

Social Participation in Long-term Residential Care: Case Studies from Canada, Norway, and Germany

Ruth Lowndes,¹ James Struthers,² and Gudmund Ågotnes³

RÉSUMÉ

L'engagement social significatif des résidents lors de leurs activités quotidiennes peut améliorer leur qualité de vie en institution de soins de longue durée. Dans cet article, les données d'une étude internationale multidisciplinaire explorant les pratiques prometteuses dans les centres de soins de longue durée au Canada, en Norvège et en Allemagne ont été utilisées afin d'étudier les conditions favorables ou défavorables à la participation sociale des résidents. Dans le cadre d'une approche d'économie politique féministe intégrant l'ethnographie succincte en équipe, des observations et des entretiens approfondis ont été menés avec la direction, le personnel, les bénévoles, les étudiants, les familles et les résidents. Nous soutenons que les conditions de travail ne peuvent être dissociées des conditions de soins. Des conditions telles que l'emplacement du centre de soins, la configuration des bâtiments, le niveau des effectifs et l'organisation du travail, ainsi que les réglementations en vigueur, influencent si et comment les résidents peuvent participer et s'engager dans une vie sociale quotidienne significative dans leur centre de soins ou à l'extérieur de celui-ci. Les conditions qui facilitent la participation sociale des résidents, en particulier celles favorisant la flexibilité et la possibilité pour les résidents de faire des choix, ont un impact direct sur leur santé et leur bien-être.

ABSTRACT

Meaningful social engagement in everyday activities can enhance resident quality of life in nursing homes. In this article, we draw on data collected in a multidisciplinary, international study exploring promising practices in long-term care homes across Canada, Norway, and Germany, to investigate conditions that either allow for or create barriers to residents' social participation. Within a feminist political economy framework using a team-based rapid ethnography approach, observations and in-depth interviews were conducted with management, staff, volunteers, students, families, and residents. We argue that the conditions of work are the conditions of care. Such conditions as care home location, building layout, staffing levels, and work organization, as well as governing regulations, influence if and how residents can and do engage in meaningful everyday social life in/outside the nursing home. The presence of promising conditions that facilitate resident social participation, particularly those promoting flexibility and choice for residents, directly impacts their overall health and well-being.

¹ Department of Sociology, York University, Toronto, Ontario.

² Department of Canadian Studies, Trent University, Peterborough, Ontario.

³ Department of Welfare and Participation, Western Norway University of Applied Sciences, Bergen, Norway.

* We thank all of the residents, families, staff and managers, volunteers, and students at each of the research sites for welcoming our research team and for sharing their experiences and valuable insights. We thank Dr. Pat Armstrong, the principal investigator, for her remarkable leadership, and the entire research team for unwavering dedication to the project. This work was supported by the Social Sciences and Humanities Research Council (SSHRC) Major Collaborative Research Initiatives (MCRI) grant (File # 412-2010-1004); and the European Research Area in Ageing (ERA-AGE2) (agreement # 01182-000) received in Canada through the Canadian Institutes of Health Research (CIHR).

Manuscript received: / manuscrit reçu : 05/10/2019

Manuscript accepted: / manuscrit accepté : 03/07/2020

Mots-clés: vieillissement, soins de longue durée, personnes âgées, centre de soins de longue durée, participation sociale, activité sociale, conditions de soins

Keywords: aging, long-term care, elderly, nursing home, social participation, social activity, care conditions

La correspondance et les demandes de tirés-à-part doivent être adressées à : / Correspondence and requests for offprints should be sent to:

Ruth Lowndes R.N., Ph.D., C.D.E.
York University
359 York Lanes
4700 Keele Street
Toronto, Ontario
Canada, M3J 1P3
(rlowndes@yorku.ca)

Introduction

In view of the global aging population and growing numbers of seniors living with multiple, complex chronic conditions and disabilities, there is an increasingly greater need for long-term residential care. “These facilities serve diverse populations who need access to 24-hour nursing care, personal care and other therapeutic and support services” (Canadian Institute for Health Information, 2018). In 2011, an estimated 250,000 Canadians lived in long-term care facilities (Statistics Canada, 2011). The number of people requiring nursing home care is expected to double over the next two decades (Library of Parliament, 2012), a trend similar across other jurisdictions that we studied, including Norway and Germany. In 2017, the total number of long-term care beds in Norway was 40,493 (Statistisk Sentralbyrå, 2018), which, for a total population of 5,300,000, is comparatively high. The number of people 65 years of age and older was 790,000 in 2017, a number that is expected to increase to 1,280,000 by 2040 (Folkehelseinstituttet, 2018). In 2018, 21.4 per cent of Germany’s total population was 65 years of age or older (European Commission, 2020). This figure is expected to increase, and by 2050, seniors will make up 38 per cent of the total population (Federal Statistical Office of Germany, 2016).

In high-income countries, long-term care homes have historically been known as under-funded institutions where residents spend their remaining days away from larger society, subjected to routinized, task-oriented care practices (Baum, 1977; Diamond, 1992; Johnson, Rolph, & Smith, 2010; Smith, Towers, Palmer, Beecham, & Welch, 2018). More recently, through the culture change movement (Rahman & Schnelle, 2008), attention is being paid to quality of life and person-centred care in these settings (Koren, 2010; Rahman & Schnelle, 2008). However, there is a lack of research that might enable informed decisions to be made as to which interventions or person-centred care principles would be beneficial (Burack, Weiner, Reinhardt, & Annunziato, 2012; Kolanowski & Buettner, 2008). A focus on improving the quality of life for this population is imperative in view of the high rates of loneliness (Cacioppo, Hughes,

Waite, Hawkey, & Thisted, 2006; Victor, 2012) and depression that they are experiencing (Cacioppo et al., 2006). “Rates of major depression among older adults are substantially higher in particular subsets of the older population, including ... residents of long-term care facilities (14–42%)” (Fiske, Loebach Wetherell, & Gatz, 2009, p. 366). Residents with moderate to severe dementia are even more likely to be passive (Kolanowski & Buettner, 2008; Zimmerman et al., 2003), have fewer visitors, and tend to be more socially withdrawn than those without dementia and/or functional impairment (Zimmerman et al., 2003). Many of their mental health and social care needs for company and daytime activities are not being met (Hancock, Woods, Challis, & Orrell, 2006).

Psychosocial care to address depression and loneliness “is typically based on a long-standing tradition of ‘light’ social events, such as games, trips, and social gatherings, planned and implemented by staff” (Theurer et al., 2015, p. 201). However, *meaningful* daily lives for residents require approaches that focus on reciprocal relationships (Armstrong & Banerjee, 2009; Armstrong & Braedley, 2013; James, Blomberg, & Kihlgren, 2014; Theurer et al., 2015), social contributions (Theurer et al., 2015), and social engagement (Ågotnes & Øye, 2018; Harmer & Orrell, 2008; Theurer et al., 2015). Rather than structured and standardized group activities, residents prefer and/or can benefit from more individualized activities geared towards their different backgrounds and interests, reciprocal interactions with staff, perceived control of their environment (James et al., 2014), and freedom of choice over the types of activities offered and their own involvement in these activities (Bocksnick & Hall, 1995). In Harmer and Orrell’s (2008) focus group study in three London care homes, residents, families, and staff all reported that opportunities for engagement in meaningful activities were lacking, and associated this outcome with low staffing levels, staff attitudes prioritizing physical above social care needs, routines within the organizations that restricted autonomy, and care philosophy statements that were incongruent with care in practice. In Knight and Mellor’s (2007) study of five nursing homes in

Melbourne, Australia, researchers explored resident and staff perceptions of activities and inclusion, and reported that staff perceived their social care obligations to be met by fulfilling superficial activities in between busy care routines.

To residents, however, social inclusion was not about joining in the various activities that were provided. It was about feeling socially connected. At the heart of such connectedness is feeling at home, at one with those around them (regardless of how many or how few), of having control of their lives, of having privacy, and of being able to make a contribution to those with whom they feel connected. This is a far cry from an afternoon of bingo or a bus trip to the local shops. (Knight & Mellor, 2007, p. 84)

A more recent analysis of “meaningful activity” in six English care homes, based on interviews with 72 residents, argues persuasively that the limited choices of what activities or occupations were on offer strongly constrained residents’ quality of life, and contributed to widespread feelings of loneliness and boredom (Smith et al., 2018).

“These accounts provide a challenge to the notion that older people living in care homes are choosing not to engage in activities ... [T]hey show residents talking of their unhappiness about doing nothing and their desire to engage in activities of their choice” (Smith et al., 2018, p. 2228).

The authors also stress that keeping residents “occupied” is “often seen as separate from the main role of caring within homes” (Smith et al., 2018, p. 2231), reinforcing earlier arguments by Ronch that “Humanization can occur only when the individual needs and characteristics of the people in the care equation ... and the *quality* of the care-giver – care-recipient relationships define the *quality* of care” (Ronch, 2004, p. 67). Including the knowledge and ongoing engagement of family members in this care equation is also essential (Lopez, Mazor, Mitchell, & Givens, 2013; Welch, Palmer, Towers, & Smith, 2017).

In the body of literature on social participation within the context of long-term care, there is a call for research that explores the physical environment and its impact on resident involvement in everyday life. Using a feminist political economy framework to guide our research, we address this gap in our analysis of care home locations and physical spaces, while also presenting our findings on other conditions such as staffing levels and work organization, care philosophies, and regulations that shape residents’ meaningful social participation. Feminist political economy, a theoretical approach that emphasizes equity and social justice,

informed the project *Reimagining Long-Term Residential Care: An International Study of Promising Practices* (led by Dr. Pat Armstrong) and this article. Within this framework, care is viewed as a relationship: “[C]are cannot be considered solely as a product, an outcome, or a service, but includes the relations of trust, mutuality, dignity, and respect that are developed when we attend to one another” (Armstrong & Braedley, 2013, p. 10). Feminist political economy enabled us to explore both the paid and unpaid care work that takes place in long-term care from the perspective of those living, working, visiting, and volunteering in these homes, and to investigate how these activities are connected to larger sociopolitical forces (Armstrong & Armstrong, 2018).

“[B]oth care providers and residents deserve to be treated with dignity and respect and our goal is to identify the conditions that are most promising for promoting this dignity and respect in nursing homes. This means identifying the contexts, regulations, funding, and conditions that are most likely to allow residents and providers to flourish” (Armstrong & Armstrong, 2018, p. 3–4).

In working on this article, we were searching for conditions such as regulations, staffing levels, care home locations, and physical environments that allow for and encourage residents’ meaningful social engagement.

Methods

Team-based rapid ethnography (Armstrong & Armstrong, 2018; Baines & Cunningham, 2013) was the methodological approach used to collect data (see also York University, 2014). Rapid ethnography is an innovative form of multi-method ethnography enabling data collection from multiple sources such as observations, document analysis, and interviews conducted over a short, intensive period of time in the field (Armstrong & Lowndes, 2018; Baines & Cunningham, 2013; Beebe, 2014). Using this approach guided by feminist political economy, we were able to collect thick, rich data about long-term care from all of those involved at the sites, while also making connections to such aspects as regulations, funding, and ownership structures that shape these everyday experiences.

The research team was composed of 26 faculty members from various disciplines, including historians, sociologists, anthropologists, nurses, social workers, an architect, an economist, an epidemiologist, and medical practitioners, as well as more than 60 students, also in different disciplines. Experienced researchers worked alongside those with less experience, some of whom were conducting field work research for the first time. This pairing allowed team members to learn from each other and adjust their perspectives throughout the

course of the project. Having people from multiple disciplines working together also meant that although we were observing at the same time in the same location, our diverse research lenses allowed us to focus on different environmental aspects, events, or interactions, which was a strength of the study that we recognized when we compared our individual observational field notes as the project progressed. For example, an historian, who initially focused on historical, geographical, and physical contexts and a registered nurse/sociologist, whose research lens was on nursing practice, wrote together about their observational experiences and how these evolved, through interdisciplinary collaboration over the course of the research (Choiniere & Struthers, 2018).

We conducted site studies over a week-long period with 12–14 local and international researchers from the larger team. All researchers who were involved in each 1-week site study worked in pairs: most often a local researcher was partnered with an international team member to facilitate “fresh eyes”, observing in shifts together in a resident living area over this period. This arrangement assisted in relationship building and developing trust both between the researchers and between the researchers and the people living, working, and visiting the nursing home. This was also the case in Norway, Germany, and Sweden, where local researchers were paired with international team members so that translation was possible for those who only spoke English.

During each week-long site visit, one of the main goals was to cover as many resident activities as possible in order to gain insight into social health and well-being. Researchers observed both structured (i.e., bingo, group exercises, cooking/baking, crafts) and unstructured activities (card games organized by residents, sing-alongs), deciding among the team who would attend each one based on people’s interest and the timing of their schedules. For example, the first author of this article was interested from the outset in resident quality of life and opportunities for meaningful social participation. In one instance, she went back after the site visit to an Ontario home to observe a spring garden planting activity, which was organized by volunteers to encourage resident involvement. The second author, an historian, was interested in how both the residents’ past and the cultural and historical context of each home were palpable through such aspects as its physical structure and location, as well as in interior displays, and activities. He was also interested in connections to the broader community and how each home facilitated them. The third author is an anthropologist and was particularly interested in the micro-interaction among the residents, and how everyday interaction played out in an institutional context, including formations of affinity, friendship, and alliances.

Our observations were based on Spradley’s (1980) principles, such as accessing and locating the social situation (p. 39–41), and conducting grand-tour, or large-scale observations (of various features of nursing homes in our case), followed by mini-tour observations or more detailed aspects such as observing a particular meal-time on a certain unit as it unfolded (p. 77–79). Field notes followed Emerson, Fretz, and Shaw’s (2011) guidelines, with each researcher focusing on certain events/activities during the work shifts that they were observing, writing their own accounts based on their individual perspectives, and uploading each one on the secure Web site (see also Lowndes, Storm, & Szebehely, 2018). One of the team members also adapted an observational guideline sheet that was placed in each researcher’s site study folder reminding us, for example, to use all of our senses, including smell and sound, while observing. Extensive observational field notes, hundreds of pages in total, captured rich data on resident involvement in both structured and unstructured activities, their engagement with staff and visitors, and their everyday routines, including instances when they were inactive.

During our week-long field work, once we initiated our full site study and had gained background information on the jurisdictions, we also conducted a “flash ethnography” in another care home using the same methodology but over a 1-day period. We made observations and conducted interviews over all shifts to obtain an accurate assessment of nursing home life, not only during the weekday hours, but also in the evening, through the night, and on weekends when there was less staff, usually no management, and often fewer activities for residents. A central objective was to obtain interviews in each category; that is, registered care staff, care aides, residents, family members, volunteers, students, recreation staff, maintenance, laundry, and food services, to capture all aspects of long-term residential care in the different jurisdictions.

We recruited participants in both the week-long and 1-day flash ethnographies by placing posters about the study around the nursing home, and by conducting pre-interviews. When possible, we also attended Resident and Family Council meetings prior to or during our site studies. During our observations, we also spoke with staff, students, volunteers, residents, and family members; explained the study; and invited people to participate in interviews at times convenient for them. With the exception of pre-interviews that were conducted with management, recruitment for almost all of our interviews was done at the site by researchers during all shifts and on weekends, not having management choose participants and arrange interviews, thus minimizing selection bias.

Ethical Considerations

Ethics approval was obtained for the study through York University, as well as through any of the jurisdictions that required further ethics approval from respective universities and/or from the selected nursing homes. Prior to conducting our pilot study, ethics approval was required from the research centre affiliated with the nursing home. Although we had obtained ethics approval from York University to conduct interviews and to use photovoice with residents with dementia to capture their voices, we had to make amendments to our protocol so that we only invited residents to participate who were deemed competent to provide informed consent. During our subsequent site visits we determined the eligibility of residents able to give informed consent and their willingness to participate by building rapport with them during observations over the first part of the week. All interviews were conducted in private rooms in the nursing homes, in the dedicated meeting room provided to us for our stay, or in places chosen by the participants. For example, for privacy, residents would sometimes invite the researchers into their bedrooms for their interviews. Otherwise, as per our protocol, researchers stayed in public spaces such as communal dining rooms and lounges, did not enter resident bedrooms unless invited, and did not observe any intimate care activities.

Semistructured interview topic guides were developed for families, residents, staff, management, volunteers, and cleaners focusing on our overall aim to explore promising practices that enable residents and staff to flourish. The interview guides consisted of open-ended questions that were meant to generate discussions: topic areas included, for example, "What does active healthy aging mean for residents? Staff?"; "What does treating residents with dignity and respect mean?"; "In your view, what is a good nursing home for residents? Staff? Family?" The resident interview guide included questions such as "Can you describe your day, starting with when you get up?" which prompted conversation about their typical day and routines. Other questions included, for example, "Do the activities interest you?" "Can you get exercise?" and "Are you able to follow your traditions such as your religion and your food preferences?" Week-long observations in the care homes and in respective resident living units complemented these interviews by providing insights into everyday life and work in long-term care.

The interviews conducted in the 13 sites that informed this article numbered as follows: 95 in Ontario, 52 in British Columbia, 41 in Manitoba, 61 in Nova Scotia, 33 in Germany, and 61 in Norway for a total of 343. Across these 13 sites we conducted interviews with 76 management personnel, 14 physicians (including

one nurse practitioner), 59 registered nursing staff, 48 care aides, 7 students/apprentices, 33 recreation/social care staff, 28 family members, 33 residents, 12 volunteers, 6 maintenance and security staff, 13 food service workers, and 14 cleaning/laundry employees. Only interviews and observations conducted at these 13 sites were included in the analysis for this article. The residents who participated in interviews were all deemed capable of providing informed consent. Interviews were audio-recorded and those conducted in English were transcribed verbatim. Interviews were conducted in Norway care homes by researchers who spoke both Norwegian and English and who had contextual insight into long-term care, to complement interviews conducted by researchers who only spoke English. Norwegian colleagues checked interpretations of questions and responses with participants throughout the interviews. Interviews in Germany were conducted by researchers who spoke both English and German, along with researchers who only spoke English, accompanied by a professional interpreter. The bilingual researchers, some of whom were senior faculty and some of whom were students, checked interpretations during interviews, and senior faculty also checked the written transcriptions. The English content of the audio-recorded Norwegian and German interviews was transcribed verbatim.

Settings

Sites were selected by consulting key informants such as government officials, unions, and community organizations that were involved in long-term care, and their knowledge was then combined with other pertinent information such as quality indicators collected by governments to select care homes that offered promising practices (see also Armstrong & Lowndes, 2018). These care homes were then approached by the principal investigator and/or co-investigators in different jurisdictions to share information about the study, and to determine the homes' willingness to participate. Over the course of our entire project, a total of 27 sites were studied between 2012 and 2015 across the six locations, and a total of 528 interviews¹ were conducted with management, staff, students, volunteers, families, residents, and union officials. Site studies were planned over a 3-year period outside of academic terms so that faculty members could travel and spend time in the various jurisdictions. For this article, 13 of the sites were included as follows: in Canada, British Columbia (2), Manitoba (2), Ontario (2), and Nova Scotia (2); and outside of Canada, Germany (2) and Norway (3). These

¹In total, across the 27 sites studied for the project, 528 interviews were conducted, and of these 343 interviews (13 sites) were included in this particular article.

13 sites were chosen for this article because at least one of the authors was involved in site studies in these particular locations, along with other team members. The care homes were in various locations, with some being centrally located in urban areas (6), some in suburban areas (3) and others (4) in more rural areas. Sizes of care homes ranged from 22 to 200 beds. Eight homes had only single bedrooms, three had both single and double bedrooms, and two had single, double, and ward bedrooms. Among the homes, seven had segregated units for those with dementia and six did not. In these latter homes, all residents, regardless of cognitive awareness, were mixed together. Three of the care homes were faith-based, all were government funded and regulated, and all were non-profit except one in Atlantic Canada, which was part of a for-profit, family-owned chain.

Analysis

There were three types of triangulation in the project: data, methodological, and investigator (Denzin & Lincoln, 2000). The data we collected came from multiple sources such as background fact sheets and documents obtained from each home (i.e., organizational charts, staffing demographics, texts describing approaches to care, institutional policies, annual reports and report cards, activity calendars, resident information packages), as well as interviews, and observational field notes. Our interview data also came from many different sources including care and ancillary staff, management, residents, family members, unions, volunteers, and students. Methodological triangulation was established by using multiple methods, including interviewing, observations, and photovoice, to collect data. Our team was composed of multiple investigators from different disciplines, for investigator triangulation.

Multiple perspectives (Beebe, 2014) were ensured using our protocol, with the 12–14 local and international, interdisciplinary team members involved in each site visit collecting data and participating in meetings before, during, at the end, and after each site study. Both data collection and analysis were iterative processes (Beebe, 2014); meetings that were held during field studies were used as a means of determining missing data in addition to initiating analytical discussions. The collective analytical process extended into larger monthly group meetings and seminars, with local researchers attending in person and international researchers attending by video and teleconference. Additionally, annual team meetings were held in which all researchers came together for a 3-day period for conference and workshop collaboration. All data were stored electronically on a password-protected, secure Web site with controlled levels of access. For example,

only researchers on the team and students who had signed a confidentiality agreement could access the primary data.

For this article, we were searching for conditions that facilitated residents' meaningful social participation within and outside of their respective care homes. During one of the annual team meetings, the authors of this article met in person to initiate analytical discussion of the article. Interview transcripts and field notes were read and reread by the authors to capture meaning and to ensure inclusion of all data related to activities and social engagement (Braun & Clarke, 2006). The first author initiated the coding of the data, throughout which notes were made on particular thoughts regarding initial patterns and potential coding schemes based on the data set (Braun & Clarke, 2006). Excerpts were then grouped loosely under thematic categories by the first author and checked by co-authors. The categories were: "location and physical structure", "social engagement/ involvement in activities", "staff/volunteer/ family member interrelations with residents", and "gender and cultural considerations". During the first reading of the draft paper, Norwegian differences in long-term care such as smaller facilities and families often living at a distance from the care home were more clearly delineated, along with how physical layout can inhibit or facilitate social engagement for those without families visiting regularly. Additionally, the focus on Ontario regulations that prioritize physical over social care needs, and recreational therapy as opposed to social activity, were also emphasized. Subsequent drafts of the article were read by co-authors and the principal investigator of the project to ensure accuracy and consensus on the emerging themes and content.

Findings

Based on the iterative process of analysis described, the core themes we collectively agreed upon that captured the prevalent patterns in the data were as follows; "location and physical spaces", "time to care", "social participation opportunities", and "flexibility and bending the rules". In this section, we present our analysis of care home locations and the physical spaces within and around the homes, to show how these features shape resident involvement in everyday life, and how the social participation of residents can be connected to other conditions such as staffing levels, work organization, care philosophies, and regulations.

Location and Physical Spaces

Care home location

Location matters. We consistently heard from families and residents that being able to go outside and easily access stores, restaurants, and other amenities was

important for socializing and for overall health and well-being. One Ontario site was within walking distance to a market where residents could independently go to shop, eat, and have a coffee. As one family member whose husband was in the care home told us:

He can go, well he can go anywhere. He has para transport but he also has learned how to use the city bus and he will go out and I think that's the only thing that's saving him from going crazy. He has the ability to go out and if he didn't have that, well I don't know if he'd be here still really. (Interview with family member, Ontario)

A resident in a British Columbia home explained that he manoeuvres his electric wheelchair and uses local transit to go shopping a few times a week, and that he enjoys socializing with people in the community while he is out and about. Although many residents are not physically capable of using public transportation, having transit available for the residents who can, and for family members and staff who do not drive, is an advantage, and was viewed positively by our interviewees.

Rural care homes, although not necessarily located near shopping centres and amenities, tended to offer a sense of belonging to a close-knit community. Residents knew staff and other residents from having lived in the area for many years. There was low turnover of staff in these homes. Volunteers, who often were family members of residents as well, had been involved with the care home for a long time. For example, like others we spoke with, a Nova Scotian volunteer grew up in the area and also volunteered at her church and the local veterans' organization. Her mother had been in the care home previously and she had known many of the staff and residents for years. She explained the impact of these close relational ties:

My sister is a [care aide] here ... and I know a lot of [staff] from them coming to my house and stuff like that. I know a lot of them. Love them. They're great people ... The hard parts of the job is when you lose people when they pass away, especially if I've known them for years. Like that 100-year-old [resident] when she goes I'll miss that because her and I have been friends for 40 years. I was just a kid when I first met her. (Interview with volunteer, Nova Scotia)

Family members also tended to visit frequently and take residents out because they too lived close by and were part of the small community. A husband of a resident in the same rural home explained that he visited "almost every day ... I miss the odd day but I seem to want to come back and the staff views me like one of themselves" (Interview with family member, Nova Scotia). Families who visited often built close ties with other residents and family members. However, some

residents in smaller communities did not have any family members nearby. Their children had moved to larger cities, creating a divide between residents who had many visitors and those who rarely had any. In some homes, we saw examples of family members of residents becoming close with those residents who lacked visitors, forging connections that reduced their loneliness.

In contrast, some care homes that we studied were in suburban areas with no easy access to the larger community. In order to go somewhere, residents needed to rely on transportation rather than walking or using their wheelchairs, which can be expensive and challenging to arrange. Some were adjacent to busy traffic thoroughfares and lacked sidewalks, making walking hazardous. Residents often required someone to accompany them, which was a further barrier, as one resident in an Ontario home explained:

What I need most of all is a volunteer to take me to [name of place]. They've got a recreation centre that you can go over there at night and play cards but I have to have a volunteer and I can't find anybody that will take me over there. (Interview with resident, Ontario)

This same resident expressed the desire to "go out more ... Well I appreciate just going to a mall but I have to have somebody with me ... Just to get out" (Interview with resident, Ontario).

Location also presented challenges for families who were not close by if the care home was, for example, on the outskirts of a city or a distance away. The desire of families and residents was to be in a care home situated where they could be in close proximity to each other. As one family member put it, when asked if location mattered:

It does, yeah. And the facilities are quite remarkable here with the garden and what not. But there are very good choices around here ... [W]e were interested in trying to keep [our mother] within a short radius from my dad so he could get to see her very often, right? He was the primary target for the planning. (Interview with family member, Ontario)

Families also described challenges if parking was not available or was expensive, and if there was no public transportation for those who did not drive. As a volunteer coordinator observed:

Well transportation is huge even for older adults because ... you know, if they've lost their licence and they're not able to drive anymore, a lot of them will not take public transit ... I mean I grew up in downtown [city] and, you know, the subway system and the transit is unbelievable. Up here it's not, right? (Interview with volunteer coordinator, Ontario)

Physical spaces

The physical layout of a building and the configuration of resident living areas can also facilitate or inhibit meaningful social participation. We observed promising structural layouts that allowed for residents' freedom of movement and their involvement in activities. For example, some care homes had no locked units and residents could come and go as they pleased.

Well you need to have the outside doors secure and allow them to roam freely in this big beautiful building. So the walking space for wanderers, where other places they've been behaviours [challenges], has settled a lot of people here. So we see that behaviour wandering I say great, that's really not a behaviour because the minute they get here they're allowed a lot of space ... Other places because they're so closed, they're on top of one another. It becomes a behaviour issue. There isn't one here. (Interview with registered nurse, Manitoba)

In a Nova Scotia site visit to a newly built care home, managers told us:

There's more space for them to live and experience life. Over in the old home they had to stay in one ... like certain dementia residents were in a locked unit. Here they can walk freely around. They seem more happy here because they have more freedom and space. (Interview with management, Nova Scotia)

Similarly, a German care home had no locked doors anywhere and had common shared units with full kitchens that were accessible by all. Residents helped prepare meals. As one nursing staff member explained: "So nine o'clock is a joint breakfast which we prepare together with the residents."

The above mentioned sites were in contrast with other homes where residents were inside locked units with little ability to move about, a concern that some of us have written about elsewhere (Tufford, Lowndes, Struthers, & Chivers, 2018). Residents lacked opportunities for social participation because few activities were organized in their living areas, and they could not go to structured programs happening in areas away from their floor. A common concern expressed by family members interviewed in these homes was the inability for residents to leave their units to attend activities or go outside, as illustrated in the following exchange with family members in a British Columbia home:

Interviewer: Is she able to get downstairs or outside?
 Respondent 1: No.
 Respondent 2: This is a locked ward.
 Interviewer: But if there was a special event or concert.
 Respondent 2: Only if one of us was here.
 Respondent 1: Or somebody takes her down from here.
 Respondent 2: They don't have enough staff so if we're

here and we know there's a special outing then we'll come. (Interview with family members, British Columbia)

In care homes where activities and events were held in central locations rather than on the individual units, staff talked about the time spent and the extra people required to transport residents back and forth. In an Ontario home, a volunteer coordinator observed, "... that's a lot of what the therapy recreation people do ... you know, especially when you're having a big special event down here it just takes a lot of bodies to bring the residents down" (Interview with volunteer coordinator, Ontario).

Similarly, in homes where gardens were centrally located in the buildings, many residents, including those in secure living areas and even cognitively aware residents who could not manoeuvre independently, were unable to access these spaces unless they were accompanied. Therefore, many residents were restricted from using the garden unless they happened to have visitors or volunteers who would take them there because care staff simply did not have time. Location and physical space can lead to further isolation for those who do not receive visitors, creating a form of division between fortunate and less fortunate residents. In contrast, a Norwegian home that we visited had designed a garden space that was surrounded by resident bedrooms. As one of our team members observed, "Unlike any other facility we have visited, these residents can exit through their room's patio doors into the enclosed garden space on their own, and have a spectacular view of the garden as well as the surrounding mountains" (Field note, Norway).

Certain spaces on individual units were inaccessible in some of the care homes (safety purposes were most commonly reported as the reason), and residents could not access them independently. For example, in an Ontario care home, the kitchen in the secure unit was locked so that residents and families had to ask staff for a drink of water or to use the microwave. In another Ontario home, the activity room in the secure unit was locked most of the time, rendering it inaccessible. A resident in a British Columbia home described a favourite spot that she enjoyed going to, but often had difficulty accessing. Because of safety concerns, it was locked every evening and only reopened in the morning.

Another common issue involved small spaces that could not accommodate enough residents with walkers and wheelchairs, a design flaw that staff, families, and residents in numerous homes described as problematic. "I think we have real parking problems," a resident told us. "It's hard to get these chairs down to the nursing station. It's very crowded. If you get

behind somebody who is very slow it starts to really pile up" (Interview with resident, British Columbia). In a Manitoba home, the central activity room was considered by staff to be too small: "Trying to get all the residents in to participate in activities, church services, bowling and things like that if we have large entertainment in or teas, having [only] that small area in front of the [nursing] desk" (Interview with registered nurse, Manitoba).

At a Norway site, during an interview, family members also lamented the absence of a good common room where people could spend time together, an observation confirmed by researchers and staff. Residents complained of boredom with nothing to do during the day except walk up and down the hallway or sit or lie down in bed (Interview with resident, Norway). On the dementia units at this site, our researchers observed many restless residents constantly wandering up and down the narrow hallways, unable to find ease. One smaller room in this home had been remodelled into a "sensory" room. Much money was spent on it, staff told us, but the room was seldom used by residents because they were not allowed in there on their own. We discovered similar gaps in other homes where expensive Snoezelen (multi-sensory) rooms had been constructed and remained unused because of insufficient funds for equipment, training, and the extra staff required to be with residents while they were in the room.

Promising location and building layout

The Norwegian care home with gardens located outside resident bedrooms (described previously) also provided extended possibilities for intergenerational social engagement with the larger community. This particular home was strategically located in the town centre. As one researcher observed:

The long-term care facility was situated along one side of a large central square, with a Lutheran church at one end, behind which was located a children's daycare centre and many two-storey duplex, assisted senior housing units. A low-rise shopping mall (the central shopping facility for the region) ran lengthwise along one side of the square. Directly opposite along the other side, facing the shopping malls, was the ... community cultural and recreational centre, containing a large indoor swimming facility, rock climbing wall, gymnasium, multiplex cinema, public library, and music instruction centre ... Also notable, upon entering the central lobby, was the multiplex cinema, advertising new feature films, a geological display of local minerals, an attractive luncheon cafe and ice cream parlour at the centre of the facility, a large basement to ceiling rock climbing wall, and a sizeable aquatic facility, complete with

a large, curving water slide at its end. Children were moving in and out of the facility to visit the public library at one end, to take music lessons, to buy ice cream, or to attend swimming lessons. The sound of their voices, as well as accompanying music from the practice rooms, permeated the centre. Immediately I was struck by how different the intergenerational ambience of this facility was from any others I had visited. (Field note, Norway)

This home's central location in the town centre, and its layout, which included open and accessible gardens and kitchens, provided optimal physical conditions for meaningful social participation. Residents were connected to the larger community where young and older people could come together. Families could bring their grandchildren for swimming or music lessons and residents could watch and then visit afterwards. They could alternatively enjoy an ice cream cone, visit the library, or watch a movie in the theatre. Additionally, this care home had a "Wellness Room" with a therapy bath that could be "either spontaneous or scheduled for residents" (Field note, Norway), as well as a spa pool for physiotherapy, which was also used by babies and their mothers. Resident bedrooms contained kitchen units with stoves so that residents and families could prepare meals and eat in their rooms or in the dining room, whichever they preferred.

Time to Care

"[T]he staff in this and actually all other facilities they work very, very hard. They have no spare time to sit and talk to people" (Interview with resident and family member, Ontario). A common concern expressed by staff, residents, and families alike across the locations we visited was low staffing levels that left little time for social engagement with residents. This lack of ability for staff to spend quality time with residents created tensions, because engagement was overwhelmingly described as being the most rewarding aspect of their job.

Knowing that you're able to make someone else's life enjoyable ... I'm pretty friendly and approachable with the residents so that brings a bit of joy into their lives. I mean it's a small amount but I mean you feel as though you've accomplished something after working here. (Interview with registered practical nurse, Ontario)

Unfortunately, staff were torn between completing mandated tasks such as awakening residents, assisting with eating and bathing, administering medications, toileting, and keeping up with documentation requirements, and trying to spend quality time with residents. The Canadian and Norwegian care homes we visited in particular placed emphasis on the medical care aspects, rather than residents' social needs. A staff member

described how increasing documentation demands alone have impacted social care:

We used to deal with them more [before RAI:MDS]² We used to go there put them to bed, we chat with them, we talk with them. There's a lot of things that we do. We used to put [on] nail polish ... After a shower I used to blow dry their hair. I could go and curl the hair with a curling iron ... but when you're in a rush you don't have time to stay with them too much. (Interview with registered practical nurse, Ontario)

We also heard from different recreational staff that prioritizing residents' physical needs negatively impacted their socializing and quality of life:

I find there are times when I'm doing an activity and I really get upset with staff because if somebody is sitting there listening to music, they'll come and just take them out to give them their bath or toilet them or whatever. (Interview with recreation worker, Ontario)

This extended to mealtimes, which can provide opportunities for resident socializing and are the most anticipated event of the day, but are often interrupted and rushed because of competing demands on staff (Lowndes, Armstrong, & Daly, 2015; Lowndes, Daly, & Armstrong, 2017).

I think if they had staff, volunteers, whatever, just to make even mealtime more joyful for them rather than just go in because that's the highlight of their day, the meals, because that's all they have to look forward to and they wait for it and they go in a half hour early most of the time. But they just sit there and there's no conversation, you know, no one to stimulate them. (Interview with family member, Ontario)

Recreation therapists, as part of their job description, are also required in some jurisdictions to address physical care needs, for example assisting residents with eating as part of the restorative care program. This, too, along with documenting outcomes, takes away time that could otherwise be used for engaging with residents in a relational way, as was expressed by a recreation team in Manitoba. "We do a lot of paperwork so the more time we spend on the paperwork aspect the less time we're actually programming with the residents whose needs are supposed to be priority" (Interview with recreation team, Manitoba). Recreation workers across jurisdictions voiced concerns about being understaffed and unable to do an adequate job with social engagement.

²RAI-MDS or Resident Assessment Instrument: Minimum Data Set is an electronic, standardized resident assessment tool.

In an Atlantic Canadian home, an administrator described the tension in trying to change the culture to prioritize social care needs:

I mean I think everybody has the best of intentions ... But when you've spent 25 years of your career feeling that you needed to get everybody done and, you know, and your routine was that by ten o'clock everybody needs to be up and their beds need to be done and their breakfast has to be finished. To switch over to see one of your colleagues sitting and talking with a resident at nine o'clock when all these beds still have to be made and recognizing that that exchange is probably more beneficial to the resident than getting ... So it's a mindset change and people don't make mindset changes really easy. (Interview with administrator, Nova Scotia)

In this care home, assisting with recreation was in the care worker's job description. In addition to performing physical care tasks, they were expected to help and coordinate work with the recreation therapists. For example, care staff help with portering and are encouraged to use their interests and creative skills to engage residents, and some also accompany residents on outings. Housekeeping staff run the bingo game and one has organized parties for residents to watch hockey games on television.

A promising example of staffing levels and work organization
In Germany, there was a federal government-sponsored training initiative that allowed homes to pay into a training fund which then reimbursed them for all funds paid out for apprentices. In a care home we studied, this arrangement essentially doubled the number of staff with 110 apprentices for 90 residents. This initiative allowed much greater time for meaningful social engagement. Additionally, there was a blurred, less hierarchical division of labour so that all care staff were intimately involved with direct resident care. The living units accommodated up to 12 residents and had full, accessible kitchens, dining spaces, and lounges, and many residents spent their days with staff in these areas. Researchers' field notes from this home provide numerous examples of staff engagement with residents as in the following excerpt:

12:27 p.m. A few of the residents are chatting. After the meal two students [apprentices] sit with the residents at the table. Some residents stay in the common shared unit, and some go to bed for an afternoon nap.

12:41 p.m. Lunch is done. Staff are in the kitchen cleaning up.

12:50 p.m. One worker sets up a game and plays it with 3 residents at the far table. (Field note, Germany)

The same researcher noted, "I am told also that residents help with work in the home and some are paid, the highest amount being 50 euros/month. They do jobs such as sweeping the floors, cutting potatoes, and setting/clearing the tables" (Field note, Germany).

Having more staff enabled a calm, relaxed mealtime atmosphere, with apprentices being able to sit with residents afterwards and to engage with others in a game as was described. Residents could also come and go as they pleased with no restrictions on dining room access.

Social Participation Opportunities

Care homes across the various locations offered in-house structured activities, including bingo, universally popular among male and female residents, as well as sing-alongs, crafts and knitting, board games, and bowling (plastic pins and bowling ball set up in an area within the care home). Events such as church services, concerts, dances, and outings to local restaurants and malls were also structured into monthly recreational calendars observed across sites. Wi-Fi availability varied from home to home, with some having a computer for residents' use set up in a common space, and others with Internet connections in private bedrooms, which could be used if paid for by the resident.

Some homes provided promising examples of activities geared towards males such as fishing and hardware store outings (Interview with recreation facilitator, Manitoba), or a men's club, and a beer night with card playing (Interview with care aide, Nova Scotia). In a German site, we observed a men's workshop on one unit and a hallway where they had positioned an upside-down bicycle, brought in for a particular male resident who in his former years fixed bicycles (Field note, Germany). Some homes provided culturally specific activities such as in Germany where we observed residents actively involved in traditional food and craft activities for a May Day holiday. In a British Columbia home with a large Asian population, Mahjong was popular as were the volunteer-organized Asian lunches cooked on site with resident assistance (Field note, British Columbia). However, most homes we studied did not provide gender-specific or culturally specific activities that aligned with their diverse resident populations. Opportunities for social engagement were limited for people from diverse ethnic backgrounds in an Ontario home, for example, where a resident lamented:

[W]e have four people at our table in the dining room ... a new person who came in a while ago is an Oriental Chinese lady. Can't speak a word of English. She will nod and she will point but that's her communication. (Interview with resident, Ontario)

Although all homes provided structured activities organized mostly by recreation therapists and volunteer groups, there were many empty hours in the day for residents to fill outside of scheduled events, as described by this staff member:

[W]hat I find in the long-term care there is a lot of resident[s] they are lonely ... they have activities but at the end of the day most of the time not a lot of them have family come in or friends come in. Most of them they are sitting. (Interview with registered practical nurse, Ontario)

Residents, families, and staff at a number of sites indicated that more and different activities were needed to prevent boredom. Weekends were particularly problematic in many homes. "There's nothing on the weekend ... No, there's nothing. And usually [contracted] agency staff ... are brought in to fill in for the regulars so it's even quieter on the weekends" (Interview with family, Ontario). At most sites there was also a significant difference between day and evenings with regard to organized activities, coinciding with the change from day to evening shift for staff. Most activities were planned for and carried out during the better-staffed day shift, while evening shifts were understaffed, making it challenging to organize activities, leaving residents with few options aside from watching television in the common rooms.

Activities that were offered in resident areas in some locations tended to be more focused on physical therapy than on social activity. We found, for example, that ball/balloon toss was offered in many homes as a form of physical activity (similar to towel folding: giving residents something to do rather than providing social opportunities).

The recreation therapist has turned off the TV and the stereo and started a two-balloon 'play therapy' session with the 18 residents now lined up in the lounge ... Only Ming³ seems interested in the balloon game ... the green balloon has bounced off Gloria's head. She screams at [the recreation therapist], "Get out. Get out. Don't come at me again." ... She refuses to hit it back, yelling "No I won't. Just shut your mouth. Get the hell out of here. I'll kick you." Florence also starts up again. "I want to get out of here. It's a terrible place. I want my money back. I have to see someone. I want to see my mother." (Field note, Ontario)

Introducing a balloon toss game in this overcrowded situation, where wheelchairs were lined up, and different residents may be bored, tired, or agitated, escalated aggression rather than providing the intended positive benefits of physical activity. Moreover, such activities can be

³All names have been replaced by pseudonyms for purposes of anonymity.

infantilizing (Kayser-Jones, 1990), with residents positioned into a circle and encouraged to hit a balloon into the air.

Residents also expressed their desire to have a choice as to whether or not they engaged in certain activities, and to have input into what activities were being offered.

Resident: To me to go out and throw a ball around in a room, is that going to enrich me? It might give me a bit more muscle in my arm but that's about all ... I don't like to bounce a ball around or pull a piece of elastic string or whatever they call that stuff. And I don't care to go to some of the musical groups. No, maybe I'm being antisocial I don't know. I mean personally my interest is doing what I want to do and if I choose not to participate in the activity things then ...

Family Member: That's your choice.

Resident: It is. Yeah.

(Interview with resident and family member, Ontario)

A manager of an Atlantic Canadian home explained the difference in offering more fulfilling social opportunities so that residents feel they are making a contribution:

... it's finding those meaningful activities for the residents instead of just folding the laundry and then shake it up so you can fold it again. Well why can't they fold the table cloths? Why can't they help set the table if that's what they want to do? (Interview with administrator, Nova Scotia)

Some homes promoted certain conditions that facilitated opportunities for residents to engage in spontaneous, meaningful activities. In the German care home described earlier, residents were encouraged to use their skills to the best of their ability and many, including those with dementia, were closely involved in activities of daily living. They assisted staff with meal preparation, using knives to cut vegetables, cooking, cleaning up afterwards, and helping other residents with eating. They were paid a nominal amount as compensation for their jobs, in which they took great pride. They enjoyed keeping busy doing the everyday household chores that they had done for most of their lives. This was possible, in part, because of the higher-than-average staffing levels that the apprentices provided, and the blurred division of labour. It also resulted from a much less "risk averse" care philosophy. Residents were encouraged to live autonomously, taking risks similar to those that they would incur if they were living in their own homes. The objective was to fill days *with* life rather than extend days *of* life.

Flexibility and Bending the Rules

Long-term residential care homes are heavily regulated in part as a result of media-reported scandals (Lloyd, Banerjee, Harrington, Jacobsen, & Szebehely, 2014). Policies that direct care provision and regulations set out in the inspection processes tend to focus on physical, measurable outcomes (Isaksen, Ågotnes, & Fagertun, 2018). The number of falls, for example, are strictly monitored and falls prevention takes priority. However, this stress on falls prevention erodes residents' quality of life. Because there are not enough staff to watch over them, they are positioned in areas, often in wheelchairs, where they can more readily be seen. In our site studies, we observed numerous instances of residents being lined up in front of nursing stations or in lounges so that they could be observed. For example, in an Ontario home, one of our researchers remarked, "each time I was there [on the unit] (three in total) the residents, many of whom were in wheelchairs, were lined up in the sitting area." And as another researcher noted about the secure unit of the same home, "The unit is very quiet. Twelve residents are sitting in the familiar lounge chair 'line-up' with the windows to their back. Others are facing them in their wheelchairs."

Promising practices were created in less risk-averse environments as well as in those that encouraged flexibility, sometimes bending the rules to enhance quality of work and life. Flexibility involved both staff and residents, for example, in decision making regarding morning awakening schedules, mealtimes, and bathing routines. In one Canadian home, being flexible was part of the overall care philosophy that this was the residents' home and that residents came first, so routines were organized to meet individual needs. As an administrator told us, "They can stay in bed as late as they like ... Everyone should have the right to sleep in. If they choose to sleep in certain meds are held ... Most sleep in on bath days" (Field note, Manitoba). She explained that the average length of stay in this care home is 3–4 years: "Here they often pick up because there is a social life, something to get up for and be active, like going fishing" (Field note, Manitoba).

Rules were also bent in some places with the aim of enhancing quality of life. For example, in British Columbia, a nurse practitioner "had to write an order ... not to put my patient who likes to stay up late to bed at 6:30 in the evening ... She likes to watch the evening news. Let her stay up." In a Nova Scotian care home, staff offered another promising example of what can happen when rules are bent:

Last summer one of our nurses went on a bus trip. We took 17 of the 18 residents in her neighbourhood, in her household, so she went on the bus trip and had a marvellous time. It was absolutely wonderful. She got

a little flack from some of the other nurses for going on the bus trip and leaving the building and not staying for her residents. Well her residents were all on the bus ... But it was great to see the residents with them outside of the nursing home. They were on swings at the park and it's just wonderful for them, the staff, to get to enjoy time with the residents without having to worry about who has got to go to the bathroom next or all of the tasks that are here waiting for them. But when you're out on the bus trip it's just about fun. (Interview with recreation director, Nova Scotia)

A manager of that same care home explained that although they had just implemented the Eden Alternative[®], registered staff were still focused on medical needs, and therefore, a transition to emphasizing personal care needs was required:

I'd like to see us get down to, you know, medications being a small part of any shift, right? And even right now we have this thing that they have to be given and I'd like to get to a place where, you know what, if a bus trip is happening in the afternoon and there's a two o'clock medication, let's let the medication go because the bus trip is probably going to offer more than that medication. (Interview with manager, Nova Scotia)

This shift to prioritizing social care needs benefits both staff and residents, with staff having opportunities to engage with residents in a more rewarding, meaningful way, and residents being able to actively socially engage with staff.

Discussion

In this section, we discuss our findings in relation to recent research in this area as well as ethnographic literature on social participation in long-term care dating back some decades, in order to contextualize changing developments over time, while also providing insights into promising practices that we found in our research across six locations.

"Ties with the outside world take precedence over any ties that clientele have in the Manor" (Gubrium, 1975, p. 91). The importance of home location for residents to connect with the outside world cannot be overstated (Armstrong & Braedley, 2016; Gubrium, 1975; Johnson et al., 2010; Struthers, 2016). In our study, we found that centrally located care homes were key to facilitating social connectedness. Residents could access local amenities and transit to leave the property, either alone or with a family member, and integrate with the larger society, which positively impacted residents' health and well-being. In contrast, care homes that were located away from amenities and at a distance from family and friends, and lacking easy access to transportation or affordable and accessible parking, created barriers to

important social participation. Thomas, O'Connell, and Gaskin (2013) argue that geography and transportation are factors that influence social participation in long-term residential care.

However, location of the home is not simply about where it is physically placed in relation to the outside world. It is also about how the outside world can be integrated into the home. In one small Norwegian home, for example, assisted living apartments were located nearby, allowing for the daytime activities of the home to be open to more than "the insiders". Other, more physically capable elderly persons joined the nursing home residents in activities such as card games, billiards, and readings in a residents' library, which itself was located beside the nursing home. This facilitated spontaneous interaction between the two "groups" as well as with staff members and visitors. This same home was located in the town square, thereby extending residents' access to the outside world and enabling families to combine shopping with visits to their relatives (Lowndes, Struthers, Chivers, & Tufford, 2016). A German site had a kindergarten located adjacent to the home, allowing residents to watch children at play in the yard. In a larger Norwegian home, previously described, a kindergarten was located on the property and was used by the staff, making it a more attractive place to work. In addition, having the kindergarten at the home created a sense of life and perhaps also of normality in the institution. It certainly provided residents with noise and variety, which they were deprived of at many other sites.

We also found that physical spaces and home layouts were important facilitators or inhibitors of resident social participation. Layout, especially how the units are connected to common areas in the homes, can either facilitate or create obstacles to social participation (see also Ågotnes & Øye, 2018). Foner (1994), in her ethnographic study, similarly found that small spaces and inconvenient common room locations impacted residents' movement and their ability to engage socially. Although the nursing home in her study had been renovated,

... offices, dining areas, and patient rooms are cramped ... The most serious problems are the extremely narrow halls and the lack of sufficient elevators. Traffic jams in the halls are not uncommon ... Patients must be ferried up and down the elevators to therapy, the main patient dining room, and various activities. (Foner, 1994, p. 20-21)

As we observed in some homes where activities such as religious services and concerts were held in one central area some distance away from resident living units, transportation of residents was challenging and time consuming. We found that residents on secure units

were often excluded from these key events because staff could not accompany them. Similarly, as Foner reported, “Most residents spend nearly all their time on the floor where they sleep” (Foner, 1994, p. 21). In contrast, some homes had building layouts and physical spaces such as accessible unit kitchens and activity rooms, opened/unlocked doors to units, and wide hallways, which allowed for freedom of movement and inclusive social participation (Lowndes et al., 2016).

Understaffing is a chronic concern in long-term care (Armstrong, 2019; Coughlan & Ward, 2007; Diamond, 1992; Foner, 1994; Gass, 2004; Kayser-Jones, 1990; Ronch, 2004; Thomas, O’Connell, & Gaskin, 2013; Welch et al., 2017), which significantly impacts residents’ care and quality of life. Staff are so busy attending to mandated tasks, including getting residents out of bed and assisting with eating, bathing, bedmaking, toileting, and documenting, that they have little or no time to spend in a meaningful way with residents. As Smith et al. argue,

[I]f somebody were unable to feed themselves, this would not be a sufficient reason to leave them hungry. Yet, both staff and residents seem to accept that reduced ability to engage in meaningful activity means that residents will simply ‘do less’ with their time. (Smith et al., 2018, p. 2229)

Given the increase in frailty of nursing home residents, we suspect that these trends will only increase.

Similarly, Gass (2004), who worked as a care aide in an American care home, aptly stated:

We are given so many directives, so many required duties, so many universally applied mandates, that it has become impossible to complete a full set of daily tasks. We are taking care of people with complex medical, emotional, and social needs. Always short of staff, we take shortcuts that put our own well-being at risk. (p. 60)

In Foner’s (1994) study, a worker reported, “You cut corners because you can’t do everything they assign you in one day,” while another aide stated, “I never have enough time to sit and talk with patients, always rushing” (p. 85). Staff members in the Smith et al. study were also well aware of how the pace of their work often impacted how they were viewed by residents. “One care worker recounted how a resident had told them that all she had to do was ‘blink and we’re [the care-worker] gone’ and that the care workers were just a ‘blue blur’” (Smith et al., 2018, p. 2229).

In a recent Norwegian ethnography, Ågotnes (2017) reported that staff must constantly choose from an overwhelming number of chores and tasks, more often than not excluding work related to residents’ social life. For nursing home staff, this is perceived not

as an open choice but as a necessity because of the demands for efficiency and documentation. In our study, residents, families, and workers all expressed the need for more staff, to allow them time to spend with residents, engaging in conversation and addressing emotional and social care needs. As noted by other care home ethnographers (such as Foner, 1994; Gass, 2004), workers (including care, ancillary, and recreation staff) often expressed connections with residents and “putting a smile on their faces” as being the best part of their jobs. Similarly, “Many aides spoke of the rewards they received from ‘doing good for people’ and having patients need them” comparing their relationships with residents to those of family (Foner, 1994, p. 104).

In other ethnographic studies (Diamond, 1992; Gass, 2004; Gubrium, 1975; Johnson et al., 2010), residents were found to spend the majority of their time not engaged in activities. In spite of having scheduled activities in both the United States and Scottish homes included in her study, Kayser-Jones (1990) noted that 50 per cent of the residents reported being bored. Twenty-eight years later Smith et al. (2018) would also discover widespread levels of resident boredom in their study of six English care homes. Diamond (1992) reported that residents carved out a recreational life: one read a lot, another played crossword puzzles, and “[s]ome maintained an interest in conversation or in the television, which was on all day. Many appeared to curl into their own worlds, sometimes nodding off” (p. 96) to pass time away.

Smith et al. (2018) found that lack of resident engagement in meaningful activity was the result of a lack of sufficient variety of activities on offer; under-resourcing because of low staffing levels and heavy workload demands; and staff perception that activities are distinctly scheduled events organized by recreation workers, rather than part of the everyday routine and the fact that ongoing social engagement is part of everyday life in care homes (p. 2234). Although we too observed residents sitting and lined up in front of a television or the nursing station in some settings (especially where staffing ratios were low and residents needed to be watched), we also observed attempts to mitigate this scenario and saw conditions that supported these efforts. Staff would stop in the middle of mandated tasks such as medication rounds to engage residents in song, dance, or conversation (Øye, Ågotnes, Struthers, & Jacobsen, 2017) or to engage residents in meal preparation and cleaning (Lowndes & Müller, 2019). Families would engage with other residents while visiting their relative and in some places, relationship building among staff, families, and residents was encouraged. Some sites prioritized social over medical care, putting the resident first by allowing

freedom of choice in bathing and mealtimes (Lowndes & Daly, 2017).

We found that males had limited opportunities to engage in gender-specific activities. Nursing home residents are mostly female, and most homes provided either gender-neutral or activities geared more towards females such as bingo, ball/balloon toss, crafts, knitting, or cooking. However, a few homes did provide promising examples of male-specific activities, which were enthusiastically attended. Activities are also lacking for younger residents, a population that is growing in many of the care homes we visited. It is also essential to foster social opportunities for people from diverse ethnic backgrounds, as many care homes are increasingly multicultural. Across jurisdictions, we did see promising examples of food and game selections, and in homes rooted in the support of specific ethno-cultural communities, we observed emphasis being placed on celebration of traditions, holidays, and ceremonies, as well as on culturally specific food choices and activities.

Finally, residents seek opportunities for meaningful social participation, want input into the types of activities offered, and prefer to have a choice regarding whether to be involved in these activities or not. Smith et al. (2018) reiterate that “activity” needs to be understood more broadly to include everyday tasks and that care staff must be supported in prioritizing collaborative methods of work organization to ensure relationships that enable resident participation in activities of daily living (p. 2234). In our study, residents found pleasure in participating in everyday activities when they were allowed to do so, as at the German site where residents of varying levels of cognitive functioning cooked, cleaned, and assisted other residents.

The finding that residents want to be valued and to engage in activities that provide meaning to their everyday lives is echoed by others (for example Harmer & Orrell, 2008; Harper Ice, 2002; Smith et al., 2018; Theurer et al., 2015). At the Canadian and Norwegian sites in particular, recreational therapy placed emphasis on physical activities and muscle strengthening rather than on informal, ongoing social engagement, which can create tensions leading to aggression and added pressure on staff attempting to calm residents. In contrast, care philosophies that put the resident first by prioritizing social care needs over physical tasks, when successfully embedded in practice, positively impact quality of life. To be able to implement such care philosophies, sufficient and permanent staffing levels are required (Armstrong, 2018b).

We argue that working conditions are also conditions of care. Management support for staff engagement in care as a relationship is therefore required, because

dedicated time must be given and worked into the daily life of care homes (Armstrong, 2018b). Meaningful social engagement also requires bending the rules and being flexible in managing “risk averse” regulations that are meant to enhance safety, but often inadvertently reduce resident quality of life (Armstrong, 2018a).

Limitations

Because of the size of this international study, covering in total 27 sites across six locations, the ability to focus in depth on each topic area was limited. However, this was a strength of the study as well. Several jurisdictions and many interviews (more than 500 in total) enabled the gathering of rich and multidisciplinary perspectives of long-term care that can be used for comparative purposes.

Conclusion

Resident social participation and meaningful engagement are facilitated through certain conditions such as home location, physical spaces within the home, adequate staffing levels, and a care philosophy that prioritizes resident quality of life. Each of these conditions will respectively and in combination positively influence residents’ everyday life in the nursing home. Optimal locations extend access and enable connectedness to the outside world. Promising physical spaces inside the care home are those that allow for freedom of movement, are large enough to accommodate residents and their mobility aids, and also facilitate connectedness to the outside. Building relationships is also an important part of socializing, and this can only happen with proper working conditions and managerial support for social care, and sufficient staffing levels that allow for the extra time required to engage in meaningful interactions with residents. Workers need to include and prioritize quality of life aspects of care, but they need the conditions that make it possible to do so. Flexibility, along with critical re-thinking of regulations are also needed to facilitate meaningful social engagement tailored to individual needs.

Additionally, considerations around gender and culture are important when planning for truly inclusive social participation. Providing residents with a variety of activities and giving them freedom to choose when to participate are also significant. Meaningful social participation that improves overall health and well-being is about much more than simply offering structured physical activities. It must also involve allowing residents to find connections and true social engagement in the everyday life of the care home and its community.

References

- Ågotnes, G. (2017). *The institutional practice: On nursing homes and hospitalizations*. Retrieved 2 July 2018 from <https://doi.org/10.17585/noasp.12.38> Cappelen Damm Akademisk.
- Ågotnes, G., & Øye, C. (2018). Facilitating resident community in nursing homes: A slippery slope? An analysis on collectivistic and individualistic approaches. *Health, 22* (5), 469–482. <https://doi.org/10.1177/1363459317708825>.
- Armstrong, P. (2018a). Introduction. In P. Armstrong, & R. Lowndes (Eds.), *Negotiating tensions in long-term care: Ideas worth sharing* (pp. 11–32). Ottawa: Canadian Centre for Policy Alternatives.
- Armstrong, H. (2018b). Tensions between risk and safety. In P. Armstrong, & R. Lowndes (Eds.), *Negotiating tensions in long-term residential care* (pp. 33–36). Ottawa: Canadian Centre for Policy Alternatives.
- Armstrong, P. (2019). Conclusion: Where do we go from here? In D. Baines & P. Armstrong (Eds.), *Promising practices in long-term care: Ideas worth sharing* (pp. 73–79). Ottawa: Canadian Centre for Policy Alternatives.
- Armstrong, P., & Armstrong, H. (2018). Theory matters. In P. Armstrong, & R. Lowndes (Eds.), *Creative teamwork: Developing rapid, site-switching ethnography* (pp. 1–20). New York: Oxford University Press.
- Armstrong, P., & Banerjee, A. (2009). Challenging questions: Designing long-term facility care with women in mind. In P. Armstrong, M. Boscoe, B. Clow, K. Grant, M. H. Brockman, B. Jackson, et al. (Eds.), *A place to call home: Long-term care in Canada* (pp. 10–28). Toronto: Fernwood Publishing.
- Armstrong, P., & Braedley, S. (2013). Introduction. In P. Armstrong, & S. Braedley (Eds.), *Troubling care: Critical perspectives on research and practice* (pp. 9–16). Toronto: Canadian Scholars Press Inc.
- Armstrong, P., & Braedley, S. (2016). Ideas worth sharing. In P. Armstrong, & S. Braedley (Eds.), *Physical environments for long-term care: Ideas worth sharing* (pp. 101–106). Ottawa: Canadian Centre for Policy Alternatives.
- Armstrong, P., & Lowndes, R. (Eds.). (2018). *Creative teamwork: Developing site-switching ethnography*. New York: Oxford University Press.
- Baines, D., & Cunningham, I. (2013). Using comparative perspective rapid ethnography in international case studies: Strengths and challenges. *Qualitative Social Work, 12*(1), 77–88. <https://doi.org/10.1177/1473325011419053>.
- Baum, D. (1977). *Warehouses for death: The nursing home industry*. Don Mills, ON: Burns & MacEachern.
- Beebe, J. (2014). *Rapid qualitative inquiry: A field guide to team-based assessment* (2nd ed.). Lanham, MD: Rowman & Littlefield.
- Bocksnick, J., & Hall, B. (1995). Recreation activity programming for the institutionalized older adult. *Activities, Adaptation and Aging, 19*(1), 1–25. https://doi.org/10.1300/J016v19n01_01.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>.
- Burack, O., Weiner, A., Reinhardt, J., & Annunziato, R. (2012). What matters most to nursing home residents: Quality of life in the nursing home. *Journal of the American Medical Directors Association, 13*(1), 48–53. <https://doi.org/10.1016/j.jamda.2010.08.002>.
- Cacioppo, J., Hughes, M., Waite, L., Hawkley, L., & Thisted, R. (2006). Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychological Aging, 21*(1), 140–151. <https://doi.org/10.1037/0882-7974.21.1.140>.
- Canadian Institute for Health Information. (2018). *Better data. Better decisions. Better Canadians*. Retrieved 25 July 2018 from <https://www.cihi.ca/en/residential-care>.
- Choiniere, J., & Struthers, J. (2018). Different eyes: An RN/sociologist and an historian invite you on a tour of our fieldnotes. In P. Armstrong, & R. Lowndes (Eds.), *Creative teamwork: Developing rapid, site-switching ethnography* (pp. 96–112). New York: Oxford University Press.
- Coughlan, R., & Ward, L. (2007). Experiences of recently relocated residents of a long-term care facility in Ontario: Assessing quality qualitatively. *International Journal of Nursing Studies, 44*(1), 47–57. <https://doi.org/10.1016/j.ijnurstu.2005.11.022>.
- Denzin, N., & Lincoln, Y. (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.
- Diamond, T. (1992). *Making gray gold: Narratives of nursing home care*. Chicago: University of Chicago Press.
- Emerson, R., Fretz, R., & Shaw, L. (2011). *Writing ethnographic fieldnotes* (2nd ed.). Chicago: University of Chicago Press.
- European Commission. (2020). *Eurostat: Statistics explained*. Retrieved 12 July 2020 from https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_structure_and_ageing#The_share_of_elderly_people_continues_to_increase.
- Federal Statistical Office of Germany. (2016). Federal Statistical Office, Older people in Germany and the EU. Retrieved 12 July 2020 from <https://www.bmfsfj.de/blob/113952/83dbe067b083c7e8475309a88da89721/aelteremenschen-in-deutschland-und-in-der-eu-englisch-data.pdf>.
- Fiske, A., Loebach Wetherell, J., & Gatz, M. (2009). Depression in older adults. *The Annual Review of Clinical Psychology, 5* (1), 363–389. <https://doi.org/10.1146/annurev.clinpsy.032408.153621>.
- Folkhelseinstituttet. (2018). Folkhelseinstituttet: Folkehelse-rapporten. Retrieved 19 October 2018 from <https://www.fhi.no/nettpub/hin/befolkning/befolkningen/#andelen-eldre-oeker>.

- Foner, N. (1994). *The caregiving dilemma: Work in an American nursing home*. Berkeley, CA: California Press Ltd.
- Gass, T. (2004). *Nobody's home: Candid reflections of a nursing home aide*. Ithaca, NY: Cornell University Press.
- Gubrium, J. F. (1975). *Living and dying at Murray Manor*. Charlottesville, VA: University Press of Virginia.
- Hancock, G., Woods, B., Challis, D., & Orrell, M. (2006). The needs of older people with dementia in residential care. *International Journal of Geriatric Psychiatry*, 21(1), 43–49. <https://doi.org/10.1002/gps.1421>.
- Harmer, B., & Orrell, M. (2008). What is meaningful activity for people with dementia living in care homes? A comparison of the views of older people with dementia, staff and family carers. *Aging & Mental Health*, 12(5), 548–558. <https://doi.org/10.1080/13607860802343019>.
- Harper Ice, G. (2002). Daily life in a nursing home: Has it changed in 25 years? *Journal of Aging Studies*, 16, 345–359. [https://doi.org/10.1016/S0890-4065\(02\)00069-5](https://doi.org/10.1016/S0890-4065(02)00069-5).
- Isaksen, J., Ågotnes, G., & Fagertun, A. (2018). Spenningsfeltet mellom standardisering, variasjon og prioritering i norske sykehjem [The tension between standardization, variation and prioritization in Norwegian nursing homes]. *Tidsskrift for Omsorgsforskning [Journal for Care Research]*, 2(4), 143–152.
- James, I., Blomberg, K., & Kihlgren, A. (2014). A meaningful daily life in nursing homes—a place of shelter and a space of freedom: A participatory appreciative action reflection study. *BMC Nursing*, 13(19), 1–13. <https://doi.org/10.1186/1472-6955-13-19>.
- Johnson, J., Rolph, S., & Smith, R. (2010). *Residential care transformed: Revisiting the last refuge*. Basingstoke, United Kingdom: Palgrave Macmillan Press.
- Kayser-Jones, J. (1990). *Old, alone, and neglected: Care of the aged in the United States and Scotland*. Berkeley, CA: University of California Press.
- Knight, T., & Mellor, D. (2007). Social inclusion of older adults in care: Is it just a question of providing activities? *International Journal of Qualitative Studies on Health and Well-Being*, 2(2), 76–85. <https://doi.org/10.1080/17482620701320802>.
- Kolanowski, A., & Buettner, L. (2008). Prescribing activities that engage passive residents. *Journal of Gerontological Nursing*, 34(1), 13–18. <https://doi.org/10.3928/00989134-20080101-08>.
- Koren, M. (2010). Person-centred care for nursing home residents: The culture-change movement. *Health Affairs*, 29(2), 312–317. <https://doi.org/10.1377/hlthaff.2009.0966>.
- Library of Parliament. (2012). *Canada's aging population and public policy: Statistical overview*. Retrieved 11 March 2014 from <http://www.parl.gc.ca/content/lop/research/publications/2011-63-e.pdf>.
- Lloyd, L., Banerjee, A., Harrington, C., Jacobsen, F., & Szebehely, M. (2014). It is a scandal!: Comparing the causes and consequences of nursing home media scandals in five countries. *International Journal of Sociology and Social Policy*, 34(1/2), 2–18. <https://doi.org/10.1108/IJSSP-03-2013-0034>.
- Lopez, R., Mazor, K., Mitchell, S., & Givens, J. (2013). What is family-centred care for nursing home residents with advanced dementia? *American Journal of Alzheimer's Disease & Other Dementias*, 28(8), 763–768. <https://doi.org/10.1177/1533317513504613>.
- Lowndes, R., Armstrong, P., & Daly, T. (2015). The meaning of dining: The social organization of food in long-term care. *Food Studies*, 4(1), 19–34. <https://doi.org/10.1177/1049732317737979>.
- Lowndes, R., & Daly, T. (2017). You've got to get up in the morning...Or do you? In P. Armstrong, & Daly, T. (Eds.), *Exercising choice in long-term residential care* (pp. 37–44). Ottawa: Canadian Centre for Policy Alternatives.
- Lowndes, R., Daly, T., & Armstrong, P. (2017). "Leisurely dining": Exploring how work organization, informal care, and dining spaces shape residents' experiences of eating in long-term residential care. *Qualitative Health Research*, 28(1), 126–144. <https://doi.org/10.1177/1049732317737979>.
- Lowndes, R., & Müller, B. (2019). Germany: Small town 2 promising practice: Time for relational engagement and skills. In D. Baines & P. Armstrong (Eds.), *Promising practices in long-term care: Ideas worth sharing* (pp. 51–53). Ottawa: Canadian Centre for Policy Alternatives.
- Lowndes, R., Storm, P., & Szebehely, M. (2018). Fieldnotes: Individual versus team-based rapid ethnography. In P. Armstrong, & R. Lowndes (Eds.), *Creative teamwork: Developing rapid, site-switching ethnography* (pp. 96–112). New York: Oxford University Press.
- Lowndes, R., Struthers, J., Chivers, S., & Tufford, F. (2016). Locks and doors matter. In P. Armstrong & S. Braedley (Eds.), *Physical environments for long-term care: Ideas worth sharing* (pp. 71–80). Ottawa: Canadian Centre for Policy Alternatives.
- Øye, C., Ågotnes, G., Struthers, J., & Jacobsen, F. (2017). Spontaneous activities. In P. Armstrong, & S. Braedley (Eds.), *Exercising choice in long-term residential care* (pp. 59–67). Ottawa: Canadian Centre for Policy Alternatives.
- Rahman, A., & Schnelle, J. (2008). The nursing home culture-change movement: Recent past, present and future directions for research. *The Gerontologist*, 48(2), 142–148. <https://doi.org/10.1093/geront/48.2.142>.
- Ronch, J. (2004). Changing institutional culture: Can we re-value the nursing home? *Journal of Gerontological Social Work*, 43(1), 61–82. https://doi.org/10.1300/J083v43n01_06.

- Smith, N., Towers, A., Palmer, S., Beecham, J., & Welch, E. (2018). Being occupied: Supporting 'meaningful activity' in care homes for older people in England. *Ageing & Society, 38*(11), 2218–2240. <https://doi.org/10.1017/S0144686X17000678>.
- Spradley, J. (1980). *Participant observation*. New York: Holt, Rinehart and Winston.
- Statistics Canada. (2011). Living arrangements for seniors. Retrieved 25 July 2018 from https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312x2011003_4-eng.cfm%23bx2.
- Statistisk Sentralbyrå. (2018). Statistisk Sentralbyrå: Omsorgstjenester. Retrieved 15 June 2018 from <https://www.ssb.no/helse/statistikker/pleie>.
- Struthers, J. (2016). Location matters. In P. Armstrong, & S. Braedley (Eds.), *Physical environments for long-term care: Ideas worth sharing* (pp. 53–61). Ottawa: Canadian Centre for Policy Alternatives.
- Theurer, K., Mortenson, W., Stone, R., Suto, M., Timonen, V., & Rozanova, J. (2015). The need for a social revolution in residential care. *Journal of Aging Studies, 35*, 201–210. <https://doi.org/10.1016/j.jaging.2015.08.011>.
- Thomas, J., O'Connell, B., & Gaskin, C. (2013). Residents' perceptions and experiences of social interaction and participation in leisure activities in residential aged care. *Contemporary Nurse, 45*(2), 244–254. <https://doi.org/10.5172/conu.2013.45.2.244>.
- Tufford, F., Lowndes, R., Struthers, J., & Chivers, S. (2018). 'Call security': Locks, risk, privacy and autonomy in long-term residential care. *Ageing International, 43*(1), 34–52. <https://doi.org/10.1007/s12126-017-9289-3>.
- Victor, C. (2012). Loneliness in care homes: A neglected area of research? *Aging Health, 8*(6), 637–646. <https://doi.org/10.2217/ahe.12.65>.
- Welch, E., Palmer, S., Towers, A., & Smith, N. (2017). Why are relatives of care home residents reluctant to 'rock the boat'? Is there a culture of acceptance? *Working with Older People, 21*(2), 124–132. <https://doi.org/10.1108/WWOP-10-2016-0030>.
- York University. (2014). *Re-imagining residential long-term care*. Retrieved 8 January 2014 from <http://www.reltc.apps01.yorku.ca>.
- Zimmerman, S., Scott, A. C., Park, N. S., Hall, S. A., Wetherby, M. M., Gruber-Baldini, A. L., et al. (2003). Social engagement and its relationship to service provision in residential care and assisted living. *Social Work Research, 27*(1), 6–18. <https://doi.org/10.1093/swr/27.1.6>.