**Title:** Caring innovation: Listening to staff to improve care for older persons in nursing homes

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**Abstract:**
Frontline workers have valuable knowledge to contribute to the improvement of nursing home care. Yet incorporating their perspectives into organisational decision-making has been an ongoing challenge. In this article we investigate a promising practice that brought workers and management together in weekly and bimonthly facilitated meetings to identify and resolve problems. Drawing on observations as well as focus groups and interviews with participants, we found the process created a safe space for staff to speak. In this context, staff felt comfortable identifying failures and problems for collective resolution. Including staff from different occupations ensured solutions were context-sensitive. While the resulting improvements to care were significant, our discussion highlights the relational work that created trust, respect and a spirit of collaboration. We suggest that such a relational process may serve as an innovative quality strategy, one that is well-suited to the dynamic nature of caring for elderly residents in nursing homes.
**Key words:**
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## Introduction

There is longstanding recognition that frontline care workers have unique perspectives on the conditions of work and the health status of residents in nursing homes which can have important quality and safety implications (Bowers & Becker, 1992; Schulmann, Gasior, Fuchs, & Leichsenring, 2016). Yet, formal means of communicating across workplace hierarchies are often lacking (Caspar, Ratner, Phinney, & MacKinnon, 2016). As a result, knowledge sharing happens in an ad hoc basis, information is lost, and health and safety may be compromised.

In 2007, a large Health Authority in British Columbia began developing a workplace initiative that brought care aides together with managers and other members of the care team to discuss challenges with caring for elderly residents. Called the Partnerships in Person Centered Care Approach (PPCA), this process involved weekly and bimonthly facilitated meetings with staff and managers. Together staff endeavored to overcome barriers to workplace safety and quality care. The process revealed problems, both serious and small, and enabled collectively designed solutions that have been implemented within participating homes.

In this paper, we present the results of a study that sought to understand whether and how the PPCA worked from the perspective of participants. The motivation for the study was the opportunity to learn from a practice that demonstrated promise improving knowledge sharing, workplace safety and the quality of resident care. What's more, given the tendency to import quality processes from other sectors, sometimes with questionable results (e.g., auditing from the financial sector) the PPCA presented an opportunity to learn from an innovation emerging from

*within* care itself: developed by and for nursing home staff. Our hope was that by studying the PPCA we could learn lessons on how care for older persons might be successfully improved.

**Background**

Frontline care workers know nursing home residents well (Kontos, Miller, & Mitchell, 2010). They are familiar with what matters to residents and are often the first to notice vital changes in health status. Frontline care workers also accrue on-the-ground experience with the implementation of organizational and policy decisions (Armstrong et al., 2009). Yet, despite their unique expertise, incorporating their insights within the organization of care has been an ongoing challenge.

Their exclusion from decision-making has been attributed to a number of factors. Heavy workloads leave little time for consultation and professional hierarchies as well as low levels of respect impede communication (Foner, 1994; Lazes, Gordon, & Samy, 2012). There are also few structured opportunities for dialogue. In an institutional ethnography conducted in the same province as our study, Caspar and colleagues (2016) discovered that communication generally flowed from the top down, reflecting concerns of team leaders and privileging clinical information. Upward flows of communication, for instance from care aides to licensed practical nurses (LPNs), happened informally. Aides resorted to communicating "on the fly," risking interrupting busy nurses and being reprimanded. As a result, the quality of these relationships played a role in determining whether communication occurred. Tellingly, the study also found that the bath and bowel lists were the only structured forms of two-way communication. Thus despite the rhetoric that aides were the "eyes and ears" of care, the organization of

communication supported a different reality, suggesting that aides' were primarily there to do the dirty work. Such findings, as the authors conclude, help explain why frontline care workers continue to feel "underappreciated, disrespected, and dismissed" (13).

Limited communication also results in the emergence of potentially harmful work routines. In a study of resident to resident violence, Snellgrove, Beck, Green, and McSweeney (2015) found that care aides resort to inventing their own strategies to protect residents. They use their bodies to shield residents from aggression and endure abuse in order to calm residents down. These measures put workers at risk yet remain invisible to management and therefore unaddressed.

In addition to limited communication within facilities, there is also a system-wide knowledge loss with the unique vantage point of care aides being excluded from policy design (Schulmann et al., 2016). As a consequence, seemingly innovative solutions may be unrealistic, lead to more work or have other unintended harms.

Moreover, as Banerjee and colleagues (2015) observe, the repertoire from which solutions to quality problems in nursing homes are imagined continues to be shaped by the reductionist metaphysics of the medical model. The growing emphasis on auditing is a case in point. As they note, auditing privileges tasks that can be counted. It also empowers documents rather than care aides or residents. What's more, the reductionist logic of auditing misses the relational dimensions that are essential to care work and so appreciated by residents. Thus it is not surprising that such forms of innovation are often experienced as counterproductive, contributing to punitive environments where workers are afraid to speak or where they enact a defensive

rather than resident centered style of care. In turning to the PPCA, we seek to learn from a practice that eschews this reductionist logic, starting instead from relationships and innovating by incorporating the knowledges of care staff into the design of solutions.

**The PPCA**

The PPCA has been instituted in nine of the Health Authority's (HAs) residential care homes. The HA is one of the largest of British Columbia's five health authorities, responsible for organizing and delivering publically funded health care to nearly two million people. The PPCA was initially imagined as a staff wellness initiative. However, it evolved to include quality of care, since workers insisted that their ability to provide good care mattered to their wellbeing.

The PPCA unfolded over several steps. The first involved ongoing facilitated "weekly meetings," open to all staff except management. Here the facilitator assisted workers in clarifying their concerns. In the second step, the manager was brought in to these meetings. The facilitator remained until the conversation flowed well. In the third step, facilitation was taken over by the manager, although the meetings continued to follow an agenda set by staff. Meetings ran anywhere from 20 to 40 minutes, concluding with action items in which responsibility for carrying out proposed solutions were delegated.

While weekly meetings provided an ongoing opportunity to address staffs' concerns, some issues required more time. The forth step involved the formation of larger "team meetings" that included workers from all occupational groups such as support service workers, care-coordinators, managers and allied health professionals (e.g., music, physical, occupational and

recreational therapists as well as social workers). Participation was voluntary, though staff were paid to attend and backfill workers were arranged to ensure resident care was not disrupted. The team meetings were led by the facilitator, and held more or less every two months. They have solved a variety of problems, notably resulting in the development of procedures to enhance workplace safety and care delivery which we describe below.

**Study design**

Our study drew on methods from participatory action research (Caister, Green, & Worth, 2011; Heron & Reason, 2001) to understand whether and how the PPCA worked from the perspective of participants as well as to produce knowledge that was mutually beneficial, contributing to the improvement of the PPCA process as well as the academic literatures on nursing home care. Research questions were formulated in consultation with the health authority leadership, the facilitator and PPCA teams. These included the following: How does the PPCA operate? What are its essential elements? What benefits does it have? What are the main challenges and are they necessary to the process? Ethics approval for the study was obtained from both York University's and the Health Authority's ethics boards.

**Data collection**

Data was collected in two stages. The first stage involved observations of weekly and team meetings to develop a familiarity with the format and issues addressed. We used purposive sampling to represent facilities at various stages. We studied facilities that had just begun the process (e.g., observing the first meeting) as well as facilities where the process was well-established (e.g., over 3 years). Permission to observe was obtained in advance from the facility

manager. Additionally, we provided an explanation of the project at the start of each meeting and requested permission to observe from participants. These meetings were not audio recorded but field-notes were taken and included as part of the data.

The second stage involved focus groups and in-depth interviews with participants to discuss their experience. We excluded senior management from focus groups to encourage open communication among workers. Focus groups were typically held after the team meetings and included all members present at the meeting (except managers) and those who had to report for duty. Separate interviews were conducted with management (facility managers and health authority leadership) as well as with some careworkers who wished to participate but could not attend the focus groups. In depth interview questions for management were similar to those noted above, though additionally we sought to explore whether the process challenged their authority and/or transformed their leadership style. A signed consent form was obtained from all participants. The interviews and focus groups ranged from 30 to 120 minutes, were audio recorded, then professionally transcribed.

In total, we observed five weekly and five team meetings. We conducted 11 interviews and eight focus groups with a total of 52 participants. While we did not systematically collect demographic information beyond occupation and gender, our sample included 23 health care assistants (HCAs), 11 registered nurses/registered psychiatric nurses (RNs/RPNs), six facility managers and senior leadership, six licensed practical nurses (LPNs), and five allied health professionals, as well as one facilitator. Reflecting the gendered nature of this sector, all were women except for two HCAs and one RN.

**Analysis**

As is typical in qualitative research, data collection and analysis proceeded concurrently. Analysis was guided by the aforementioned research questions. The research team met after each interview/focus group to debrief, discuss emerging issues and raise questions for further exploration. Based on these conversations, we modified the interview protocol to follow up on these emerging issues as well as questions that participants stated were important (e.g. the cultivation of respect, the integration of workplace safety and clinical practice, the need for emotional venting). Data gathering continued until meaning saturation was achieved for key questions (Hennink, Kaiser, & Marconi, 2016).

We performed a conventional content analysis (Hsieh & Shannon, 2005). The primary author coded the data using the research questions as sensitizing concepts as well as inductively identifying codes. A comparative approach was then used to aggregate codes, using similarities, differences and inter-relationships to develop initial themes. The data was re-engaged with to refine themes and identify negative cases. Detailed results of these analysis as well as primary data were shared among all authors, who met at various points to refine themes.

We used multiple strategies to ensure the trustworthiness of the data (Shenton, 2004). These included studying meetings at various stages of the process, post-interview debriefs, ongoing discussions among researchers, negative case analysis, and presentations back to participants. In the presentation of our analysis below we ensure anonymity by identifying quotes with an

alphanumeric code referencing focus group (FG) and interview (I). We note the participants' occupation where possible.

## Results

In presenting our analysis of what the PPCA does and how it works, we distinguish between the context and content of communication. The first three themes describe how the process created a safe space for communication to occur. The next two themes focus on content and, particularly, the capacity of these meetings to surface difficult issues while supporting collective problem-solving. And finally we discuss some of the challenges of the process.

### *Creating a safe space*

The most commonly reported accomplishment of the PPCA was that it created a space for honest communication to occur. "*One of the benefits [of the PPCA] is that it cracks open an opportunity to have a conversation that might not have existed in some sites because of the culture of the units*" (Health authority leadership, I1).

While workplace culture was not uniform, staff routinely reported feeling afraid to speak openly. "*What happened before [the PPCA],"* according to a care-coordinator, *"was the frontline staff were scared to speak their mind because they felt 'I'm dead if I speak out'"*(FG1). Workplace hierarchies were also perceived to have a silencing effect. As one manager explained:

> *Some of my leadership staff are very hierarchical in their thinking and that has been a struggle. My RCC is very much medical model, very much the army model, where there's always been a hierarchy: You do what I say because I've got more education*

*than you, or I'm better than you are, or I'm more important than you are, because my name has got a bunch of initials behind it and I'm a nurse and you're just a care aide…(I4).*

Against this backdrop, the PPCA meetings stood out as a safe space:

*I felt it was made clear [what was said] stays in the room. I felt comfortable that I could say anything to anybody.* (HCA, FG4)

*Now we are not afraid to talk. We know we have a support. We have somebody who will listen to us and say: 'Here you can talk. We'll make sure that your concerns are going to be listened to.'* (RN, FG1)

The safety of the PPCA meetings was attributed to several factors. Most significant was the presence of the facilitator who was familiar to staff through her previous job as the health and safety educator. Moreover, because she did not work directly for the facility manager but was employed by the health authority, workers did not perceive her to represent management but believed she had their interests at heart.

The exclusion of managers also created a context where workers felt free to express. Initial sessions were characterized by considerable emotional venting. According to the facilitator, venting was a necessary first step. It was particularly important in those facilities where staff had longstanding, unexpressed grievances. Still, there came a point when she needed to corral their emotions, and a key task was to assist staff in transforming their distress into a set of actionable

items. As she put it, her job was to "*pull the meeting forward*" by "*pick[ing] out the issues and making sure we talk about them*."

Even with space given for staff to vent before managers were brought in, several of the managers we interviewed recalled the initial meetings being difficult:

> *I must admit that I felt like I was going to scream and run out of the building. It was like: how many times can one manager be – I called it attacked – you felt like you were being attacked. Because in the first few meetings, if there was anything negative to say the staff would say it! (Manager, I6)*

Yet managers also saw these meetings as an opportunity to share their experience, responsibilities and concerns with staff. Enabling staff to understand the constraints they worked under as well as their commitment was reported to be helpful in building trust. The above quoted manager (I6) observed that after several meetings:

> *We felt more like a team. It was almost like the light went on and they were much more respectful. They realized that I didn't have the solution for everything. We had to work and talk and figure it out. I mean, nobody has all the answers by any means, so it was just like they came around.*

***Changing the direction of conversation***

The PPCA "*gets everyone going a different direction than we are kind of used to*" (HCA, FG1). Rather than focusing on leadership's concerns or what educators felt workers needed to know,

the staff's concerns oriented these meetings. This was a crucial shift, as one care coordinator explained:

> *Every meeting that they had [prior to the PPCA] was about our agenda: what we wanted to give them or what we needed to give them.…When it changed for us was when we opened the floor and said, What* do *you want to talk about? What are your issues? What matters to you?( FG3)*

This shift reflected an approach to knowledge that assumed "*everybody's got a piece of information about this whole.…Everybody has a piece of wisdom in terms of care, and a way to make the workplace safer: I have tried this and it seems to work* (Manager, I4). As a consequence, many aides reported feeling heard, some for the first time. But aides were not the only ones that felt heard. Managers and nurses described similar experiences.

The facilitator's role was crucial in ensuring that staff could speak and be heard. She encouraged active listening, pausing or slowing the conversation as needed, containing staff with domineering personalities, and modeling paraphrasing and asking for clarification. When required, she also spurred hesitant staff to speak. *"I had somebody pull me aside and say 'This is what happened. I'm terrified to bring it up'. I said '[Be courageous]. Bring it up.' She did. And it was really good"*(I8).

Another change in the direction of conversation involved expanding the dialogue to include the experience of workers from different positions, rupturing occupational silos. Nurses, aides, LPNs, physiotherapists, and managers shared their perspectives. In doing so, competing interests

and differing concerns were revealed. Divergent perspectives were actively sought out by the facilitator, treated not as problems but as opportunities to learn and develop a fuller picture of the issue at hand.

Staff routinely described PPCA conversations as unique, in that they were distinctly respectful. When we asked staff to clarify what they meant by respect, they typically pointed to a willingness to get into the world of others. "*Listen. Try to understand where people are coming from…. Have empathy for one another. That to me is respect"*(HCA, I10).

One outcome of the PPCA that was attributed to being heard was the improved sense of self-worth reported by participants. The process "*has started to make people feel more valued at what they do"*(I9). The PPCA also contributed to aides' confidence. "*It has helped me come out of my shell and helped me to dialogue better"*(I9). These transformations were evidenced by staff outside PPCA meetings as well. For instance, several managers remarked that PPCA participants were more likely to speak up on the unit. Or as one aide observed: "*It's made me not so afraid to go talk to the bosses and [have] lots more communication"(I10).*

***Cleaning the content of communication***

Lack of regular communication, particularly across occupational groups could lead to animosity especially in cases where the motivations behind colleague's demands or actions may not be well-understood. The PPCA provided a forum to address such resentments. This was described as "*pulling back the curtains," "stripping the varnish," "getting rid of crap*." These metaphors conveyed the work of moving beyond superficial collegiality and revealing the sometimes ugly

truth. "*What the PPCA has done*," one care coordinator remarked, "*was brought us to the table…and said okay here you are. This is our laundry. We have to wash it [laughter]*."

Hearing their colleagues' perspectives was sometimes enough to make a difference. "*We can see their point of view. They will explain to us why they do certain things.…When I understand why they do something, it's okay*" (HCA, I10). In some instances the weekly meetings had to be cancelled for a short period of time. We were told that when they resumed, it was once again necessary to begin this process of healing resentments.

Rumors also needed to be addressed. They were commonplace and could have a "*destructive*" effect on morale. We saw a number of myths busted in the meetings we observed, including: fears that the facility was being privatized (false); concern that some workers were going to be fired (true); anger that some staff were using volunteers to do their work (false); or that some residents were receiving preferential treatment (not so simple). Gossip was so prevalent and divisive that several of the managers routinely began weekly meetings by asking "*What's the rumor of the day?*"

This relational work was reportedly essential in moving beyond complaining and blaming to resolving practical matters. "*Where we would just fly off the handle…people are listening to what is being discussed. There is conversation happening to understand what is being brought forth.*" Another HCA put it bluntly: "*When all the other crap is aside, you can actually look at what you are here for."*

***Getting things done***

*Most of the meetings that we've attended in the past, nothing gets resolved, so it's a waste of time"* (HCA, FG5). The PPCA was unanimously regarded as unique because it resulted in action. One aide likened the process to a steam powered engine that channeled frustration into forward motion. We provide a partial list of issues addressed during the meetings we observed in Table 1.

**Table 1:**
**Concerns we observed being addressed during weekly and team meetings**

| |
|---|
| Younger residents upset because they are not allowed to sleep in |
| A resident upset about hair cutting |
| Some residents are asleep during lunch |
| Requiring residents to get up for breakfast |
| Physical and verbal violence from angry residents |
| LPNs refusing to help aides |
| Aides missing breaks |
| Two-person lifts done by one person |
| Knowledge and concerns communicated by aides ignored |
| Aides accused of being slow |
| Insufficient instructions for casual staff |
| Tensions between visible infection control signage and patient confidentiality |
| Sharing slings among residents and risking contagion |
| Unsafe procedures not being reported |
| Computer registration procedures not working |
| Difficulty with computerization as not all workers are computer literate |
| Using sick time for leave of absence |
| A broken hairdryer needing replacement |
| Lack of sufficient stock, particularly incontinence products |

Well-established PPCA teams could move quickly from problem identification and analysis to proposed solutions. However, newer groups needed to develop trust in their ability to problem-solve. As the facilitator described:

*At the initial stages of the PPCA work, the teams really struggle with this idea of developing solutions to problems for which they think there are no solutions. As the teams mature, they realize that they are able to come up with a solution and try the solution out. Even if the solution doesn't work the first few rounds, eventually, folks get the idea to be looking for ways to address issues that are unique and comprised of a team effort.*

Action items and meeting minutes were important in maintaining momentum, allocating responsibility and serving as an indication that management took workers' concerns seriously.

*I listen and I hear them and at the end of the day when we have an action plan I ask them if the action plan is suitable to what they want, anybody wanting to help or sometimes I'll delegate things and they're good with it because it's all been their idea and it's all been what they wanted to talk about. That is why it started to change, because they were starting to recognize that we were listening.* (RCC, FG3)

The publication of the meeting minutes on bulletin boards also made the work of the PPCA visible to others and encouraged participation.

Not all problems could be resolved. In these cases, having a clear explanation as to why not helped maintain the processes' credibility (e.g., the solution was too expensive, would violate labor laws or patient confidentiality, etcetera).

In most cases however, we observed that solutions were proposed. These were treated in an experimental fashion, to by trialed and if it did not work, modifications could be made or the

team would again *"hit the drawing board."* This trial and error approach contributed to creativity a sense of empowerment. *"If the solution doesn't work the first few rounds, eventually, folks get the idea to be looking for ways to address issues that are unique and comprised of a team effort."(Facilitator, I8).*

If the proposed solution worked, they would be instituted as regular practice. The "work-plan" was one such example. It was a document developed in response to aides' frustration that their knowledge was being either lost or ignored by nurses. The document provided a place for aides to record their observations about residents' preferences and health status. It was kept on the nurses' desk, and nurses were required to initial each entry after reading it. "*The built in accountability of the work plan,"* according to the care coordinator:

> *has given a lot of our HCAs a sense of empowerment to be able to recognize those things for the resident sooner than later….I don't have to hear "I've been reporting that for three weeks now and nobody has done anything about it!" I don't hear about bed sores when they're this big [gestures with hands]. I hear about it when they are red. Because they are recognizing. They are documenting. They are noticing it. [It's] not perfect. There are still gaps. But [it's] definitely a huge improvement.*

Team meetings also provided an opportunity for cross-pollination with participants invited to attend meetings in other facilities. We witnessed several instances where team members shared solutions developed in their facility. Some processes, such as the work plan, were thereby extended across several facilities. We also noted one instance where the facilitator was asked to solicit staff input on a health authority policy initiative. Several participants greeted these

developments with caution, suggesting that this sharing could compromise the intent of developing site-specific solutions. It was important, according to one manager, to ensure that the adoption of these practices was understood to be voluntary. Moreover, we wondered whether using team meetings as 'ready-made' opportunities to obtain staff feedback could become a means of slipping into a top-down agenda.

***Pealing the onion***

In addition to an experimental ethos, the PPCA meetings were characterized by a spirit of discovery. Through openness and listening, the PPCA process relinquished over-simplification and the urge to impose premature diagnoses. Instead, it traced out the complexities of problems, in a process the facilitator likened to "*pealing back layers of an onion*."

The safety of the space supported staff in revealing failures of care and risky work-routines. In so doing, the conversation surfaced serious problems that were frequently invisible to all but a few. For example, in one meeting we observed dayshift workers admitting they were being helped by their nightshift colleagues who would wake residents exceedingly early to get them dressed and ready for breakfast. This practice was rationalized as a workaround to address staffing shortages but it was also clearly poor care. None but the few staff involved knew this was going on.

In another meeting, aides revealed that two person lifts were routinely performed singlehandedly putting their health and that of residents at risk. In some cases, workers had been reprimanded multiple times but the practice persisted because, as workers revealed, they were afraid to ask for help. When we shared our surprise that dangerous practices could remain invisible, one

participant explained that scared workers became adept at telling leadership what they wanted to hear.

The presence of multiple occupational groups – in combination with the facilitator's capacity to encourage staff to speak/listen – enabled the team to trace the complexity of issues. In an example of what one manager referred to as a "root cause analysis," a care aide voiced her concern that a male resident was taking too much time to get ready in the mornings. Aides were frustrated because they were being blamed for falling behind schedule. The Residential Care Coordinator (RCC) said she'd look into this. But when pressed for specific action items by the facilitator, she had none. It was clear the RCC was not going to follow up. She confessed she did not believe the aides. Some were new and, she felt, inexperienced and therefore slow. In response, aides clarified that he was "*younger and more directive*" and both newer and experienced aides were taking time. The RCC then raised a seemingly tangential concern that many residents were "*half asleep around the lunch table,*" so why were they getting up so early? The manager suggested that not everyone needed to get up at the same time. One of the HCA's responded that they had to get them up for physiotherapy. This prompted a discussion about the scheduling of physiotherapy. The action item that resulted from this pealing back of layers required the RCC to collaborate with the physiotherapist to create a schedule that allowed residents who so desired to sleep in, thereby creating more time for aides to dress him and other 'directive' residents.

The above example typifies how the process moved from anger and blame to an empathic understanding. Moreover, by respectfully listening to various perspectives, the team was able to

trace out the interconnected parts of a problem, identifying conflicting desires, responsibilities and pressures and design a solution that took situational factors into account. The resulting innovations were often surprising. Indeed, re-scheduling physiotherapy was not a solution that could have been anticipated from a cursory understanding of the problem, which was initially presented as workers struggling with a directive resident.

***Into the fire***

The process was not without difficulties. As noted, the initial meetings were painful. "*Where I hear the pain coming from is from the leaders, because they feel quite assaulted. That's the language they use – 'assaulted' by staff. It takes them about six meetings before they stop feeling assaulted"* (Health authority leadership, I4). The bitterness expressed by workers shocked some managers. Other managers felt unseen, with their work invisible and their efforts unappreciated. The volume of complaints could overwhelm managers, and yet they recognised that it was essential to ensure space for such negativity. To better manage this tension, several participants suggested preparing managers undertaking the PPCA process, warning them of the difficulties and letting them know the process got easier and would enable them to make their commitment and care understood.

We identified other challenges. There was a tension between scheduling meetings at a consistent time and ensuring diverse participation. Staff agreed it was important to hold the meetings at a regular time and the facilitator believed this consistency was crucial to building trust. Unfortunately, this meant that while the weekly meetings were open to all staff, in practice they

were attended by those scheduled to work on meeting days. This compromised the process's ability to include different people and could lead to missing problems.

In some facilities finding a room big enough for the PPCA meetings was a challenge, indicating a team meeting room needs to be designed into facilities. Finally, there were questions of workload, particularly for managers. Some managers admitted that addressing the action items took time. They suggested that while meetings needed to be scheduled weekly, more time was required to complete action items. Nevertheless, managers expressed that the effort was worth it. "*It is an hour and a half out of my week that can probably change my whole week*"(FG3).

Despite these challenges we observed that the process brought hope and pleasure to workers. This was most clearly witnessed during a PPCA education day, an event gathering over a 100 PPCA team members to celebrate their accomplishments. The education day we attended concluded with what has become a tradition in PPCA process: staff expressing their emotions in a single word. These expressions conveyed a sense of belonging, commitment and even joy, with staff saying they felt "encouraged, inspired, educated, refreshed, informed, lucky, and not alone."

**Discussion**

One of the main achievements of the PPCA was creating a safe space where problems could be raised and collectively resolved. It is tempting to focus on the practical improvements to quality and safety but this risks reproducing the reductionist ethos that valorises objective outcomes and is already over-emphasised in nursing homes. Rather, what our analysis indicates and what we wish to reinforce in our discussion is importance of the relational work which made it possible for these conversations unfold in a manner that led to the collaborative development of solutions.

Considerable relational work needed to be done to create a context of safety, wherein staff were willing to be vulnerable and raise concerns, fears and failings. This relational labor included making space for venting and hearing complaints. It drew on the skills of validation and empathy. It involved creating a context in which feelings mattered and could be explored. Relational work was also essential in fostering rapport such that staff felt at ease with one another and were able to work together. Here we witnessed efforts to dispel rumors, move through resentments, and foster an understanding of differences. We suggest that these relational practices were not tangential but central to the PPCA's productivity. Taken together they exemplify what that Fletcher (1999) terms "creating team," specifically a type of relational work that creates the "background conditions" for group life to flourish. In the case of the PPCA, this relational practice transformed an *ad hoc* group – often fraught with misapprehensions and resentments –into a collaborative, effective and at times even joyful team.

Another relational practice that made a difference was listening. When thinking about communication there is a tendency to emphasize speaking, knowledge transmission or, with respect to marginalized groups, giving voice (Kagan, 2008). However, while sending obviously matters, for information to make a difference it must be received. In this the PPCA was notable. It created the conditions for listening by allowing for silences or slowing the conversation down. The facilitator also modeled active listening, by clarifying, paraphrasing and asking participants to do the same. Thus, although speaking and listening are often viewed as separate, our findings show that the PPCA connected speaking and listening. Participants inquired, checked their understanding, summarized and responded to the meanings conveyed. In the process there was

less talking past one another and staff felt heard. Given the scholarship that suggests our sense of self is developed through relationships, language, and particularly through being listened to (Kagan, 2008), we can better appreciate why staff consistently linked feeling heard to an increased sense of self-worth and self-confidence.

We may also understand as relational work the negotiation of tensions, particularly between the individual and the institution. This tension, expressed for instance between state regulations and the personalizing of care is pervasive in North American nursing homes (Baines & Daly, 2015). Yet, many of the issues the PPCA grappled with had to do with following or resisting regulations. In some cases, we saw exceptions made to meet particular residents' preferences, in which case concerns that this might be unfair to other residents or set bad precedents were raised and discussed. In other cases, we saw considerable efforts made to support staff in following regulations that were being consciously ignored. Each was considered on a case by case basis and deliberated collectively.

These deliberations were aided by the presence of participants who could speak for institutional requirements (e.g., staff who knew union and labor regulations, managers who knew Health Authority policy, and nurses who knew clinical guidelines) and staff who were advocating on behalf of residents. This diversity in participation ensured that the solutions would remain grounded in and compatible with occupational and organizational realities, likely reducing their unintended negative consequences. In this way, we may understand the PPCA as a deliberative process that contributes to a more caring institution or "caring bureaucracy" in Bourgault's (2017) terminology. Such an institution does not eschew regulation nor stratification for that

matter but recognises their tensions with the needs of caring and builds in processes for responsiveness. The PPCA may be seen as such a process.

Thus, to the degree that reductive epistemologies continue to shape innovation and the organisation of care work in nursing homes (Banerjee et al., 2015), we suggest the PPCA is a step in a different – more relational – direction. It is an example of an innovation that respects the personal, interconnected, and multi-perspectival dimensions of caring. The process has its limitations of course. Notably it could do better at incorporating residents' perspectives, perhaps by including residents or residents' council representatives. Our study too is limited by its focus on meetings and participants. Research tracing the implementation of solutions and their practical effects would be warranted. Nonetheless, we want to highlight the values of listening and connecting, as well as respecting the practical wisdom of staff because these are so often missed in innovations that celebrate technology and the kind of reductive expertise that impedes two-way communication.

Our emphasis on the relational work that went on in the PPCA downplays the practical outcomes that were produced. Yet, given the dynamic nature of caring for persons who are aging and in ill health, the problems encountered will change and, as a consequence, responsive solutions must as well. In this context, the specific solutions may matter less than having a process in place that can accommodate and respond to such dynamism. There is a role for organizational and public policy in supporting the resourcing and development of such programs within homes. Similarly, private sector collaborations among unions and provider organizations may also be a promising

means of developing similar relational practices that can integrate staff and manager perspectives to improve the quality of both work and care (cf. Leutz, Bishop, & Dodson, 2010).

Finally, we conclude by recalling the optimism and hope encountered. One of the fundamental assumptions behind relational practice, as Fletcher (1999) observes, is that connection is of value in and of itself. By starting from this presumption and fostering respectful communication camaraderie and joy resulted, serving as a welcome reminder that residential care work can be deeply fulfilling when appropriately valued and supported.

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