning-making dynamic includes specific tools and strategies. Most significantly, staff construct and maintain a shared understanding of the floors during the

morning report sessions and through ongoing momentary interactions that occur throughout the shifts. Texts are a resource for this process, and are treated as helpful but problematic—another administrative task that keeps them from their busy routine. The culture is fundamentally oral and action-oriented; texts provide information, but oral accounts are often preferred. When problems arise, staff often collaborate on creating a narrative that provides explanation and direction. These stories are not intended to create a repository of solutions that can be accessed later, but rather help to maintain an environment that is coherent and purposeful, and that allows for skilled practice members to accomplish their immediate tasks.

Staff are also adept at decoding the meanings of residents, many of whom suffer from cognitive impairments and have difficulty communicating their needs. Staff occasionally engage in meaning making around recent workplace events, or about the work or the Lodge in general, describing the value of the work, their own identity as compassionate caregivers, their fondness for residents, and the frustrations they experience because of staff shortages and heavy workloads.

Ultimately, the immersion of skilled practice members in this unfolding oral culture takes the form of "knowing the floor," the most valued form of knowledge in the Lodge. Knowing the floor brings stability to the work, assures that mandated work will be accomplished, and is a key factor in determining power distribution on any given shift. Knowing the floor consists of four key elements: knowing the residents on the floor; knowing the other staff on the floor (because staff's immediate priority is to provide support to valued teammates, and through this support they create an environment in which care can be delivered to residents); knowing the work routine on the floor; and

knowing the physical layout of the floor, and where things are kept. Knowing the floor is the ongoing conversation, the searching for meaning that provides a ground for action. It is transcribed in texts as each shift draws to an end, and then is recovered from these texts and conversations as each new shift begins, through the report session, where texts are read aloud, assignments are negotiated to ensure people are aligned with their preferred teammates, and the inevitable, all-consuming flow of action is initiated.

THE MEANING-MAKING DYNAMIC IN THE RIVER LODGE

The eight thematic components of meaning making that I reviewed on the preceding pages interact with each other to form a meaning-making dynamic on the floors. This dynamic allows RNs, RPNs, and HCAs to create a sense of coherence and stability on the floors, and to cope with the demanding task regime that is characteristic of LTC homes. Meaning making allows staff to communicate, solve problems, organize work, and complete tasks. It allows them to create and sustain a body of knowledge and skill that is suited to the purpose of these caregivers: to see to the basic needs of residents, and to attend to their complex health conditions. It shores up their sense of who they are and how they fit into the work that is carried out: skilled but overburdened caregivers who toil in a corner of the health system that is overlooked and neglected by managers and policy makers.

Figure 4 provides a meaning-making map that illustrates the meaning-making dynamic at work in the Lodge.

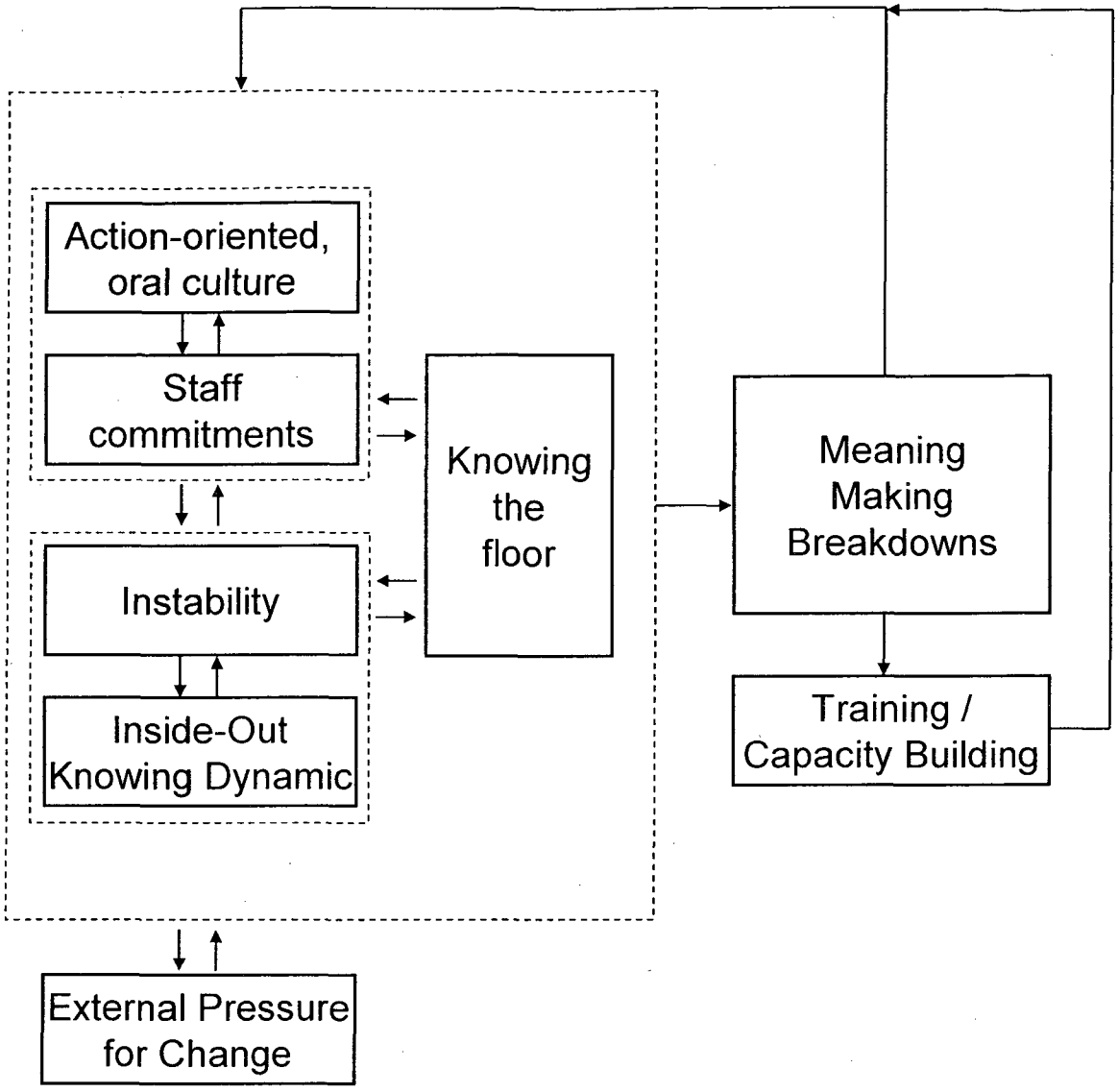

Figure 4. **Meaning-Making System Map for the River Lodge**

The factors within the large dotted-line rectangle are internal system factors. The two smaller dotted-line rectangles that lie inside the internal system are factors that combine to create effects through their interaction. The five internal factors do not have causal relationships, but rather have a systemic relationship—they hold each other in place, and their intensity can vary at different times.

The Lodge possesses an action-oriented oral culture that places priority on the here and now, the immediate, the daily regimen of tasks that must be accomplished, and the sharing of information through quick, task-focused interactions. Getting work done is highly valued, and life on the floors is organized around the demanding flow of tasks.

Given the immediacy and narrow, task-focus of experience on the floors, staff have developed a set of commitments that allow them to maintain stability within their volatile environment. Staff are committed to specific teammates as trusted partners. Like everything else on the floors, relationships are integrated only to an extent: hence there is no strong sense of an overall team, but there are cliques and dyads, small groups that are committed to each other and that show care and support for each other. They get their work done, help each other, and (when time permits) show a caring attitude toward residents. These relationships and ways of working are seen as vital to their success in carrying out their tasks. They therefore protect the status quo because change is perceived as a threat to their ability to get their work done and to provide brief moments of compassionate care.

To support this fast-moving, task-focused environment, the staff have devised a way of knowing, a meaning-making dynamic, that I have labeled *knowing the floor*. I selected this term because I heard it used several times by staff during the research period, and because it implies a way of knowing that focuses on issues of immediate relevance that are grounded in an experience of a very specific context. Knowing the floor consists of intimate familiarity with the residents, the other staff, the work routine, and the physical environment. Knowing the floor is highly tacit, and is manifest through an oral culture that includes the daily construction of shared understandings and

strategies, and the construction of narrative accounts and explanations. This form of meaning making allows staff to tackle the daily workload, solve immediate problems, and convey important information to their teammates and to the next shift.

Instability, however, is a constant threat to task achievement. The primary source of instability takes the form of a constant flow and turnover of people. This turnover occurs at all levels, including senior leadership, and results in confusion over longer-term priorities and direction (which reinforces the focus on the here and now) as well as confusion in the daily flow of work as newcomers are unable to integrate into and provide support for the core team. Staff are encouraged to help newcomers fit in, and staff recognize that this is important; however, the existing methods for including newcomers meet with inconsistent success, and staff become suspicious of the sanctioned methods and wary of newcomers. Staff come to view improvement initiatives with suspicion, and this suspicion is labeled by others as "resistance to change." Though this resistance is often attributed to staff attitudes, it appears to have more to do with the heavy workload, the limited information flow, and the worry that change may negatively impact the workers' sense of purpose and identity.

If the major meaning-making dynamic is knowing the floor, the major challenge for this dynamic is to create and implement an inside-out flow of tacit, contextual knowledge. In other words, to maintain a high level of stability in the work environment, the quality of "knowing the floor" must somehow be shared with newcomers and outsiders. Knowing the floor, however, is highly contextual and tacit. It takes time to become familiar with teammates, residents, work routines, and the location of tools and supplies. Newcomers are often surprised by the unique features of work in the Lodge (so

different from work in other healthcare environments), and find themselves faced with an unexpectedly heavy workload, and with a need to fend for themselves and take initiative. Their skills are often those of newcomers to the practice, and they require mentoring, support, and encouragement—but these factors are not always present. The inside-out flow of knowledge is seen as both imperative and problematic. Insider knowledge is blocked by the existing system, and the implementation of an effective inside-out dynamic is an ongoing preoccupation and challenge.

The result of the interplay of these factors is a meaning-making dynamic that is capable of handling task-related issues that come to light in the daily flow of activity, but that is less able to cope with long-term and system-wide issues—particularly those associated with the arrival of new people and/or new ideas on the floors. As a result, there are continual meaning-making breakdowns. These breakdowns are addressed occasionally through efforts to create new capacity that would allow the floors to resolve these breakdowns. In the Lodge, capacity building occurs through formal and informal training, and through the work of the Eden Implementation Committee. However, formal training is rare, and tends to focus on compliance factors (training that is mandated in order to meet regulations rather than deriving from internal system needs). Informal training, though mandated in job descriptions and in occupational rules, is difficult to implement in an action-oriented environment where staff shortages are common. Instances of informal training were observed, but they are not the rule. The Eden Implementation Committee does not represent the entire social system on the floors, and its work is hampered by the demands of the task system. It has come to focus largely on

implementing small, homey touches—and the success of the implementation varies from floor to floor and from day to day.

Meaning-making breakdowns in the Lodge are not met with a thorough diagnosis of issues and interrelationships. The focus on action and on contextual tacit knowledge results in a reframing of large problems in terms of small, concrete issues (where to position a soiled linen cart, whether and how to use teacups rather than Styrofoam cups) or in terms of "off-the-shelf" organizational interventions (conflict management training, teambuilding exercises) which themselves must be chunked into pieces that are possible to deliver in the busy environment. The existing meaning-making dynamic reduces big breakdowns into bite-sized, digestible pieces that are inadequate to address the problems that gave rise to them, and thus the big breakdowns tend to recur.

Donald Schön (1983) has shown that when a practitioner confronts a challenge at work, his/her first step is to frame the challenge as a problem that can be solved. At the Lodge, the framing of solvable problems is mediated by the shared meaning-making dynamic that staff have created to handle their most urgent dilemma: a heavy workload that must be accomplished during a 6.5 hour shift. But framing a challenge as a solvable problem can also reshape the challenge, focusing attention on some issues and ignoring others. This, I believe, is what happens when staff confront problems that require a reconsideration of the underlying constraints and assumptions on which the current work system is based. For example, funding shortages have led to the shortened shift and heavy workload; this in turn leads to a focus on immediate tasks; the problem solving capacity that allows for an efficient handling of immediate tasks is inadequate for deeper changes, such as the culture shift required by the Eden Alternative; and this, finally,

results in the Eden implementation being translated into small tasks such as the occasional use of teacups instead of Styrofoam cups. Or again, the design of work using a medical model (derived from the flow of work in hospital environments) rather than a social model (which sees a LTC home primarily as a residence) allows work to be scheduled and segregated using the scope of practice rules of occupational governing bodies; this promotes a focus on accomplishing in-scope tasks, which in the current environment involves a heavy workload; the difficulty in completing required tasks means that staff experience anxiety when they encounter threats to add new tasks to their in-scope workload; and hence staff attempt to insist that their workload, and the work system, should be left in its current state and should not be altered.

The problematic nature of this meaning-making dynamic is evident to outsiders who feel responsible for promoting improvement—organizational leaders who come onto the floors occasionally and who receive formal and informal reports about the challenges faced by staff; licensing bodies who are aware of the pressures on these LTC systems and who are investigating potential improvements to LTC; change agents who have devised fundamentally new approaches for the design and operation of LTC facilities and who win converts and advocates among educators and practitioners who interact with the Lodge; and regulators who conduct inspections of the Lodge that result in visits from external professionals who try to introduce changes to local practices. These external sources propose improvements that Lodge staff experience as pressures for change originating from outside the system. These pressures are pulled into the internal meaning-making dynamic and are dealt with on its terms. Eden, for example, is reduced to a set of concrete tasks. Compliance interventions are added to the daily task lists

(positioning of the linen carts, use of portable trays, compelling all residents to eat in the dining rooms, completing documentation accurately and fully, etc.), and are implemented in a piece-meal and inconsistent manner, depending on the daily workload and staffing assignments. The inherent instability of the floors is addressed through congratulatory cards and thank-you cakes for staff, intended to motivate them to be more congenial toward newcomers. All of these externally-imposed solutions are pulled into the internal dynamic, reduced to a size that can be handled by the action-oriented culture, and are negotiated on a case-by-case basis through the interplay of staff commitments and knowing processes—hence one day the linen cart is positioned where the regulators require, the next day it is not.

Through the interplay of these factors, staff have created a way of working and living on the floors. They get their work done. When possible, they provide moments of compassionate, personal care to residents. They make sense of external pressures to change their practice, and they protect the integrity of their hard-pressed system. They cope with newcomers who try to help, but often create new problems. They support each other. They create for themselves an identity of unsung heroes, overlooked and derided within the larger health care system, but committed to and often passionate about the need to provide care for the elderly and infirm, and determined to succeed despite the barriers and challenges that are placed in their way.

CONSTRUCTING COHERENCE, PURPOSE, IDENTITY, AND COMPETENCE.

The participants in this study create a sense of purpose through the commitments they make, in words and action, to the residents of the Lodge and, more significantly, to

each other. They are committed to delivering the basic care needed by residents, and to providing emotional support to residents whenever their hectic schedule allows. Through these commitments, they become loyal to the Lodge as it is presently constituted—not because they believe that change is necessarily bad, but because the changes that have been introduced, and the imminent changes that they hear discussed, put additional pressures on their over-burdened workload, and make it more difficult to maintain their commitments to residents and each other. Their purpose-making, though under clear and constant pressure, is largely successful.

Participants create identities of unsung heroes who cope successfully with an enormous workload, who work in a world that is described by phrases such as "the gods must be crazy." They are conscious that they work in a neglected corner of the health system that is unique in several respects: residents often have two or more chronic conditions, making the caregiving task more complex, and the resident-worker ratio places a much greater demand on staff in LTC than in other health contexts. Staff often form close, caring relationships with the residents they serve, and they dread the inevitable day when these residents will die. They see those who are external to the Lodge, particularly regulators and those who develop policy on how resources should be allocated and how work should be organized, as remote and poorly informed bureaucrats who treat the residents like pieces of paper or like furniture rather than as human beings. Despite these incessant pressures and challenges, and despite the high emotionality that is an integral part of the workplace, participants adopt the role of unsung hero, and get their work done.

Participants create and sustain regimes of competence through a highly adapted meaning-making dynamic that is well-suited to a fast-moving, overburdened task system. They focus on tasks, they move swiftly to action, and they create and implement tacit plans through the morning report session and through their frequent, brief exchanges throughout the day. However, the adaptive qualities of their system are simultaneously sources of enormous pressure—legitimate peripheral participation is often problematic, as newcomers are required to immediately join the struggle, immediately fit into the environment. The inclusion of newcomers, vital to the system, often fails. Moreover, the system is adaptive in relation to maintaining the status quo, keeping the work flowing day after day, but it is significantly less successful in creating the conditions that might allow participants to see ways out of their current systemic dilemmas. Learning is restricted to a single loop, and focuses largely on immediate problems and tasks. Larger issues, such as the desire to implement a broad program to create a more compassionate and home-like environment, are broken down into discrete, small-scale tasks. The existing task system may be incapable of coping successfully with transformative change.

If the creation of competence is problematic, then the creation of coherence is a constant preoccupation of participants. The central purpose of the meaning-making dynamic in the Lodge is to create and maintain coherence. Coherence is created in the morning during the report session, and is maintained throughout the day through quick verbal exchanges. Coherence is a matter of matching tasks and procedures with the resident environment: participants follow a sequence of getting people up, feeding them, bathing them, moving them around, and feeding them again. Coherence comes from knowing the floor (the physical layout, the work routines, the residents, the other

workers), and it is kept in place by the action-oriented oral culture and by staff commitments to their coworkers and residents. Coherence is constantly threatened, however, by the arrival of newcomers who are unable to answer the basic, coherence-making question: what is going on in this place? They do not know the floors, and their behaviour introduces uncomfortable levels of uncertainty and instability into the busy flow of work.

THE ARRIVAL OF THE NEW: THE EDEN ALTERNATIVE

In the struggle to maintain stability, the Lodge's meaning-making dynamic renders newcomers problematic. This is true of both new people and new ideas. The existing dynamic is perhaps comparable to a work system on a sinking ship: the crew must keep bailing, or the ship will sink; but if the crew devotes itself entirely to bailing, they won't be able to repair the leak. Staff in the Lodge are so intent on keeping the floors afloat, they are reluctant to take on new roles or tasks (integrating newcomers, or implementing the Eden Alternative) for fear that they will be overwhelmed and unable to provide basic care.

Consider the case of the Eden Alternative, and its five-year implementation cycle that has left it, in the words of one participant, "still struggling at the beginner level." Table 5 summarizes the impact that Eden could have on HCAs in terms of the four modalities of meaning-making: purpose, coherence, identity, and competence.

Table 5:

The Impact of Eden on HCA Experiences of Purpose, Coherence, Identity, and Competence

	Purpose	**Coherence**	**Identity**	**Competence**
Currently:	HCA purpose is to provide basic care for elderly residents, to support teammates, and to provide emotional support for residents when possible.	HCAs create coherence by matching tasks and procedures with the resident environment: HCAs know their responsibilities, and follow a sequence of getting people up, feeding them, bathing them, moving them around, feeding them again. Coherence comes from stability, and stability means that HCAs know the floor (the physical layout, the work routines, the residents, the other workers). Coherence is created in the morning during report, and is maintained throughout the day through quick oral exchanges.	HCAs are skilled (and overworked) caregivers. An HCA is a valued member of the shift who knows the floor. The HCA works hard. Workers in other healthcare environments look down on HCAs in LTC, but these HCAs know that what they do is important. They care for the elderly. They do their best in the face of a difficult situation. They try to be compassionate in the bits of time they can afford to spend with residents.	HCAs know the floor: HCAs know their teammates, the residents, the work routines and procedures, and the layout of the floor. They create, maintain and share this knowledge by being present each week, working shifts. The competence of the HCAs is clearly delineated by scope of practice rules.

	Purpose	Coherence	Identity	Competence
With Eden:	Eden changes the HCA purpose. It removes the boundaries afforded by scope of practice. An HCA becomes responsible for everything. Task work increases and the ability to provide emotional support is diminished. The HCA must now clean birdcages, load and empty dishwashers, water plants, and look after pets. Instead of scheduling work in advance, the HCA will be required to adapt the work flow to the desires of residents. HCAs are not involved in the process of implementing Eden, because they do not have time to participate.	Eden removes the coherence afforded by the way that work is currently divided and sequenced. The Lodge becomes less of a workplace and more of a home. The HCA's orderly sequence of tasks and procedures is gone. Without additional resources, Eden will bring instability. If workload increases and HCAs lose their sequential routine, how will HCAs get their work done? Given the time constraints today, HCAs need to sequence work in a way that favours the flow of tasks, not the needs of residents.	Eden changes HCA identity. What will an HCA's title be? Will HCA work be seen as more or less valuable? Eden means that everybody is responsible for everything. An HCA no longer belongs to a clearly bounded practice. With the removal of practice boundaries, gone also is the way of ordering relationships and distributing power. The result is chaos. "Who am I in Eden?" There appears no clear answer to the question.	Eden changes the existing regime of HCA competence. Competence used to be established in relation to scope of practice. With Eden, scope of practice boundaries are blurred. All staff are expected to be more responsive to resident needs. An HCA can no longer predict what tasks will need to be performed, and in what order. Because it increases workload, Eden diminishes the personal time an HCA can spend with residents.

In terms of the meaning-making dynamic depicted in Figure 4, Eden enters the Lodge as an external pressure for change. To implement a cultural transformation of this

magnitude, the Lodge would need a meaning-making capacity focused on long-term problem solving, and would require a way of working that would allow a cross-section of staff and other stakeholders to become familiar with and involved in the implementation. The existing meaning-making capacity is inadequate for this type of transformation. The Eden implementation adds to the instability on the floors; it is seen as creating demands that cannot be met, and as threatening the ability of staff, especially HCAs, to complete their work. Consequently, it results in a meaning-making breakdown that cannot be addressed through any existing capacity-building mechanisms. Instead, Eden, rather than transforming the Lodge, is itself transformed by the Lodge's meaning-making dynamic into a series of small-scale projects that are often implemented intermittently and inconsistently on the two floors. Teacups are occasionally used on the second level, but not on the first. The birds are cared for on the first level, but are complained about on the second. The existing scope of practice remains unchanged. When discussing why the Eden implementation is stalled, the HCAs and RPNs invariably say that Eden is a good idea, while they simultaneously point to the current workload and say that it is simply not feasible.

ANSWERING THE RESEARCH QUESTIONS

The above description and analysis provide the answer to the primary research question for this study: "*How is knowledge created, sustained, used, and altered in workgroups in one long term care facility in Ontario?*" Knowledge is created, sustained, used, and altered through a meaning-making dynamic that emphasizes a tacit knowing of the floor that helps to promote stability within a turbulent and demanding work

environment. This dynamic is constantly threatened by instability, often in the form of the arrival of new people or new ideas on the floors. Newcomers must quickly access and participate in the existing meaning-making dynamic, but this is inhibited by the current focus on action and a heavy workload. New ideas are needed to promote a better balance of basic care and psychosocial care, but these ideas are experienced as threats to the precarious stability of the existing task system. The key limitation of the meaning-making dynamic is its inability to support the "inside-out" flow of knowledge to newcomers, which is essential if the practice is to support legitimate peripheral participation. Meaning-making breakdowns are common, and often lead to problems being reframed in smaller terms, or in solutions being contested on a daily basis by staff as they carry out their work. This could imply that the meaning-making capacity of the existing dynamic is limited to relatively small, immediate, contextual problems, and could be inadequate to allow staff to make sense of changes to the system's underlying culture or to its overall structure for delivering care.

The second research question informing the study is: *Do workgroup members consider some or all of this knowledge to be usable—that is, do they believe that this knowledge contributes to the performance of the workgroup's task? What constitutes "usable knowledge" for workgroup members?* This study indicates that the meaning-making dynamic described above is the primary source of usable knowledge for the members of this system. The system is constantly contending with threats to its stability, and the meaning-making dynamic focuses on creating sufficient stability to allow for a coherent and purposeful flow of work during the shift. Usable knowledge is produced primarily by *knowing the floor*. This knowledge is highly contextual, and has to do with

the work routines, the physical layout of the floors, the preferences and conditions of residents, and the skills and preferences of coworkers. To know the floor is to know how to get the work done in a volatile and demanding environment. Knowledge is usable if it is relevant and contextual, and if it is immediately available to use in the performance of tasks.

The third research question in the study is: *Do workgroup members believe that usable knowledge results in changes to their work? If so, how do they describe the way in which these changes occur?* In this environment, usable knowledge sustains the work more than it alters the work. Change is not viewed as a realistic option. The key purpose of the meaning-making dynamic is to support the busy flow of work that occurs throughout the shift, to create the stability needed to allow for the completion of tasks and to preserve a modicum of time for the provision of compassionate care. Change tends to originate outside this bounded system, and is often perceived as having been formulated in ignorance of the pressing challenges of this workplace, and as bringing unwelcome additions to an already overburdened workload. Ironically, many of the proposed changes to the system that came to light during this study are motivated by a desire to create a more caring and compassionate environment for residents; at the same time, staff often oppose these changes because, in their view, the changes would simply add new tasks to their daily routine and thus make it more difficult to provide compassionate care to residents.

CHAPTER SEVEN: CONCLUSIONS

In Figure 4 in chapter 6 I presented a map to depict the meaning-making dynamic at work during the day shift on the two floors of the River Lodge. The map shows the pattern of interactions through which meaning is made on the floors, and it also indicates the existence of pressures from the external environment, along with a systematic way of handling (or mis-handling) breakdowns in meaning making. The map shows how a group of people working in long-term care have created collective ways of knowing and acting in order to carry out their work, and it also indicates possible weaknesses in these collective capabilities and activities.

In this chapter I will conclude the inquiry by summarizing where all of this leaves us. I will *speculate* (and I intentionally emphasize this word) on some possible implications of the inquiry for our general understanding of meaning making in workgroups, and I will offer suggestions for conducting further research that might build on the results of this inquiry. I will also describe the limitations of the inquiry, and will position these results in the context of the literature that I reviewed in chapter two. Finally, I will discuss some of the implications of these findings for practice, emphasizing the current interest in knowledge flows within the Canadian health sector, as well as a more general interest in organizational learning and effectiveness.

LESSONS LEARNED FROM THE INQUIRY

The purpose of this inquiry, and the methods used to conduct the inquiry, focused on bringing to light the meaning-making dynamic in a specific organizational context.

The inquiry was not intended to construct a generalizable theory of meaning making in workgroups. Nevertheless, meaning making is characteristic of most, if not all, workgroups; for example, the literature reviewed in chapter four indicated that meaning-making may involve four modalities that allow for the construction of experiences of coherence, purpose, identity, and competence. The meaning-making map presented in the previous chapter depicts meaning making as a dynamic anchored in the codes and themes derived from the data. Further reflection upon this map, and upon the way that the elements within it function together, may allow us to derive a clearer picture of the systemic nature of meaning making in these workgroups at the River Lodge, one that will lend itself to comparison and even testing in other organizational contexts. I will therefore begin by attempting to translate Figure 4 into a form that might help to explain the meaning-making dynamic in workgroups outside of the River Lodge.

For example, the map depicts an element labeled "knowing the floor" as being in interaction with two other elements. Knowing the floor is a way of knowing that is highly adapted to the priorities and needs of the floors. It includes a staffperson's tacit knowledge of residents, teammates, work routines, and physical layouts, and it is evident in ongoing verbal exchanges that allow for the construction of shared understandings, strategies, narrative accounts, and explanations. Knowing the floor is a specific, adaptive *meaning-making strategy* that allows staff to get their work done. I suggest, then, that other workgroups may over time create meaning-making strategies that are adapted to the exigencies of their workplace and environment.

The first of the two elements that "knowing the floor" interacts with involves an interplay between the action-oriented oral culture of the floors with staff commitments to

their teammates, to their busy workload, and to the residents they serve. The reliance on tacit knowledge exchanged through verbal interaction, and a set of commitments that clarifies priorities and gives focus to action, act as *stabilizing factors* that allow staff to create some degree of continuity and certainty within a challenging, changing environment. The prevailing meaning-making strategy is tailored to these stabilizing factors: the action on the floors calls for a meaning-making strategy that is specific, immediate, and pragmatic, and that brings enough stability and coherence that staff can carry out their tasks. I therefore suggest that other workgroups may also experience a set of stabilizing factors that bring continuity and a measure of certainty to the workplace.

The meaning-making map of the River Lodge also includes factors that promote instability on the floors. The destabilizing factors that were most prominent during the research period had to do with interruptions to the daily work routine; staff are so hard-pressed to get their work done, that any interruption could prevent them from accomplishing their required tasks. These interruptions often took the form of newcomers, usually temporary replacement staff, who came to fill in for an absent full- or part-time employee, as well as of new ideas (standards, rules, improvement programs) that were intended to improve conditions for residents. It may be the case that many workgroups in diverse organizational contexts must also contend with a set of *destabilizing factors* that challenge the capacity of the workgroup's existing meaning-making strategy.

The meaning-making dynamic in a workgroup might thus be seen as an interplay involving three internal factors: stabilizing factors, destabilizing factors, and meaning-making strategies that support stability and contend with instability. The stabilizing

factors give continuity to the group's experience, and create a stable ground for knowing and acting; in the case of the River Lodge, the stabilizing factors include a focus on the completion of tasks, a commitment to teammates and residents, and a sense of identity as marginalized heroes within the health care system. The meaning-making strategies are adapted to the sensemaking and learning needed to support these stabilizing factors; in the River Lodge, meaning-making takes the form of tacit knowledge maintained within an oral culture that puts a premium on immediate problems and rapid action. The destabilizing factors are threats to the stabilizers, and are not fully handled by the existing meaning-making process; in the River Lodge, the destabilizing factors include staff shortages and the frequent arrival of new people and programs in the Lodge. Clearly, these three components (the meaning-making strategy, stabilizing factors, and destabilizing factors) are not discrete or independent from one another; rather, they make up an interdependent meaning-making system that is open to the external environment, and that perpetually struggles to maintain itself.

The result might be depicted as shown in Figure 5.

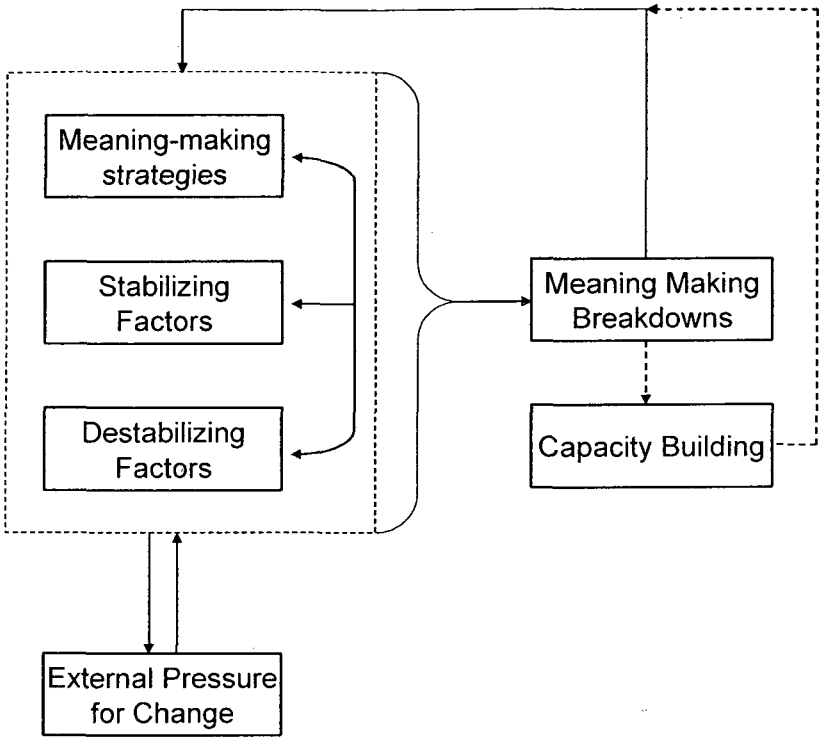

Figure 5. **Towards a General Theory of Meaning Making in Workgroups**

Stabilizing forces could be such things as staff commitment, hierarchical arrangements, resource allocation, external consultants, etc. The meaning-making strategies will be adapted to helping staff make good on their commitments—this suggests, for example, that a meaning-making dynamic that includes dependence on external experts would be suited to an organization that has adopted the use of external consultants as a stabilizing strategy. Destabilizing factors could be of a variety of sorts—pressures from outside the system, shortages of key resources, volatile markets, distrust between layers in the system or between key occupation groups, and so on. These destabilizers are likely to give rise to their own meaning-making needs that are to some extent managed by the existing meaning-making dynamic.

The result is meaning-making breakdowns. Breakdowns might culminate in highly effective problem solving if, for instance, a capacity for double-loop learning exists in the system (Argyris, 1990, 1993, 2004; Argyris & Schön, 1978; Schön, 1983). For example, a capacity for double-loop learning could involve a workgroup experiencing the same breakdown a number of times, and responding by analyzing and identifying the root cause of the breakdown, then devising and implementing changes to eradicate the root cause, and finally evaluating the success of its change effort and making any needed adjustments. However, it is also possible that such breakdowns will be handled by meaning-making processes that lack the capacity to analyze and resolve the problem. This more limited meaning-making capacity might resemble single-loop learning, where each meaning-making breakdown is handled as a separate and unrelated incident, or where workgroup members are unable to see how behaviours and attitudes are interconnected in ways that create recurring patterns that undermine the integrity and performance of their system.

In the Lodge, this meant that big problems were dissected into small pieces that could be dealt with by an environment that focuses on action and rapid, contextual exchanges. Breakdowns persist, and system pressure builds. Interpersonal conflict may be apparent, due to the difficulty in coping with instability; absenteeism may increase, as people experience work-related burnout. Some people might suggest training in conflict resolution, teambuilding interventions, or employee reward programs, but these responses are not likely to repair the problems that are at the heart of the system's dilemma. External decision makers or people of influence may attempt to introduce beneficial change to bring stability, to address symptoms, or to shift the system in what is deemed a

desirable direction, but these interventions will have to be handled with the existing meaning-making dynamic, which may not be adequate to the task.

Meaning-making breakdowns might be seen as a sort of madness that enters the group (double binds, the constant reframing of questions, avoiding problems or conflicts, topic jumping during meetings, and high emotionality among workgroup members), in which the group cannot reach a decision (faced with a problem that cannot be solved, at least not by the means being used), or when "paralysis by analysis" sets in.

Arguably, Eden gives rise to a breakdown of meaning making in the River Lodge. The breakdown here is partly structural—that is, the breakdown has to do with the exclusion of HCAs from the Eden Implementation Committee. However, the HCA perspective is announced through action and conversation—that is, the organizational texting, to borrow the term used by Taylor and Van Every (2000), is insufficient to effectively implement Eden, and in the organizational conversation the HCA double bind emerges: implementing Eden defeats the purpose of Eden.

Certain events, then, may trigger a disruption to meaning making, and these disruptions could be evident in one of the meaning-making modalities. Figure 6 offers a representation of these breakdowns.

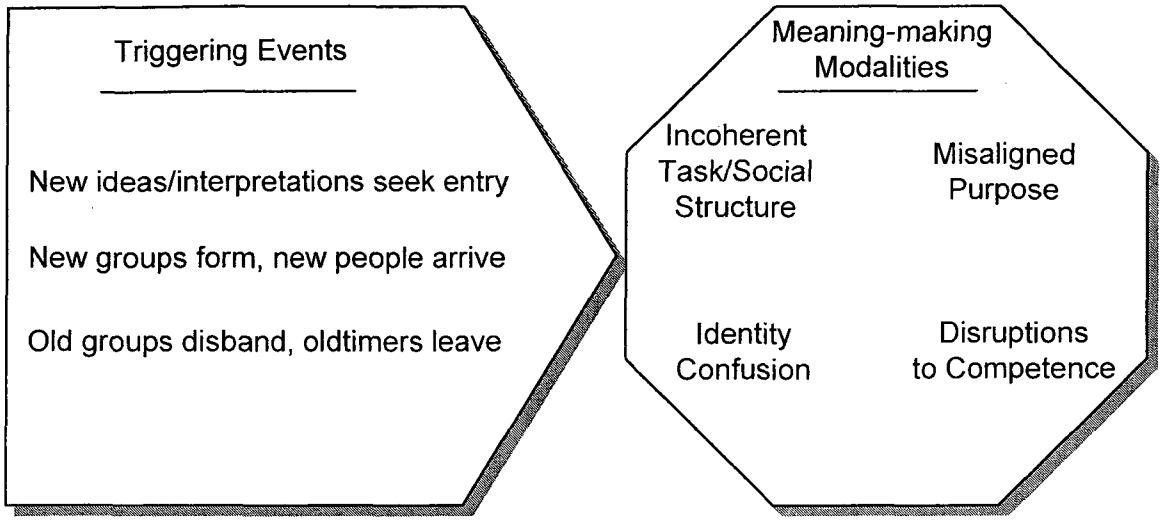

Figure 6. **Disruptions to Meaning Making**

For example, the absence of experienced staff from the workplace, and the ongoing arrival of newcomers who are not yet competent to carry out the work, heightens the sense of confusion on the floors (and thus detracts from experiences of coherence). Newcomers who are unable to cope with the work also diminish the competence that is available on the floor to complete the required tasks. Newcomers force the core team to spend more time on basic tasks, and less time providing compassionate care—and hence this triggering event also may be seen to affect the sense of purpose in the Lodge. Newcomers are often unable to take on the roles needed to work in the Lodge, and hence cannot take on the identities that are available to them.

Like the chronic turnover and the ongoing influx of newcomers, the Eden implementation is experienced in the context of the existing struggle for stability. Staff want to know the residents and the work regimen, and they want to know the location of trusted colleagues and vulnerable residents. With Eden, activity would become less predictable (residents would have more autonomy, the task flow would become less

defined and controlled)—hence there would be more uncertainty and instability. Resistance to Eden seems to be a simple opposition to uncertainty. Eden is a threat to scope of practice, and scope of practice is fundamental to how work and relationships are organized on the floors.

In a sense, meaning making, and the movement of knowledge from person to person and from group to group, is what these floors are all about. It is a central function of the floors. Without meaning making, the work would be impossible.

However, whereas policy makers and researchers have tended to focus on the importance of moving new knowledge into these settings from the outside—new research findings, Ministry directives, best practices from other facilities—these settings, at least as exemplified by the Lodge, focus with equal tenacity on the importance of moving internal, local knowledge held by insiders to newcomers from the outside. This latter imperative, which I witnessed on a daily basis, seems to be either taken for granted or overlooked by outsiders (if only the workers would be more careful about creating and using texts, one insider/outsider told me, then all would be well).

However, insider knowledge is tacit. It takes the form of knowledge of the routines and locations on the floor and, more significantly, of the likes and dislikes, the idiosyncrasies, and the stories of residents and staff. The Lodge is a vibrant and shifting social milieu that hosts a complex and regulated task environment. It is a complex and stressful setting, where valued loved ones occasionally die, where crises among residents and staff are acted out, and where mistakes can carry high costs. Texts function as cues for the ongoing flow of insider knowledge, and as aids to succeeding in a busy task environment. People do not work with a procedures binder near at hand. They work

with their shorthand lists, with their deep, tacit understanding of the work and the people, and with their knowledge of how to interact effectively in the oral culture. A newcomer must quickly fit into this milieu, and must be adept at forming relationships and absorbing information.

SUGGESTIONS FOR FUTURE RESEARCH

To build upon the results of the research reported in this dissertation, two specific directions suggest themselves. First, with the growing interest in bringing about quality improvement in Canada's LTC sector, it would be interesting to extend this study, using the same ethnographic and case study methods, to other LTC homes. In particular, it would be useful to carry out several studies in different types of homes, including municipal homes, for-profit homes, and nonprofit homes. The purpose of this research would be to determine if a similar meaning-making dynamic is at work in many LTC homes. If this were found to be the case, researchers, policy makers, and caregivers would be in a position to design and test interventions to bring about quality improvement, and then to share best practices across the long LTC sector.

Since ethnographic methods are time-consuming and require several months to implement, an alternative approach would be to develop a case study protocol (using focus groups, interviews, and document analysis) that could be implemented with relative ease in a large number of LTC homes. The case study could focus on two major dimensions: the meaning-making dynamic currently at work in the home; and the experience of the home in implementing a specific change initiative. For example, LTC homes in Ontario are currently attempting to design and implement improvements in a

number of key areas such as incontinence care, mobility, dementia care, end-of-life care, spiritual care, and behavioural issues (see the Seniors Health Research Transfer Network website at www.shrtn.on.ca for a list of communities of practice that are currently working on specific changes in LTC homes). A researcher (or research team) might identify one or two of these province-wide intervention efforts, and design a case study program that would follow the successes and challenges encountered by specific homes as they attempt to implement the changes.

Such a research program could reveal whether the existing meaning-making dynamic in LTC homes inadvertently acts as an impediment to change initiatives. I have suggested that in the River Lodge, the meaning-making dynamic is ideally suited to handling the small, contextual problems that arise over the course of a shift, but that it is less suited to handling major changes that require training, reflection, or adjustments to the work routine. If a research program were to reveal that this is a system-wide characteristic of the meaning-making dynamic in LTC homes, then LTC leaders would be in a position to assess whether a specific change initiative would require an intervention into the meaning-making dynamic itself, to create a greater capacity for change within the homes. Alternatively, this research program might bring to light an intervention design with characteristics that are compatible with the local, tacit meaning-making dynamic revealed in this inquiry—for example, the "plan-do-study-act" cycle (Langley et al., 1996), that has shown some promise as a vehicle for changing continence care in complex continuing care (Macintosh-Murray, 2007).

A second direction for additional research would be to look at meaning-making in other types of organizations (i.e. beyond the LTC sector). Is it the case that all

workgroups can be characterized by a specific, contextual meaning-making dynamic that allows group members to construct experiences of coherence, purpose, identity, and competence? If so, does this meaning-making dynamic allow the workgroup to cope with the most pressing issues that typically arise during their work, and is it sometimes less able to cope with more fundamental issues? This research program could reveal the potential and limitations of meaning making in a variety of workgroup contexts, and may lead to a better understanding of the factors that affect the success or failure of change initiatives.

It would also be interesting to investigate the extent to which meaning-making dynamics inevitably have limitations. For example, it might be possible to conduct a program of research that compares the meaning-making dynamic in workgroups engaged in routine activities (for example, claims examiners in insurance companies) with the meaning-making dynamic in workgroups engaged in activities that are less predictable (for example, a senior executive team negotiating a merger). Such a study might yield a rich description of the learning capacity in different workgroups, similar to the single- and double-loop learning theory advanced by Argyris (1990; 1993).

LIMITATIONS OF THE STUDY

An ethnographic inquiry with an embedded case study focused on activities within a single LTC home in Ontario cannot be said to yield results that are applicable to all LTC homes. Although the research design allowed for the discovery of a specific, contextual meaning-making dynamic, it is possible that these findings cannot be transferred to other sites. To address this limitation, I provided a "thick description" of the research site and findings so that readers can judge for themselves whether my

findings are transferable; and further, in the next section of this chapter I will demonstrate that the findings of my inquiry are consistent with those evident in the literature.

A number of other potential limitations are worth noting. Although the primary working language at the research site was English, the mother tongue of many employees was not English. Many employees were bilingual francophones, and they sometimes conversed together in French. The use of two languages, English and French, and the presence of speakers of both languages, was part of the reality of the site. It may have been interesting and useful to gather data in both languages; however, I gathered data only in relation to interactions in English.

The Research Ethics Board at the research site required that I exclude all personal health information from my data. In practice, this meant that I was required not to include interactions between staff and residents or family members in the data, and I was required to ignore personal health information pertaining to specific residents. I was therefore not able to record the details of exchanges between staff members about the health condition of a specific resident. Although I was concerned about this limitation when I began the study, I found that it did not have a major impact on my ability to gather useful data. Much of the interaction between staff focused on how, in general terms, the workgroup would complete their tasks over the course of the day, and how new people would be integrated into these work routines. Now and then they discussed specific cases, but these were generally touched on lightly and briefly. I did not sit in on any detailed case discussions. I did not find that I constantly had to walk away from discussions—in fact, this rarely occurred.

However, some aspects of the meaning-making dynamic on the floor were necessarily excluded from the study. For example, the research site has a family council and a resident council, and the functioning of these bodies may have some impact on the overall meaning-making dynamic at work in the site. I was unable to observe or record data related to these two councils. Moreover, although I did observe the change-over from the night shift to the day shift, the majority of my observations focused on the day shift on the two floors of the Lodge. I did not gather data during the evening shift or the night shift.

CONTRIBUTION TO KNOWLEDGE

This inquiry confirms the findings reported in several recent works on long-term care and health care organizations, and contributes to our understanding of organizational change.

This study supports the claims made in the gray literature on the predicaments faced by LTC homes in Ontario. For example, this study provides support for claims that frontline caregivers in LTC usually work alone, and that their current workload in some cases creates high levels of workplace stress (Canadian Healthcare Association, 2004; Canadian Nurses Association, 2008; National Union of Public and General Employees, 2007). The study also confirms the suggestion that LTC workers have, of necessity, developed a strong focus on the completion of tasks, and that they are often unable to interact informally with, or provide emotional support to, residents (Canadian Healthcare Association, 2004).

This inquiry is consistent with the findings of O'Brian-Passal et al. (2007a, 2007b) concerning the barriers that prevent frontline LTC practices from adopting new

knowledge from external sources: a lack of time; heavy workloads; insufficient frontline involvement in the change process; a lack of collaborative work practices; high levels of staff and management turnover; and negative staff attitudes toward change. My study adds to the these findings, however, by indicating that in some cases staff may be skeptical about change not because they are entrenched in their current ways of doing things, but because they are cautiously conserving their ability to provide emotional support to the residents they serve.

The findings reported here are also consistent with the findings of Ross et al. (2002b) who report that LTC caregivers are both proud of their work and experience high levels of emotional exhaustion, and that the current LTC environment has resulted in a routinization of caregiving. Moreover, my findings are also consistent with the conclusion of Ross et al. (2002b) that this routinization has not led caregivers to depersonalize LTC residents. These findings are also consistent with those of Anderson et al. (2005a) who suggest that most knowledge among frontline workers in nursing homes derives from ongoing daily experience rather than from scientific research.

My research also provides one concrete example of how a group of frontline caregivers in an LTC home create the holding environment envisaged by Kahn (2005) needed to support frontline workers. By creating an adaptive, fast-moving oral culture, frontline workers share their dilemmas, help each other, and construct agreeable interpretations of the events unfolding around them.

This inquiry supports the contention that strategies to implement a one-way transfer of external knowledge into a frontline practice will likely confront stubborn barriers, and that change in healthcare organizations should take into account the fact that

knowledge moves through processes of exchange—through relationships and interactions—rather than transfer. In particular, my inquiry offers one example of the PARiHS framework in action by revealing some of the interplay among evidence, context, and facilitation in a specific healthcare organization. The results reported here indicate how a local organizational context might possess only a limited capability to implement a worthwhile change, because the capacity of the local meaning-making dynamic is incapable of coping with the demands of an ambitious change program. A workgroup's meaning-making dynamic may approach a proposed change by, first, framing the change in terms that the context can comprehend. In the case of the River Lodge, this meant that the proposal to implement an ambitious social model of care was reframed as a series of small, discrete tasks, which were implemented inconsistently on different floors and different days. These results therefore also support the findings of Greenhalgh et al. (2004), who argued that evidence tends to be contested and ambiguous, and that an innovation should be presented to frontline caregivers in ways that highlight its relevance to local needs. It is my hope that this report also responds to the suggestion by Greenhalgh et al. (2004) that research is needed on the factors within a specific, frontline caregiving organization that contribute to or impede the implementation of new innovations.

This inquiry also confirms and extends the work of organizational researchers and theorists who have attempted to reveal the dynamics of collective learning and sensemaking in workgroups. To begin with, the inquiry supports the notion that a workgroup participates in a form of practical, useful meaning making that allows group members to communicate and learn, and to create and maintain a shared pool of

knowledge to support their collective endeavor. This meaning-making dynamic is similar to the narrative rationality envisaged by Fisher (1984a, 1984b). It is a form of highly contextual, local (and largely tacit) knowledge that allows group members to create and sustain the expertise needed to carry out their work.

This research also adds to the findings of empirical studies that describe meaning making in specific organizational contexts (Bechky, 2003; Boreham and Morgan, 2004; Cook and Yanow; 1996; Hutchins, 1995; Orr, 1996; Wenger, 1998; Yanow; 2000; Weick & Roberts, 1993). Unlike these other studies, however, this report focuses on a healthcare organization, and may provide insights that could facilitate the introduction of innovations to improve the health outcomes and quality of life of LTC residents. Whereas Orr found that photocopy repair technicians create narratives about machine breakdowns and repairs as a way of creating a repository of relevant, tacit knowledge, in the River Lodge, where change is fast and bewildering (with staff turnover, resident health problems, regulatory monitoring, and an increasingly heavy workload), frontline caregivers have created forms of rapid interaction that allow for a pooling of contextual knowledge that serves two key purposes: first, they are able to construct a shared understanding of the status of their floor, which allows them to design the way their shift will operate over the next several hours; and second, they have devised rapid interaction routines, often in the vicinity of the medication carts in the central hallway, that allow them to quickly help each other to analyze and resolve specific challenges that arise during the shift. Although staff occasionally construct narrative accounts of situations, their story-making activities are pragmatic and opportunistic: interaction and exchange is

almost always in the service of rapid action, and exchanges come to a halt as soon as the caregiver is able to reach a decision and resume work on the task at hand.

Finally, it is my hope that this inquiry enriches our understanding of why some workgroups appear to resist worthwhile changes. In the River Lodge, it appears that frontline caregivers are skeptical about the Eden Alternative not because they are overly fond of their existing routines, or because they have negative attitudes, but because at least some of them are concerned that the proposed change could be self-defeating: instead of improving the situation of residents by making the Lodge a more home-like environment, it could deteriorate the situation by making it more difficult for caregivers to provide emotional support through informal interactions. Moreover, the meaning-making dynamic that the caregivers have designed and implemented represents their current capacity for learning, adapting, and changing. This dynamic is well-suited for bringing a measure of stability to the fast-moving workplace. However, it is not well-suited for absorbing new people or ideas into the practice.

IMPLICATIONS FOR PRACTICE

My findings confirm the extraordinary strains and pressures that exist in the LTC sector in Ontario. Well-intentioned administrators and policy makers are keen to bring improvements to LTC homes, and are aware that caregivers are buckling under a heavy workload. These change agents may find it helpful to consider how they might design interventions that focus on the current meaning-making capacity in the LTC homes, in order to increase the ability of frontline practices to implement important changes.

As I spent time at the River Lodge, observing and listening to staff interactions, at times it occurred to me that the flow of work in the Lodge was like an ongoing

conversation. Indeed, as the Lodge's oral culture became apparent, it seemed that conversation is a vital resource for the Lodge's workgroups. It also seemed to me that the well-intentioned change agents who hope to bring improvement to the Lodge (including researchers, organizational leaders, and policy makers) act as though their task is to introduce a new and different conversation into the Lodge. To introduce change into this environment, it is essential to realize that change agents are not merely initiating a new conversation; rather, they are attempting to join a conversation that is already underway. It is curious to note that external experts are preoccupied with moving new knowledge (in the form of new programs, standards, and rules) into LTC homes, but the homes themselves are preoccupied with sharing insider knowledge with outsiders. At times it struck me that this situation was akin to two ships passing each other on a dark night, each unaware of the other's existence. Yet surely it would be helpful for both well-intentioned outsiders, keen to introduce improvements into LTC, and overworked insiders, trying to keep up with ever-increasing workloads, to be aware of each other, and to share ideas and concerns and find ways to make it possible to implement helpful changes in LTC homes.

The key meaning-making technology on the floors today is conversation. Leaders might consider how they can leverage the power of the conversations that unfold during a shift—a conversation that begins with the daily report session, and that continues with fast, contextual exchanges among caregivers throughout the day. This conversation, the living form of the oral culture that creates the means for carrying out the work, is, in a very real sense, the way in which staff *know the floor*. Since this is the knowledge that allows the work to be accomplished, it is vital that this knowledge be sustained and

shared. When newcomers arrive on the floors, to fill in for staff who are on sick or disability leave or who are on vacation, they must be brought into the conversation.

Administrative and clinical leaders in LTC might therefore consider how they can increase a frontline team's meaning-making capacity by strengthening the conversations that occur during the shift. At the present time, the River Lodge makes use of the morning report session as the only formal, regular exchange of information during a shift. However, this conversation includes only the members of the shift who are about to begin work, and excludes members of the shift who have completed their work and are leaving. It may be useful to have one or two members of the night shift participate in the morning report session, and to allow for this overlap between all of the shifts. This could allow for a more complete and accurate flow of relevant information about the current status of the floors. It might also be useful to develop standard protocols for welcoming newcomers to the floor. Temporary replacement workers could be welcomed and introduced, and could be offered a seat at the table where the discussion is occurring. The basic requirements of the shift could be briefly explained to the newcomer, and they could be introduced to the people they will be working with for that day.

Moreover, it may be possible to create the time for some additional report sessions during the day, to formalize and strengthen the informal exchanges that currently take place in the vicinity of the medication carts. Perhaps it would be possible to experiment with a mid-day report session, or with brief team huddles, at which interim results can be discussed, questions could be raised, and team members could ask for advice or help with a specific situation. These mid-day sessions could take place in an office or lounge, and could be conducted while standing—to ensure that the exchange of

information is carried out quickly, so as to minimize the interruption to the busy work routine. These brief huddles could also allow a mechanism for meeting the needs of newcomers to the floor. At each huddle, the newcomers could be invited to ask questions, and experienced team members could offer suggestions and reassurance.

It also seemed to me at times that change agents are asking River Lodge staff to move to a new and better place, as though staff are positioned on a network of roads that lead in different directions; staff, however, are actually located on a circular treadmill that spins round and round as they walk. Change agents give new tasks to staff, in order to move them to a new location on the road; and staff start to move faster and faster, but are unable to leave the spinning treadmill. I present this image as a way of suggesting that what might be needed more than anything else are structural changes to the way that work is organized in the Lodge. The current structure, which functions as a treadmill, must be replaced by a new structure that lends itself to movement, change, and improvement.

One such structural change might be to find ways to leverage the existing oral culture in order to enhance the Lodge's meaning-making capacity. I have already mentioned the possibility of creating new opportunities for staff to converse and share information. A structural change that might achieve this goal would be to introduce a greater level of teamwork in the way that work is conducted at the Lodge. At the moment, work is generally carried out in an independent fashion, with HCAs and RPNs working alone (except when help is needed to complete a physically demanding task, or when a worker finds that a task lies outside of his/her scope of practice—for example, when an HCA realizes that a resident may need a medication). However, the data shows

that when necessary, it is possible for HCAs to work as a team (this was evident in the way that some HCAs tried to integrate newcomers onto the work of the floors). If workgroup members were to work together more often, then tacit knowledge would flow more easily throughout the team. Moreover, a team approach would help to integrate the HCAs into the decision making processes on the floors. HCAs would be given a voice on committees, and at meetings where changes are being considered. This would help to ensure that knowledge is shared more effectively, and that the most relevant knowledge is available when needed.

A more significant structural change would be to increase the ratio of HCAs to residents. At the moment, the Lodge has a ratio of 1 HCA to every 8.3 residents. By adding two more HCAs, one to each level during the day shift, this ratio would change to 1 HCA for every 6.8 residents. This could help to alleviate the demanding workload, and allow the HCAs to spend more time providing psychosocial support to residents. It could also make it easier for HCAs to participate on decision-making forums such as the Eden Implementation Committee.

The study also reveals some things that could be of interest to people who are working in the area of knowledge translation in Canada's health system. A theory of knowledge flows that emphasizes interaction and exchange rather than linear transfer necessarily requires that key people who are vital to the implementation and use of new knowledge in a frontline practice must be brought into the interaction. However, it was evident in both the literature and in my study results that RPNs and, especially, HCAs are often not involved in the discussions and planning that occurs when an innovation is introduced into a LTC home. To improve the uptake of relevant research evidence in

LTC settings, it will be essential to find ways to reach and involve the frontline workers who will often be responsible for applying the evidence.

Finally, it seems to me that it may be possible to develop a change readiness diagnostic tool using the four modalities of meaning making discussed in this study. One way to analyze a group's readiness for change would be to consider the extent to which a change could negatively impact the group's experiences of coherence, purpose, identity, and competence. This could allow for the development of strategies to ensure that group members are able to find a new sense of coherence during and after a transformation, and that they are able to maintain and adapt their sense of purpose and identity during change. It could also help to ensure that any adjustments to group competence could be anticipated and planned for during the transformation process.

It also seems to me that it might be possible to fuse these meaning-making dimensions with the PARiHS model, to allow for a thorough analysis of a workgroup's likely response to a change. This could involve gathering data in relation to a grid consisting of twelve cells, with the horizontal axis showing the meaning-making dimensions of purpose, coherence, identity, and competence, and the vertical axis showing the three dimensions of the PARiHS model (organizational context, evidence, and facilitation). As an example of how this could work, Table 6 shows this framework populated with questions concerning the impact of change upon a group's sense of purpose, coherence, identity, and competence. The row labeled "context" could be used to reveal the current functioning of the meaning-making dynamic in that organizational context: what processes and outcomes are in place related to the construction of experiences of purpose, coherence, identity, and competence. The row labeled

"evidence" can be used to consider the likely impact of the change (which could arrive in the form of new research evidence, best practice guidelines, quality improvement programs, new government regulations, etc.) upon this meaning-making dynamic: how will the change affect the group's sense of purpose, coherence, identity, and competence. Finally, the row labeled "facilitation" can be used to identify existing mechanisms and processes that are available to help introduce the evidence into this organizational context in ways that will promote its acceptance and use.

Table 6

Analyzing the Impact of Change on a Group's Meaning-Making Dynamic

	Purpose	**Coherence**	**Identity**	**Competence**
Organizational Context	How do people construct and maintain a sense of purpose? What is the purpose of individual group members, and what is their shared purpose? Is the group currently achieving its purpose?	How do people ensure that experiences in this workplace are coherent? To what extent is this place stable and coherent? Do group members understand what is going on? Are the flows and interdependencies of work clear to people? Do they know their priorities?	How do people construct and maintain identities? In this context, who are these people? What is their role, responsibilities, scope of work? What is their status within the practice, and within the organization?	How do people construct and maintain the competence needed to do their work? What regimes of competence are characteristic of the different practices? What competence characterizes a newcomer and

	Purpose	Coherence	Identity	Competence
				an experienced practitioner?
The Evidence Being Moved into the Context	Does the new idea confirm or disconfirm the local senses of purpose? Does it help people to achieve their goals? Does it strengthen or diminish their sense of purpose?	Does the new idea make sense to people? Does it explain, or does it bring dissonance? Does it solve a current problem?	Does the new idea make sense in terms of who these people are? Does it bolster their existing identity, or does it require that they adapt their identity to this new idea? Will it change who they are?	Are these people competent to implement and use this new idea with their present knowledge and skills, or do they need new knowledge and skills? Does this extend or diminish the regime of competence. Does the work become "smarter" or "dumber"?
Facilitation Techniques for Promoting the Acceptance of the Evidence	What facilitation could be used to align the purpose of this	What facilitation could be used to position this new idea within a coherent	What facilitation could be used to absorb this new idea into	What facilitation could be used to allow people to

	Purpose	**Coherence**	**Identity**	**Competence**
by the Context	new idea with the overall purpose in doing this work? How will the change be communicated to people? Will people be invited to participate? Does a respected leader explain how this fits with the strategic objectives? Do colleagues say that this will help the group to achieve its goals?	experience of this workplace? Will this new idea solve compelling problems? Do the idea's supporters explain, answer questions, address concerns? Do people make sense together, or are they simply told to support the idea? Does the new idea add to the workload or create new problems?	peoples' sense of identity as skilled practitioners within this workplace? What can be done to help people feel appropriately consulted and involved? How can status and position be respected?	absorb this new idea into the regime of competence—what new skills are needed, what existing skills must be set aside? Is training and support being offered?

A diagnostic framework of this sort would need to be tested and validated in numerous research, evaluation or consulting endeavors.

CONCLUDING THOUGHTS

What, then, is the main message to be gleaned from this inquiry?

I suggest it is the following.

The workgroups studied here engage in a meaning-making process that allows members to create a sense of coherence about their tasks and the environment in which they work, and a sense of purpose that invests the work with some level of importance or, at the least, makes the work bearable. This meaning-making process also allows for the construction of individual and group identities, which allow people to understand how they fit into the context and the social group, as well as the creation and maintenance of the competence needed to complete the required tasks. This dynamic takes the form of patterned interactions that unfold through time, and that bring stability—while fending off destabilizing factors—to the experiences of the group.

If an insider or an outsider hopes to introduce an improvement into the workgroups studied through this research, or into other workgroups that function along similar lines, then an appreciation of the existing meaning-making dynamic would certainly reveal much about the capacity of the workgroup to embrace change.

The movement of new ideas between social groups is not, in the messy, ever-changing world where people live and work, a matter of transferring a packet of information through some well-honed distribution channel. It is more akin to the formation of vibrant, shifting relationships through well-designed conversations. The key point for the change agent to remember, as he/she arrives with the new knowledge that is meant to bring improvement through change, is that a conversation is already underway in the workgroup, and this conversation is experienced by group members as vital to their

survival and success. To succeed, the change agent must find a way of joining the conversation that is unfolding, rather than drowning it out with a bellowed, arrogant announcement that something new and better has arrived.

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APPENDIX A – INFORMED CONSENT FORM

Department of Applied Human Sciences, Concordia University

Student Research or Field Projects With

Human Subjects

INFORMED CONSENT FORM FOR INDIVIDUAL PARTICIPANTS

This is to state that I, _____, agree to participate in a program of research being conducted by James Conklin of the Specialized Individual Program (SIP) of Concordia University.

Contact Information: Ph 613-843-1811

jamie@cadencehs.ca

In signing this *Informed Consent Form*, I indicate that I understand:

— That James is supervised by Dr. Ghislaine Guérard. Dr. Guérard can be reached at Applied Human Sciences Department, Concordia University.

— That the purpose of the research is to study how knowledge is created, sustained, used, and altered in workgroups in the River Lodge. I understand that the project is part of the researcher's program of Ph.D. studies. I understand that this is the project's only purpose.

— That the research will be carried out in English. I confirm that my level of English fluency meets one of the following criteria:

- I have had at least one part of my formal education (primary, secondary, post-secondary) in English; or
- English is my maternal language; or

- I have spent at least five years in an employment situation where English was the main language of the workplace; or
- I confirm that my English fluency is comparable to somebody who meets one of the previous three criteria.

— That James has discussed the research with River Lodge's management. He has also discussed the research with our union representative.

— That participation in the research project will be during normal working hours. I will not have to re-organize my work schedule to participate. However, participants will sometimes be asked to answer questions to help the researcher understand what he is observing.

— That the research will include 30 days of observation over 12 weeks. During this period the researcher will be at River Lodge, observing caregivers and administrators and listening to conversations. James will observe and listen, and will write down notes in a research journal.

— That if I agree to participate, James may sometimes ask to observe me at work. He will occasionally ask me questions, and will write down or record answers. James may also ask me to participate in an individual or focus group interview. An individual interview would involve James asking me questions, and me providing answers. A focus group interview would involve James asking questions of three or more members of River Lodge's staff. During these interviews, James will ask questions about how knowledge is created and used in the workplace. These interviews will take about 30 minutes to complete. The individual interviews can be divided into several brief question-and-answer sessions spread out over two days, to minimize the impact on

work. The interviews will be recorded, and James will use the recording to create a transcript on a computer.

— That if I participate in a one-on-one interview, James will give me a copy of the interview transcript.

— That James will schedule a group feedback session when his research is nearly finished. This session will give participants a chance to review and comment on his preliminary findings. The length of the feedback session will be negotiated with River Lodge managers and staff, and will not be longer than 4 hours. James will request permission to gather additional data during this feedback session. If River Lodge managers and staff decide that a group feedback session is not feasible, James will work with them to identify an alternative way of feeding back the findings and analysis to research participants.

— That the research will include a "case study." This case study will be a specific example of how new knowledge (such as a new standard, policy, procedure, etc.) is implemented in River Lodge. James will identify and select the case study through discussions with River Lodge managers and staff.

— That if I agree to participate in the research, I will control when and how James can collect information from me. I can tell him to stop observing me whenever I wish. I can decline to talk to James whenever I wish. If I tell James that I do not wish to participate in the research for a period of time, he will respect my wishes. If I refuse to participate in the research for a specific period of time, this will in no way affect my employment.

— That participation is voluntary and I can withdraw from the research at any time. If I withdraw, there will be no negative consequences to me, and my employment will not be affected.

— That it may be difficult to prevent people from knowing who is participating and who is not participating in this research study. To try to conceal the identity of participants and non-participants, James will take these steps. He will circulate throughout the work site, speaking casually to all staff. James will also not tell anybody the names of who is participating and who is not participating in the study.

— That James should not see or hear the personal health information of River Lodge residents. If I talk about a resident while James is observing me, I will not use the resident's name. I will also conceal the resident's gender, room or bed number, diagnosis or treatment details, and other personal details.

— That my name will not be used in any reports or presentations. James may use long quotations from the data transcripts that he creates, but these quotations will not be attributed to specific individuals. Also, non-relevant details will be removed or changed to further conceal the identity of the speakers.

— That all data gathered through the research will be stored in digital format on James's secure laptop computer. Transcript data will be gathered on a digital recording device, and will be transcribed into computer files. Journal data will be stored in computer files. The computer is password protected, and only James and his supervisor know the password. After James has completed the research and his dissertation has been accepted, he will destroy all copies of the un-encoded data.

– That James will use the research data to write his Ph.D. dissertation. He will submit this dissertation to his supervisory committee at Concordia University. If his dissertation is accepted, it will be published and will be accessible through the National Library of Canada.

In the event that I wish to discuss this project or any ethical concerns, I may contact:

<name removed>

Director, Ethics, Valley Health Centre

Tel. : (nnn) nnn-nnnn xtnnnn

Fax : (nnn) nnn-nnnn

E-mail: nnnn@nnnn.on.ca

<name removed>

Chair, AHSC Ethics Committee,

Concordia University

Ph: (nnn) nnn-nnnn xtnnnn

Fax: (nnn) nnn-nnnn

E-mail: nnnn@nnnn.on.ca

I have carefully studied the above and understand this agreement. I, _____, agree to participate in the project under the conditions described above.

NAME: (please print) _____

SIGNATURE: _____

WITNESS NAME (please print)

_____

WITNESS SIGNATURE: _____

DATE: _____

APPENDIX B—CONSOLIDATED LIST OF QUESTIONS TYPICALLY ASKED ON THE FLOORS BY STAFF

Questions about basic identity:

Who are you?

Who are you?

Who are you?

Who are you?

Questions about role and responsibility

Who am I working with?

Who is your partner?

Who is my partner?

Where am I working?

Who is the RN today?

Who is doing this?

Who has Mrs X?

Who can orient the new person?

Who is coming to the bbq?

Who is our fourth person?

Who is working here today?

Who is working where

Who is taking who here?

Who is working at that end?

Who is orienting these new HCA's today?

Who are my residents?

Who are you working on?

Who is the fifth HCA today?

Who is replacing who?

Questions about where people and things are

Where is the RN?

Where is the RPN?

Where is the replacement HCA?

Where is the RPN?

Where is XXX

XXX, where are you?

Where am I working today?

Where is the assignment sheet?

Where are you?

Have you seen [HCA name]?

Questions about the meaning of texts?

What does this chart entry mean?

What do we need to do about this chart entry?

What does this chart entry mean?

Questions about what do to

What should I do about XXX?

Should I start my work, even though we are short staffed?

How do I fill out this form?

How do we chart this situation?

Where am I working today?

Who should work upstairs?

Requests for facts, information and explanations

Do we have enough people today?

Have you worked here before?

What happened [e.g. to Resident X]?

When was this task last performed?

What went wrong with that order for tables and buckles?

What have you tried to do to handle that resident's aggression?

Why don't we need to wear gowns?

Has she worked here before?

Can the replacement RPN take some residents?

When are you taking your break?

APPENDIX C—EXAMPLES FROM THE CODE BOOK

EXAMPLE 1: CODE #32—"STAFF FOCUS ON ACTION"

32. Staff focus on action	
Staff move to action. They are seen doing, performing, almost all the time. When there is a barrier to performing a routine task, they complain about the barrier and find a way to perform the task. They are required to carry out a set routine of tasks, in part to comply with the Ministry (e.g. two baths per week), and hence focusing on tasks means satisfying the Ministry and providing the basic care and the medications for residents.	
Number of codes:	25 codes from 4 data sources
Field Notes:	51, 55, 56-7, 67, 75, 100, 115, 150
Eden Interviews:	E-1, 2, 5, 11, 18, 23, 24, 27
Mini-Interview:	
Outsider Interviews:	I-18, 19, 20
Documents:	6-4, 7-2, 7-4, 7-6, 13-1, 13-3

EXAMPLE 2: CODE #35—"KNOWING MY FLOOR"

35. Knowing my floor
Statements from staff (and in documents) that directly concern the importance of knowing the floor, as well as examples of behaviour in relation to the importance of knowing the floor. Knowing the floor brings stability to the work, assures that mandated work will be accomplished, and is a key factor in determining power distribution on any

given shift. Knowing the floor consists of four key elements: knowing the residents on the floor; knowing the other staff on the floor (because staff help each other, not residents); knowing the work routine on the floor; and knowing the physical layout of the floor, and where things are kept. Knowing the floor is the ongoing conversation, the searching for meaning that provides a ground for action. It is transcribed at the end of each shift, and recovered at the beginning of each shift, through the Report session, where the texts are read, assignments negotiated, and action initiated.	
Number of codes:	40 codes from 4 data sources
Field Notes:	52, 61, 65, 71, 77, 78, 80, 85, 86, 87, 88, 89, 93, 94, 97, 113, 114, 115, 116, 123, 126, 130, 133, 138, 149, 151, 154, 172, 174, 175, 179, 182, 183, 187
Eden Interviews:	
Mini-Interview:	M-1
Outsider Interviews:	I-20
Documents:	6-2, 7-2, 7-3, 7-6

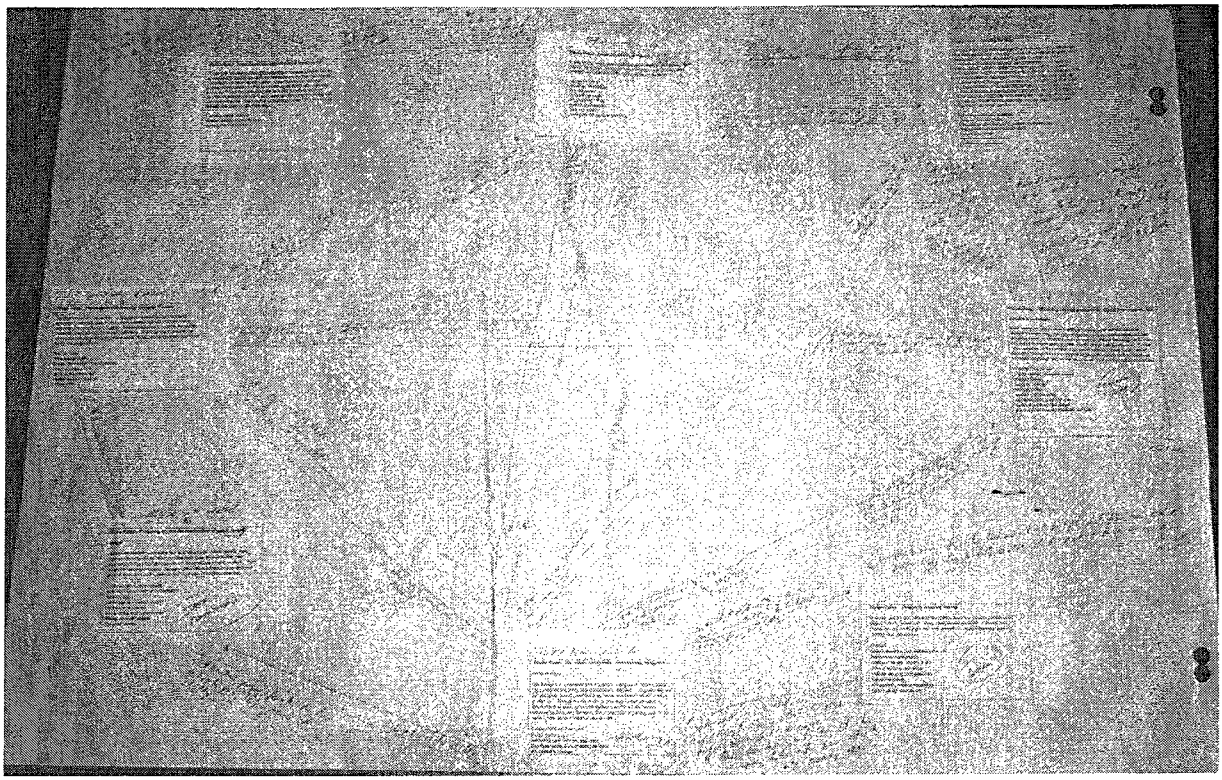
APPENDIX D—THE THEMES

	Theme Name and supporting codes	Total Instances	# of data sources
Theme #1: Action-focused oral culture			
6	Texting on the go	19	2
7	On-the-go interactions	30	3
10	Here and now	20	4
16	The med cart – hub	15	1
17	Sensemaking is fluid	16	2
32	Staff focus on action	25	4
40	Tacit care plans	30	4
46	Getting the information "out there"	15	3
	Totals and avgs	170	2.9
Theme #2: The inside-out knowledge exchange dynamic			
3	Staff are busy	47	4
11	Short-handed work	22	3
24	Sharing knowledge with newcomers	52	3
36	Newcomers must fit in	28	2
52	Outsiders are not trusted	9	2
31	Informal social exchanges	23	2
	Totals and avgs	181	2.8
Theme #3: Formal and informal learning is inconsistent			
43	Receiving formal training	12	4
53	Informal training and mentoring	19	3
54	Learning and compliance	7	2
	Totals and avgs	38	3.0
Theme #4: Protecting against the ramifications of poorly designed change			
5	Cross-discipline sensemaking	12	2
18	Instances of teamwork or collaboration	36	4
37	Showing care	25	4
50	The Lodge as a change context	21	2
51	Facilitators of change	18	4
15	Stories about staff commitment	16	3

	Theme Name and supporting codes	Total Instances	# of data sources
	Totals and avgs	128	3.5
	Theme #5: Instability, emotionality, and reluctant allegiance to the status quo		
1	Director of Care Turnover	12	4
4	People come and go	39	5
9	Instability (and stability) and chaos	35	5
34	Emotions on the floor (Feeling the floor)	18	3
48	Resistance to change	19	2
	Totals and avgs	123	3.8
	Theme #6: Absorbing external pressures for change into an unruly and unstable environment		
19	Documenting the day	18	3
20	Taking charge, assuming control	20	4
21	Planned change	18	4
22	Scope of practice	15	4
27	Ministry rules	26	4
28	Instances of hierarchy	25	4
49	The Eden idea - pros and cons	20	3
55	External pressures for change	10	2
57	Knowing the practice standards and rules	15	3
	Totals and avgs	167	3.4
	Theme #7: Knowing the floor		
8	Specific sensemaking incidents	33	1
25	Using and not using texts	31	3
26	Constructing and maintaining a shared understanding	36	4
33	Making sense of the day and the work	16	4
35	Knowing my floor	40	4
38	Decoding resident meanings	10	2
41	Collaborative narratives	12	2
	Totals and avgs	178	2.9
	Theme #8: Threats to meaning making		
2	Conflict	18	3
12	Stories about the first and second levels	13	3
13	Impression management	9	1
14	Espoused theory / theory in use	15	3
23	Who is working and where	26	3

	Theme Name and supporting codes	Total Instances	# of data sources
29	Making sense of contradictions	14	4
30	Factory or family	32	4
42	Not knowing what is happening	6	2
45	Sensemaking breakdowns	8	4
	Totals and avgs	141	3

APPENDIX E—PHOTOGRAPH OF THE MEANING-MAKING SYSTEM MAP



APPENDIX F— SUMMARY OF ONTARIO LTC COMPLIANCE STANDARDS

Ref. #	Standard Description	# of criteria related to this standard
1:A	Resident Safeguards: There shall be mechanisms in place to promote & support residents' rights, autonomy and decision-making	32
2:A	Admission Agreement: Written admission agreement in place to delineate the accommodation, care, services, programs, and goods that will be provided to the resident and, the obligations of the resident with respect to their responsibilities and payment for service	14
1:B	Assessment: Each resident's needs for care and services shall be determined with the resident/representative through an interdisciplinary assessment process.	23
2:B	Planning: Each resident's care and services shall be planned with the resident/representative through an interdisciplinary planning process	14
3:B	Provision of Care and Services: Each resident shall receive care and services consistent with his/her plan of care and with Residents' Rights outlined in the Bill of Rights.	64

Ref. #	Standard Description	# of criteria related to this standard
4:B	Monitoring and Evaluation: There shall be ongoing monitoring and evaluation of each resident's care, services, and care outcomes.	6
5:B	Documentation: All significant information about each resident shall be recorded in his/her document.	6
1:C	Service Provision Nursing Services: There shall be an organized program of nursing services to meet residents' nursing and personal care needs, consistent with the professional standards of practice of the College of Nurses of Ontario.	20
1:D	Staff Education: There shall be an organized orientation program that responds to the learning needs of new staff.	5
2:D	Inservice Education: There shall be an organized inservice education program that responds to the assessed learning needs of staff.	9
1:E	Service Provision: There shall be recreation and leisure services organized to provide age-appropriate recreation, leisure, and education opportunities based on and responsive to the abilities, strengths, needs, interests and former lifestyle of the residents.	12
1:F	Social Work Services: There shall be an organized	1

Ref. #	Standard Description	# of criteria related to this standard
	program of social work services, or arrangements are made to access available social work services to meet residents' psychosocial needs.	
1:G	Spiritual and Religious Care Program: There shall be an organized spiritual and religious care program to respond to the spiritual and religious needs and interests of the residents.	6
1:H	Therapy Services: There shall be an organized program of Therapy services or arrangements shall be made to access available therapy services to meet residents' identified therapy needs.	9
1:I	Volunteer Services: There shall be an organized program of volunteer services.	5
1:J	Dental Services (deleted)	0
1:K	Foot Services (deleted)	0
1:L	Other Approved Programs: Other programs/services provided by the facility shall be organized to provide services to respond to residents' identified needs/preferences.	3
1:M	Organization and Administration: The programs and resources of the facility shall be organized to effectively	20

Ref. #	Standard Description	# of criteria related to this standard
	manage the facility and each of its programs and services, in keeping with Ministry Acts, Regulations, policies, and directives.	
2:M	Monitoring, Evaluating, and Improving Quality: There shall be a comprehensive, coordinated, facility-wide program for monitoring, evaluating and improving the quality of accommodation, care, services, programs and goods provided by the facility.	7
3:M	Risk Management: There shall be coordinated risk management activities designed to reduce and control actual or potential risks to the safety, security, welfare and health of individuals or to the safety and security of the facility.	26
4:M	Records Management: There shall be an organized system of records management which includes the components of collection, access, storage, retention and destruction of records.	3
1:N	Medical Services: Service Provision: Medical services shall be organized to meet residents' medical needs, including assessment, planning and provision of residents' individualized medical care, consistent with	17

Ref. #	Standard Description	# of criteria related to this standard
	professional standards of practice.	
1:O	Environmental Services: Environmental services shall be organized to provide a safe, comfortable, clean, well-maintained environment for residents, staff, and visitors.	24
2:O	Maintenance Services: The facility including furnishings and equipment shall be maintained.	16
3:O	Housekeeping Services: The facility, including furnishings and equipment, shall be kept clean.	9
4:O	Laundry Services: Laundry services shall be organized to meet the linen and personal clothing needs of residents.	33
1:P	Dietary Services: Service Provision: There shall be an organized program of dietary services to respond to residents' nutritional care needs and to provide safe, personally acceptable, nutritious food to residents.	39
1:Q	Diagnostic Services: The facility shall make arrangements for diagnostic services to meet residents' needs as ordered by the residents' physician.	1
1:R	Pharmacy Service: There shall be an organized program for the provision of pharmacy service to meet the residents' identified needs.	6
2:R	Organized Review Process: There shall be an organized	3

Ref. #	Standard Description	# of criteria related to this standard
	interdisciplinary review process for directing the facility's pharmacy program and service.	
3:R	Prescription Ordering, Transmission: The prescription ordering and transmission of orders shall support the safe provision of drugs to residents.	9
4:R	Drug Dispensing: The pharmacy service shall provide for the accurate, safe dispensing of prescription drugs and biologicals to meet residents' identified medication requirements.	2
5:R	Recording Receipt and Disposition of Drugs: A system of records for the receipt and disposition of all drugs received by the facility shall be maintained in sufficient detail to enable accurate tracking, reconciliation, and auditing, in accordance with applicable legislation.	1
6:R	Drug Storage: All drugs and biologicals shall be stored under proper conditions of sanitation, temperature, light, humidity and security.	4
7:R	Drug Disposal, Destruction: Disposal of drugs shall be in accordance with established ministry policy	2
8:R	Medication Administration: Errors / Adverse Reactions: There shall be a system for immediate reporting of each	3

Ref. #	Standard Description	# of criteria related to this standard
	medication error and adverse drug reaction, with specific follow-up action to be taken.	
37	Totals	454