An Examination of Quality of Work Life

And Quality of Care

Within a Health Care Setting

by

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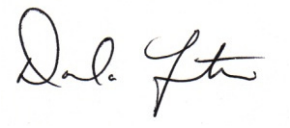

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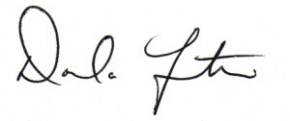

ABSTRACT

Unsatisfactory working conditions and job stress may be indicative of working in a society where work-life balance is a desired, but often elusive, goal (Duxbury & Higgins, 2001; Smola & Sutton, 2002; Sturges & Guest, 2004). Working conditions in the healthcare sector are reported to be particularly problematic and stress inducing compared to other work sectors (Yassi, Ostry, Spiegel, Walsh, & de Boer, 2002). In fact, quality of work life (QOWL) among healthcare workers is believed to have deteriorated to the point where it is impeding the capacity of the system to recruit and retain staff needed to provide effective patient care (Koehoorn, Lowe, Rondeau, Schellenberg, & Wager, 2002). The purpose of the study was to examine the experiences of healthcare staff who participate in QOWL initiatives aimed to provide employees with creative, educational, and fun activities designed to address feelings of stress. This study included thirteen staff members from disciplines that comprise the Health Care Team at a facility specializing in aging and veteran's care. Data were collected through conversational interviews with staff from each of the following disciplines: nursing, recreation therapy, physiotherapy, creative arts, clinical nutrition, social work, audiology, occupational therapy, and pastoral care. The data were deconstructed into common themes through an open-ended process, which lead to the identification of common experiences across the data provided by the staff. Upon further comparison of the themes, it was identified that work demands were believed to detract from care provision and strained manager relations were believed to minimize quality of care. However, a strong professional identity was evident as staff described being able to rise above adversity and use their skills and competencies to provide quality care to residents. The data also suggested QOWL initiatives seem to be valuable because they provide opportunities for staff to interact socially. This interaction helps foster and strengthen connections amongst staff, which they feel transfers to the work place through improved working relationships. Participants described feelings of personal gratification that can be derived from team cohesiveness. They also acknowledged the carry over value that team work brings to residents by way of improved care provision. Furthermore, the relationships that staff members develop with one another were viewed as sources of strength, particularly in times of increased stress. In addition to the social element associated with the QOWL initiatives, these initiatives also seem to address a need for restoration, humour, and balance within the work day. Without planned opportunities for rejuvenation and humour appreciation, participants admitted that they would seldom take the time to incorporate these into their work day. Therefore, QOWL initiatives can provide staff with a reason to take a break and find their balance. The findings indicate the factors affecting QOWL are varied and complex. The findings also indicate that there can be a paradoxical nature to work within a health care setting. Paradoxes exist in relation to the provision of professional care and the provision of minimized care. Paradoxes also exist in relation to the expressed need for restoration, humour, and balance and the low priority staff will place on taking time to fulfill these needs.

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CHAPTER ONE

INTRODUCTION

This thesis describes a qualitative study that was aimed at exploring the perceptions and experiences of healthcare staff relative to quality of work life initiatives and the provision of quality care. Chapter one serves to introduce the study by highlighting important background information, the purpose of the study, the central research questions, and the rationale for conducting this research. The second chapter provides a detailed look at the literature that has helped to guide the direction of the study. Chapter three offers an overview of the specific methods that were used. Specifically, this chapter identifies the conceptual framework, the procedures for participant selection, data collection, and analysis. Chapter four provides details around the findings of the study and chapter five presents the five major themes that emerged. The final chapter offers a reflection of the themes and how they relate to each other. It also explores how these findings relate to previous research and describes the significance and limitations associated with the study.

Background

According to the Canadian Institute for Health Information (2000), "Healthcare providers and administrators are the backbone of our healthcare system. They are trained to promote good health, to care for and comfort the sick, to expand what we know about health and healthcare and to improve the effectiveness of the way the healthcare system functions…If one of the goals of the healthcare system is to promote health and prevent illness and injury, it may be logical to start with those who work in the system."

Unsatisfactory working conditions and job stress may be indicative of working in a society where work-life balance is a desired, but often elusive, goal (Duxbury &

Higgins, 2001; Smola & Sutton, 2002; Sturges & Guest, 2004). Working conditions in the healthcare sector are reported to be particularly problematic and stress inducing compared to other work sectors (Yassi, Ostry, Spiegel, Walsh, & de Boer, 2002). In fact, Yassi et al. examined the healthcare research and concluded that stress and burnout plague the healthcare workforce and it is increasingly becoming a worldwide problem. As Lowe (2002) explains, in Canada, the cumulative impact of years of cost cutting, downsizing, and restructuring has left the healthcare workforce demoralized, overworked and coping with working conditions that diminish both the quality of working life and organizational performance. Furthermore, quality of work life among healthcare workers is believed to have deteriorated to the point where it is impeding the capacity of the system to recruit and retain staff needed to provide effective patient care (Koehoorn, Lowe, Rondeau, Schellenberg, & Wager, 2002).

There is support in the literature for the idea that work stressors adversely affect healthcare staff job performance and have a negative impact on the quality of care received by both hospital patients and long term care residents (Cohen-Mansfield, 1995; Hannan, Norman, & Redfern, 2001). With quality of care being a top priority in all healthcare institutions, it is not surprising that quality of work life initiatives are receiving greater attention in the healthcare sector (Koehoorn et al., 2002; Yassi et al., 2002). Some of these initiatives, such as workplace wellness programs, deliver impressive cost savings and positively influence productivity (Lowe, 2002). Lowe further explains that successful quality of work life initiatives are comprehensive in scope, integrated with other human resource programs, and have well-designed implementation strategies based on strong leadership, good communication, and extensive participation.

Despite research that points to causal links between work stressors, poor working conditions, and jeopardized quality of care (Cohen-Mansfield, 1995; Hannan, Norman, & Redfern, 2001; Schaefer & Moos, 1993), a significant knowledge gap seems to exist. For example, little is known about whether initiatives designed to improve quality of work life are also effective in improving the provision of quality of care. Therefore, research designed to elicit staff perceptions of how quality of work life initiatives might translate into the provision of quality of care is an important step in addressing the knowledge gap that currently exists.

A comprehensive program designed to improve the quality of work life for healthcare staff exists at a large healthcare organization located in Toronto, Ontario. With over 12,000 staff, physicians, volunteers, and students, this healthcare organization provides services to patients in such areas as Aging and Veteran's Care, Neurosciences, Orthopedic and Arthritic Institute, Prenatal and Gynecology, The Schulich Heart Centre, Toronto Regional Cancer Centre, Trauma, and Women's Health.

The quality of work life program at this organization is characterized by four main components which include social and recognition activities, wellness activities, awards, and a category labeled as 'other'. Social and recognition activities are comprised of activities such as golf tournaments, BBQ's, health discipline awareness weeks, and service award celebrations. Wellness activities consist of fitness programs, nutrition classes, weight watchers programs, Restorative Lunch Breaks, and Random Acts of Restoration. The various awards include Nursing Education Awards and Practice Base Research Awards. Activities that fall into the category of 'other' include organizational development, orientation, and leadership development.

Prior to this study, there was no in-depth research conducted with staff members who participate in the quality of work life activities that are offered at this organization. Evaluations of specific programs, such as the Restorative Lunch Breaks, revealed that participants are appreciative of the program, find it informative and engaging, and would like to see such initiatives continued. Therefore, it was important to expand on these program specific evaluations in order to get a better sense of how staff members perceive the overall quality of work life program and how they think it relates to their provision of quality care.

Given the complexity and size of this organization, it was decided that this research should concentrate on a specific area of the facility. Therefore, this study focused specifically on Aging and Veteran's Care, a 523 bed long term care facility comprised primarily of veterans. Staff members working in long term care facilities seem to face stressors that are unique compared to those of other health care professionals. The most widely studied stressors in long term care facilities are time pressure, role ambiguity, and resident-specific stressors related to caring for people who are chronically ill (Cohen-Mansfield, 19995; Hannan, Norman & Redfern, 2001; Schaefer & Moos, 1993).

Purpose

The overarching purpose of this study was to explore the experiences of staff with the quality of work life (QOWL) initiatives offered within the healthcare organization in which they work. However, as the findings suggest, QOWL initiatives can not be viewed in isolation from other factors that impact on QOWL for staff. Two sub-questions

addressed by this study examined staffs' perceptions of the quality of care they extend to residents and whether, in their view, this is affected by the QOWL initiatives.

Despite the influx in recent years of employee wellness programs aimed at improving quality of work life (McGillivary, 2005), little was known about how staff perceive these programs. Furthermore, with respect to the healthcare sector, little was known about whether employees perceive quality of work life initiatives to be related to their provision of quality of care. Such programs were traditionally believed to be successful if they showed outcomes that resulted in higher work productivity and lower absenteeism (Ellis & Richardson, 1991; Smith, Everly, & Haight, 1990; Watson & Gauthier, 2003). Wellness programs were generally believed to have a limited impact on employee health and well-being (McGillivary, 2005). However, comprehensive quality of work life programs that aim to improve the overall quality of work life for employees are worthy of more attention.

Specifically, this study addressed the following research questions:

1) How do staff members experience their work environment in terms of stress, work load, time pressure, and work-life balance?
2) What is the experience of staff relative to QOWL initiatives?
3) How do staff members perceive their managers in relation to supporting their involvement in QOWL initiatives?
4) What role can leisure play in helping to shape QOWL initiatives that aim to reduce work related stress and promote work-life balance?

5) What is the perception of staff regarding the quality of care they provide and to what extent do they feel it is influenced by QOWL initiatives?

Rationale

This research was motivated by an interest in the study of leisure and an understanding of how leisure can provide an effective coping strategy for dealing with stress and, in particular, work-related stress. Iwasaki and Mannell (2000), for example, found that people believe their leisure involvements provide the opportunity to develop and strengthen friendships and personal autonomy that aid them in dealing with stressful events. The potential for leisure to be a coping strategy for work related stress was also highlighted in the study by Iwasaki, Mannell, Smale, and Butcher (2002). Their findings suggested that leisure coping enhanced mood and facilitated palliative coping and companionship, thereby improving the overall mental health of police and emergency response workers.

The emphasis on leisure as a means of coping with stress and promoting restoration is what attracted my attention toward the quality of work life initiatives that were being implemented at this particular facility. All too frequent are examples of wellness programs that focus primarily on physical health improvements and behaviour modifications for employees (McGillivary, 2005). Examples of quality of work life initiatives using leisure to provide enjoyment and stress relief seem to be lacking (Ellis & Richardson, 1991). However, I discovered two examples of initiatives that were using leisure as a strategy to improve work life at this healthcare organization, they include the Restorative Lunch Break and the Random Acts of Restoration program.

The Restorative Lunch Break aims to provide employees with creative, educational, and fun lunch hour sessions designed to address feelings of stress. The Recreation Therapy Department conducted staff surveys prior to the launch of this initiative which indicated that a majority of staff do not take regular lunch breaks, are looking for more leisure in their lives, experience frequent stress, and are striving for greater work/life balance. Therefore, the basis for the Restorative Lunch Breaks is to provide staff with the opportunity to take time and enjoy their lunch hour, socialize with coworkers, and participate in a creative hands-on leisure activity or listen to an educational and motivational guest speaker. The leisure activities previously incorporated into the Restorative Lunch Break have included yoga, massage and relaxation, humour appreciation, and entertainment provided by a hypnotist. Sessions have also included educational components to address such issues as sleep enhancement, time management, and positive thinking.

The Random Acts of Restoration program stems from a belief in the value of creating a harmonious balance between work and personal lives for staff in order to enhance wellness. This program invites staff to nominate a coworker who they think is in need of restoration. Every week the Recreation Therapy staff selects, from the list of nominees, an employee with the most compelling case for a need of restoration. The employee then receives a gift related to their leisure interests. The Random Acts of Restoration awarded thus far have included gift certificates for books, restaurants and movies, tickets to the theatre, aromatherapy kits, CD's and DVD's. Follow up evaluations conducted by the Recreation Therapy staff revealed that employees are

appreciative of the opportunity to take time out of their day to be recognized and, in turn, recognize their coworkers.

This study provides valuable insight into staff perceptions of quality of work life initiatives in relation to the provision of quality of care. Therefore, healthcare decision makers, employees, and long term care residents may be impacted by some of the findings. As more is learned about quality of work life, employee health, and the provision of quality care, healthcare decision makers may look to such data to provide support for placing a higher priority on creating healthy working organizations and justifying making the necessary investments in pursuit of this goal.

The potential for this research to shed light on quality of work life initiatives as a means of coping with work stress can be beneficial for both employees and long term care residents. Participation in such initiatives may help employees minimize the effects of stress of their work day, help them discover ways in which leisure can play a more central role in their lives, and help them achieve a better work/life balance. It may be that as quality of work life for employees improves, so too will quality of life for patients and residents as they experience improved quality of care.

It is expected that this research will also contribute to the current body of literature that focuses on leisure, work, and stress. There has been extensive work done in these topic areas but little research has been done to ascertain whether leisure can be a vital part of work life initiatives and whether such initiatives are perceived by healthcare staff to translate into quality of care.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Research on work and stress suggests that today's workplace can be a major source of stress and ill health (Duxbury & Higgins, 2001). Many people seem to be working longer and harder than ever before and are finding it increasingly difficult to achieve a much desired work-life balance (Sturges & Guest, 2004). Stress and job dissatisfaction seem disproportionately linked to employment in the health care sector where the pressures of demanding work exist within the context of insufficient time and recourses (Callaghan, Tak-Ying & Wyatt, 2000; Jinks & Daniels, 1999). Work stressors experienced by health care staff have been found to adversely affect job performance and negatively impact the quality of care received by patients and long term care residents (Cohen-Mansfield, 1995; Hannan, Norman, & Redfern, 2001).

There has been extensive research done which suggests that leisure can be an effective means of coping with stress, particularly work-related stress (Coleman, 1993; Heintzman & Mannell, 2003; Iwasaki, MacKay, and Mactavish, 2005l; Iwasaki & Mannell, 2000). There is also support for the idea that, for some people, certain aspects of work can be considered leisure (Lewis, 2003). Work has also been found to provide people with enjoyable flow experiences not found in other aspects of their lives (Bryce & Haworth, 2002). Having opportunities to socialize with co-workers has been linked to enhanced quality of work life (Requena, 2003) and better self-rated health among employees (Luikkonen, Virtanen, Kivimaki, Pentti, & Vahtera, 2004).

The relationship between work stress and absenteeism and between leisure and stress reduction has undoubtedly influenced quality of work life initiatives over the years,

resulting in the establishment of wellness programs aimed primarily at increasing work productivity and decreasing time lost due to illness (Ellis & Richardson, 1991; Smith, Everly, & Haight, 1990). However, in many cases, wellness programs have seen only marginal success. One reason attributed to this lack of success is that wellness programs typically place an emphasis on physical fitness which is often resisted by many employees (McGillivary, 2005). The leisure literature clearly suggests that passive leisure, which can provide recuperative and therapeutic opportunities for employees, may be more effective than active leisure in dealing with work related stress (Trenberth, Dewe, & Walkey, 1993). Furthermore, the use of leisure for enhancing mood and facilitating companionship is also linked to the maintenance of mental health and the management of work stress (Iwasaki, Mannell, Smale, & Butcher, 2002).

Wellness programs are also believed to have only a limited impact on the health and quality of work life of employees because they often treat the symptoms of unhealthy employees and ignore the underlying causes of an unhealthy workplace (Lowe, 2004 & Mitchell, 1998). Putting an emphasis on the health of employees rather than on the health of the organization is considered to be particularly detrimental in the health care sector where it has been argued that the policies and working environment of an organization can have a significant impact on quality of life for both staff and patients (Kane, 2003). Therefore, any initiatives aimed at the health and well-being of employees are urged to also consider how the organization's policies and culture impact the health and quality of work life of employees (Canadian Council on Integrated Healthcare, 2002).

Stress and the workplace

Research on workplace stress shows that stress is positively correlated with high job demands and low job control (Shain, 2000). When employees have too much to do with constant imposed deadlines they have high job demand. When employees have little or no influence over the day to day organization of their work they have low job control. Shain's data show that people working with high demands and low control, compared to workers who have a high level of control, experience significantly higher rates of cardiovascular disease, anxiety, depression, and infectious diseases. His research also suggests that stress can result from an imbalance between effort and reward. In other words, if employees expend a great deal of effort to achieve organizational goals and this effort is not rewarded or acknowledged it is more likely that job stress will occur. While high demands, low control, and high effort, low rewards are influences of workplace stress, the effects of these influences are believed to multiply when workplace conditions are perceived to be unfair. Burton (2002), for example, summarizes recent research which indicates feelings associated with a sense of unfairness in the workplace are anger, depression, demoralization, and anxiety.

Stress is also found to be associated with a perceived lack of work-life balance. Work-life balance is believed to exist when there is good functioning at work and at home with a minimum of role conflict (Sturges & Guest, 2004). Thus, when demands from the work and non-work domains become incompatible and conflict occurs, people experience a lack of work-life balance. There is evidence suggesting that people entering the workforce today are emphasizing the importance of work-life balance more than their predecessors (Smola & Sutton, 2002). However, the extent to which this balance is being achieved is far less than it is desired. In fact, findings suggest that graduates are being

drawn into situations where they work increasingly long hours and experience an increasingly unsatisfactory balance between home life and work life (Sturges & Guest, 2004). The results of a recent survey conducted by Ipsos-Reid (CBC Health Science News, Sept. 5, 2005) revealed that one in four Canadians are not taking all of the vacation they are entitled to for fear of falling behind at work or jeopardizing opportunities for advancement. Employees also indicated that there is stress both in preparing for time off and in dealing with the work that piles up while they are away. Research done by Duxbury and Higgins (2001) supports these results. Their study, which compared the results of a work-life balance survey conducted in 2001 to the results of a survey previously conducted in 1991, determined that over this ten year period there had been a significant increase in job stress and a corresponding decrease in job satisfaction. Duxbury and Higgins also found that workers reported they were less pleased with their life in general and more likely to say they were depressed than ten years earlier.

It is not surprising that as stress levels rise so do absentee rates. Data published by Statistics Canada (2001) show that absentee rates averaged 8.5 days per year for full time employees in 2001 which was up from an average of 7.4 days just five years earlier. Absentee rates for some segments of the workforce, such as the health care sector, are even more disconcerting. For example, Statistics Canada's Labour Force Survey findings show that not only do health care workers have the highest number of days lost due to illness or injury compared to any other occupation, their rates are more than double the national average (Akyeampong, 2001; Brown, 2001).

Stress and the healthcare worker

Sources of stress among health care workers include work overload, poor communication with colleagues, patient deaths, erratic nature of work and working against the clock, inadequate staffing, and poor opportunity for advancement (Callaghan, Tak-Ying & Wyatt, 2000). Causes of workplace stress identified in a study by Jinks and Daniels (1999) include the nature of work, staffing levels, volume of work, management styles and the general work environment. The overwhelming opinion of staff interviewed in this study was that stress was the most important work-related health issue concerning them.

A report on the quality of working life for nurses in Australia (Ellis, 2002) revealed that a high proportion of respondents felt that the level of stress associated with their job was uncomfortable most of the time and considered it to be a serious concern. Factors identified in this report as having the most negative impact on job satisfaction, health and well-being were lack of trained staff, dealing with constant change, lack of recognition, and physically and emotionally demanding work. Conversely, satisfaction, health and well-being were perceived to be positively impacted by the nurses' relationships with patients, relationships with co-workers, a less formal working environment, capacity to make a difference, and flexible work shifts to accommodate family and other commitments.

The healthcare sector is often characterized by changes resulting from reforms and restructuring. Such changes often result in the downsizing or merging of departments, adjustments of managerial staff, and the redesigning of roles and responsibilities at the clinical level (Blau, Bolus, Carolan, Kramer, Mahoney, Jette, & Beal, 2002). In their study, Blau et al. examined the experiences of physical therapists

providing patient care during a period of systemic change in a large academic medical center. Constantly changing expectations and policies, working more than eight hours per day, decreased opportunities for professional development, less control over patient treatment, and a loss of ability to influence the working environment culminated in feelings of loss of control by the physical therapy staff. Feelings of stress resulted from the increased work load associated with a greater number of patients and documentation demands. Staff also reported feeling disheartened and discontented by their overwhelming work responsibilities, detachment from support networks and a sense of hopelessness about their work environment and its effect on patients.

A study by Haggstrom, Skovdahl, Flackman, Kihigren, and Kihlgren (2004) focused on the narratives supplied by nurses of a newly opened nursing home in Sweden. The narratives revealed that although the staff derived joy from their personal contact with the residents, they also felt largely abandoned in their complicated daily activities. They described feelings of disappointment with management over the amount of working time that was used for other tasks which were not directly connected with resident care. Budget cuts had resulted in a common perception that the staff members were expected to supervise themselves. This feeling of abandonment resulted in anger, concern, and dejection. Staff also expressed feelings of stress associated with not being satisfied with the effort they put into their work. Stress was manifest is several different situations, both at work and in their spare time. Staff reportedly forgot things, became unfocused and distant in their work and their behavior towards the residents. When not at work, stress was evidenced by difficulties relaxing and sleeping, ruminating about work, and problems in their personal relationships.

Walters, Lenton, French, Eyles, Mayr, and Newbold (1996) found that nurses who report greater concerns about overload and exposure to health hazards are more likely to report health problems associated with stress. Thus having too much to do, having to deal with emotionally difficult situations, having to cope with a fast and demanding pace, being exposed to illness or injury are directly associated with the extent to which nurses experience exhaustion, headaches, lethargy, insomnia, back pain, fatigue, and depression.

Williams (1998) found that when nurses worked within the constraints of insufficient time they were unable to consistently provide quality nursing care to all their patients. Furthermore, nurses were said to feel dissatisfied with their work and experienced stress when quality care was not delivered. The data revealed the existence of a process, referred to as selective focusing, used by nurses to cope with the difficulties they encountered in their daily work. Selective focusing was found to consist of four phases which were labeled as self focusing, needs focusing, patient focusing, and quality focusing. The phase engaged in by the nurse was influenced by the amount of time available and perceived level of stress.

Self focusing described the phase when nurses did not involve themselves with patients, they were indifferent in their attitude, and they tended to deliver lower quality care. High stress levels were associated with a change in behavior where the nurse's usual attributes and competence were not practiced. Needs focusing occurred when there was insufficient time available and patient needs had to be prioritized to ensure that care was delivered in a safe manner within the time available. Patient focusing was used by nurses to keep their stress levels manageable. In attempts to lessen the dissatisfaction associated with being unable to provide quality care to all of their patients, nurses would

select certain patients with whom they had developed therapeutically conducive relationships. When using this phase nurses focused their attention and care on particular patients at the exclusion of other patients. Quality focusing was mostly found to be possible when the nurse was caring for a very ill patient on a one-to-one basis. This phase occurred when there was abundant time available for the nurse to deliver care and nurses were able to be totally present for the patient when they were needed.

Stress and quality of care

There is support in the literature for the idea that work stressors adversely affect health-care staff job performance and have a negative impact on the quality of care received by both hospital patients and long term care residents (Cohen-Mansfield, 1995; Hannan, Norman, & Redfern, 2001). Three of the most widely studied work stressors in care for long term care residents are time pressure, role ambiguity, and resident related stressors (Cohen-Mansfield, 1995; Hannan et al.,2001; Schaefer & Moos, 1993). As Williams (1998) describes, time pressure has a negative influence on health care job performance and on the quality of care. Role ambiguity, referring to a lack of clear goals and clarity in the behavioral requirements of one's job, has been shown to unfavorably affect job performance (Jamal, 1984). Resident related stressors happen because work in a health care setting involves caring for people who are often chronically ill (Schaefer & Moos, 1993). Pekkarin, Sinervo, Perala, and Elovainio (2004) surveyed employees and relatives of residents in 107 residential home units and health care bed wards and found that resident related stressors, role ambiguity, and in particular time pressure were related to the reduced quality of life of residents.

The provision of quality care is seen as a priority in all health care institutions; however, there does not seem to be a single, universally accepted definition of quality care (Currie, Harvey, West, McKenna, & Keeny, 2005). Instead researchers have endeavored to elicit perceptions of quality care from health care staff, patients, and families through the use of qualitative approaches. Williams (1998), for example, used the grounded theory approach in her interviews with ten registered nurses from an acute care hospital in Australia to derive their perceptions of quality care. She found that quality care was perceived to relate to the degree to which patients' physical, psychosocial, and extra care needs were being met. The consequences of quality care were interpreted as therapeutic effectiveness, where the therapy provided by nurses was perceived to positively affect patients' healing.

Attree (2001) conducted a study on patients' and relatives' perceptions of quality care and learned that from this perspective good quality care was described as individualized, patient-focused care that related to need and was provided in a humanistic manner through the presence of a caring relationship. Good quality care encounters were characterized as being practiced by staff who were friendly, warm, sociable and approachable and who developed a bond or rapport, as opposed to adopting a more formal and professional staff-patient relationship. Findings from Fosbinder's study (1995) also support the use of interpersonal processes and relationships as key criteria of quality care. A study of surgical patients' perceptions of quality care by Kralik, Koch, and Wotten (1997) found that patients rated the engagement/disengagement of the nurse as important. When engaged nurses provided care they acknowledged patients' physical

and emotional dimensions. Disengaged nurses, on the other hand, provided depersonalized care and avoided social contact with patients.

Clemes, Ozanne, and Laurenson (2001) conducted telephone interviews with a sample of 389 respondents in New Zealand in order to explore patient perceptions of health service quality. Findings suggest that the respondents perceive the service quality dimensions relating to the core products in health care delivery (for example, outcome and reliability) as more important than the service quality dimensions relating to the peripheral products in health care delivery (for example, food, access and tangibles). The results of this study also suggest that patients with different geographic, demographic, and behavior characteristics have different needs and wants during health care delivery and therefore perceive different service quality dimensions as important.

Interviews with nurses from two different nursing homes in the United States found that their main source of job dissatisfaction was too little time (Bowers, Lauring, & Jacobson, 2001). This lack of time often forced nurses to make impossible choices between completing their tasks and providing high quality care. As a result, they often felt frustration related to both the inherent unpleasantness of always feeling rushed and the awareness of their failure to provide good quality care. Nurses reportedly developed strategies to deal with time pressure in which they described completing the work that they must do, but often at the expense of the work they should do.

Lovgren, Rasmussen, and Engstrom (2002) provide support for the idea that optimal working conditions for healthcare staff are a requisite for the possibility of providing quality care. Their study examined job satisfaction, work climate, and the prevalence of burnout among healthcare staff both at the beginning of the implementation

of a policy for good care and three years after its implementation. The findings suggested that many aspects of working conditions deteriorated between the baseline and the follow-up measures in the study which caused the staff some difficulty in offering good care in line with the policy. This coincided with a simultaneous deterioration of patients' assessments of the care quality. The researchers pointed out that the implementation of the care policy occurred as structural changes and cuts in both personnel and resources were initiated as a result of political decisions. They further explained that the frustration experienced by staff over these changes and cuts drastically reduced the possibility for effectively implementing a care policy.

Citing frequent reports that nursing homes in the United States are providing substandard care, Kane (2003) points to the need for new configurations of personnel in order to deliver a better quality of life to nursing home residents. She argues that staff providing care to residents will need more human relationship skills and more assessment skills related to quality of life than is usually the case. However, as she also points out, this type of individualized care planning requires both adequate time and human resources and time is something that many stressed out health care workers report they do not have enough of. Therefore, in order for quality of care, and subsequently quality of life, to become a reality there is a need to direct attention to ways in which time pressure, stress, and absences due to illness can be reduced. Researchers have suggested one possible way of doing this is through the use of leisure (Coleman, 1993; Heintzman & Mannell, 2003; Iwasaki and Mannell, 1999-2000; Iwasaki & Mannell, 2000; Iwasaki, Mannell, Smale, & Butcher, 2002).

Leisure and stress

Leisure is believed to be an important means of helping people cope with stress and maintain or improve their health (Coleman, 1993; Heintzman & Mannell, 2003; Iwasaki and Mannell, 1999-2000; Iwasaki & Mannell, 2000; Iwasaki, Mannell, Smale, & Butcher, 2002). Coleman's study (1993) found that perceived leisure freedom interacted with life stress in a manner consistent with its being a buffer against the negative influence of life stress on general health. His study also found that if people perceive their leisure time as constrained they were less capable of coping with life stress.

Iwasaki and Mannell (2000) conceptualized the ways that leisure can help people cope with stress. They determined that people believe that their leisure involvements provide the opportunity to develop and strengthen friendships and personal autonomy that aid them in dealing with stressful events. They also describe leisure palliative coping as an escape-orientated strategy in which leisure provides a temporary escape from stressful events in people's lives. Finally, Iwasaki and Mannell found that certain types of leisure have stress reducing potential by helping to enhance a positive mood or reduce a negative mood.

Heintzman and Mannell (2003) developed a model in support of the spiritual functions of leisure acting as leisure coping strategies for people dealing with time pressure and they suggest that spirituality can be integrated into the categories of leisure coping described by Iwasaki and Mannell (2000) as self-determination, social support, empowerment, palliative coping, and mood enhancement. Their model also illustrates that participation in leisure activities can contribute to spiritual well-being if the spiritual functions of leisure are triggered. Iwasaki and Mannell (1999-2000) tested several models of leisure health with a sample of eighty-five undergraduate students. They

determined that the use of leisure for enhancing positive mood or reducing negative mood was found to contribute to health and well-being when coping with both academic stress and interpersonal stress.

More than simply reducing stress, participation in leisure activities has been shown to reduce depression and anxiety, produce positive moods and enhance self-esteem and self-concept, facilitate social interaction, increase general psychological well-being and life satisfaction, and improve cognitive functioning (Haworth & Lewis, 2005). However, Haworth and Lewis also argue that if active leisure is used as avoidance behavior in order not to face up to problems which require attention, it can lead to increased stress and ill health. Specifically, they argue that for people who are experiencing heavy demands from their work, trying to participate in too much active leisure may in fact exacerbate rather then ameliorate stress.

Iwasaki and Mannell (1999-2000), however, point to the findings of their research to suggest that it is difficult to generalize about the ways in which leisure can help people cope with stress. They argue that the source of stress (stressor), coping strategies, and a person's individual characteristics all need to be taken into account. Certain types of coping strategies are only effective under specific circumstances, therefore, Iwasaki and Mannell emphasize the importance of matching the appropriate leisure coping strategy to the appropriate stressor.

Leisure and work stress

Considering that today's workplace is often portrayed as a significant source of stress and ill-health and recognizing that there is a connection between leisure and stress, it should not be surprising that researchers have taken an interest in examining the

specific relationship between leisure and work stress. For example, Trenberth, Dewe, and Walkey (1993) collected quantitative data from 695 principals and deputy principals at secondary schools in New Zealand who were reportedly experiencing the effects of work stress. The purpose of their study was to determine what was important about leisure for them as a means of coping with their work stress. Findings suggested that the passive dimension of leisure in this instance was more important as a means of coping with work stress than the active dimension. Based on their findings, Trenberth et al. suggested organizations committed to promoting employee health and well-being should consider the benefits of providing recuperative and therapeutic opportunities in a similar manner to providing opportunities for employees to engage in social, physical and health related activities.

A recent study, Iwasaki, Mackay, and Mactavish (2005), collected data with a series of focus groups to examine how female and male managers cope with stress. Leisure specific examples were prevalent in the managers' descriptions of stress-coping. The nine themes that emerged from the data included socialization through leisure and leisure-generated social support, deflecting stress-inducing thoughts through leisure, feeling rejuvenated through leisure, leisure as personal space, humour and laughter, spiritual coping, altruistic leisure coping, leisure travel, and problem-focused coping. The researchers highlight several differences in the meaning that female and male managers attached to their stress coping strategies. For example, female managers valued leisure for self-rejuvenation as a means of compensating for the cumulative effects of juggling a wide range of stressors while male managers' motivation for self-rejuvenation

of leisure appeared to be the act or the process of leisure itself rather than compensating for cumulative stress.

Iwasaki, Mannell, Smale, and Butcher (2002) examined the contributions of leisure coping and general coping with stress and the maintenance of physical and mental health among police and emergency response workers. The results indicated that leisure coping, rather than general coping, significantly predicted the mental health of this sample. Leisure was used to enhance mood and facilitate palliative coping and companionship, all of which were found to be related to improved mental health.

Not only has leisure been linked to a reduction in the stress that people may experience from work, leisure has also been reported to exist within the context of work as employees describe elements of choice and enjoyment being present within their jobs (Lewis, 2003). Studies have also shown that people reportedly have found enjoyable flow experiences to occur during work time (Bryce & Haworth, 2002; Csikszentmihalyi & LeFerve, 1989) Working environments that foster cooperative relationships and bring employees together to connect, share stories, and build trust are believed to facilitate the building of social capital (Cohen & Prusak, 2001). Employees have reported that social capital can enhance both their quality of work life (Requena, 2003) and feelings of personal wellness (Liukkonen et al., 2004).

Work, leisure, flow, and social capital

The idea that work has become, in some cases, so engaging that people choose to work long hours and report enjoyment doing so has raised the question of whether work has become the 'new leisure' (Lewis, 2003). Lewis uses an example of chartered accountants to provide insight into why some people thrive on long intense hours of

work. For these workers putting in long hours became a way of affirming their professional identity. However, many workers admitted that, although they chose to work long hours because they enjoy their work, they also felt a sense of pressure to work long hours as a result of structural and cultural forces present within their organizations.

Bryce and Haworth (2002) examined flow experiences, measured as perceived balance skill-challenge experiences above a person's average level, of office workers in a large insurance company. The results show that, for these workers, enjoyable flow comes more from work than from leisure. This was the case for both female and male workers. Females reportedly experienced flow during activities using their social interaction skills such as problem solving, organization of tasks, and dealing with staff. Males, on the other hand, experienced flow in more individualistic and competitive situations involving meeting deadlines, completing projects, and in gaining new business or setting claims as quickly and cheaply as possible.

Csikszentmihalyi and LeFerve (1989) used the experience sampling method with seventy-eight adult workers to study if the quality of an experience was influenced by whether a person was at work or at leisure or more influenced by whether a person was in a state of flow. Results not only showed that the quality of experiences were more affected by flow than whether the respondent was at work or in leisure, they also showed that the majority of flow experiences were reported during work rather than during leisure.

Requena (2003) analyzed data obtained from Spain's 2001 Quality of Life at Work Survey to determine the nature of the relationship between social capital and satisfaction and quality of life in the workplace. Social capital, defined by Requena as the

set of cooperative relationships between social actors that facilitate collective action, was measured using the dimensions of trust, social relations, commitment, communication, and influence. Findings suggest that higher levels of social capital lead to greater levels of satisfaction and quality of life at work. Liukkonen et al. (2004) investigated social capital as a workplace characteristic that can potentially affect employee health. They used the indicator of trust, both in job security and co-worker support to determine the extent to which social capital exists. The researchers determined that a high level of social capital existed for people who had a high level of coworker support. High levels of social capital were associated with better self-rated health, particularly for the female respondents.

The examples provided above highlight certain aspects of work that make it possible for employees to experience pleasurable enjoyment and health benefits from their jobs. However, the research reviewed here suggests that for many employees, particularly healthcare employees, work is anything but a contributor to enjoyment or health. The realization that work can often be stress inducing and demoralizing points to a need for action to be taken that will lead to improvements in the quality of work life and the health and well-being of employees. It seems only reasonable to expect that at least part of the responsibility for this action should lie with the organizations' leadership who has helped to create stressful and unhealthy environments in the first place.

Quality of work life: employee health and well-being

The apparent trend involving increasing levels of stress, ill health, and absenteeism that is prevalent in today's workplace may seem discouraging. However, evidence suggests the workplace is well positioned to create an environment that can

support employees in ways that promote, rather than compromise, their health and wellbeing. Shain and Suurvali (2001), for example, have acknowledged that the workplace is a major determinant of health. They have identified four elements of the workplace that can influence the health of employees. The first element, the physical environment, refers to a well designed workplace that promotes employee safety. The second element, the psychological environment, describes a workplace culture that is supportive and flexible. The third element is personal resources, referring to employees who have control over their work and the resources to do their job. The final element influencing employee health is identified as personal health practices. This element is described as the opportunities to make healthy lifestyle choices that contribute to overall health and well-being. For workplace health promotion to be effective, Shain and Suurvali argue that it should be comprehensive and aim at improving each of these elements in ways that maximize employee wellness.

In recent years the most common approach for promoting workplace health has been the promotion of individual employee wellness through the establishment of health and fitness programs (McGillivary, 2005). Wellness programs have been a popular health promotion strategy because research has found they can result in an increase in productivity and a decrease in time loss due to illness (Ellis & Richardson, 1991; Smith, Everly, & Haight, 1990). In their review of the literature on organizational wellness, Ellis and Richardson describe studies that highlight the benefits of organizational wellness programs for both employers and employees. For example, the benefits for employers include decreased health care costs and absenteeism, higher employee morale, and an increased ability to retain talented employees. The benefits for employees include

improved health and quality of life and reduced stress related indicators. Ellis and Richardson are quick to point out that wellness programs primarily consist of fitness and exercise programs and usually have no other element of recreation and leisure. Since participating in an activity for enjoyment has not been shown to provide companies with similar benefits to those mentioned above, the emphasis of employee wellness programs continues to be on physical exercise and behaviour modification (Ellis & Richardson, 1991; McGillivary, 2005).

Watson and Gauthier (2003) demonstrate that successful wellness programs, measured in program attendance, can not only improve employee health, but can also have a positive impact on work attendance and the overall mood state of employees. They also demonstrate that programs that have low levels of support from top management will have low employee participation rates and will have a limited impact on the health of employees. A key finding of their study is that for wellness programs to be successful and have an impact on employee health they require support from the organization's leadership. Another finding of their research is that the majority of participants in the programs they studied were comprised of the employees who were most fit. This finding is supported by Fielding (1990) who cautions organizations investing in workplace health and fitness initiatives about the real possibility of resistance from the non-health oriented portion of the workforce. In fact, he produces evidence indicating that only a minority of the employee population will be willing to participate in such programs and these are the employees who already invest time and effort in body maintenance.

McGillivray's research (2005) shows that employees will often challenge and even reject the role their employer plays as a guardian for their wellness. Using information gathered from three case study organizations, McGillivary's data reveal that organizations will often discount more passive and collective leisure forms in favor of active leisure, especially in the form of health and fitness. His research also indicates that those employees most at risk for major health problems will often resist participation in health and fitness programs. These results put into question the effectiveness of workplace leisure initiatives in affecting both employee health and the organization's bottom line.

There is clear support in the literature for the argument that individual wellness initiatives are only part of a health promotion strategy. Lowe (2004), for example, argues that this strategy alone overlooks the job characteristics and work environment as determinants of employee health and wellness. In other words, an individual wellness promotion strategy fails to incorporate the necessary components of organizational wellness. Mitchell (1998) supports this view by asserting that workplace wellness involves much more than providing a wellness program. He argues such programs treat only the symptoms of unhealthy employees and fail to examine the underlying causes of an unhealthy workplace.

Quality of work life: organizational health

Research conducted by the Canadian Council on Integrated Healthcare (2002) suggests that in order to fully invest in the health of employees, organizations must have supportive policies and an enabling culture. Also suggested is that employee health initiatives should be nurtured by organizational leaders as part of their strategic plan.

Based on this research, several characteristics were developed that serve as a guide for organizational wellness. One characteristic is the presence of a supportive environment or culture, referring to safe work practices, a culture that encourages social cohesion and the balance of work and personal time, and supportive management policies, programs, and practices. Another characteristic, program planning and evaluation, includes the capacity to recognize the needs and priorities of a dysfunctional environment and having plans or policies in place to avoid or respond to problems and their root causes. A reward system that ensures employees are recognized for the good work that they do is another important characteristic of workplace health. Finally, the leadership within the organization must make organizational wellness a priority because without demonstrated leadership and commitment, it is argued that workplace health initiatives simply will not move forward.

A study by Lowe, Schellenburg, and Shannon (2003) determined that workers are more likely to perceive their workplace as healthy if certain working conditions exist. The conditions identified in their study include having reasonable demands, high intrinsic and extrinsic rewards, good social supports, influence over workplace decisions, and available resources to do the job. Based on their research, Lowe et al. argue that organizations should not only pay attention to individual health initiatives, they should also focus on employment conditions and the way in which work is organized. Both sets of factors are believed to be key correlates of the extent to which workers perceive their work environment to be healthy.

Kane (2003) advocates for changing the way work is organized within health care settings. She suggests that a transformation in the relationships and structure that has

prevailed in nursing homes will positively affect both residents and staff. Specifically, Kane supports a culture change that will empower front line workers and break down the hierarchical management. Such a change may alleviate the imbalance between high job demand and low job control described by Shain (2000), thereby potentially reducing some of the stress that is impacting many healthcare workers.

CHAPTER THREE

METHOD

In order to better understand how staff experience quality of work life activities, qualitative methods were employed in this study. Creswell (2003) explains that qualitative research takes place in the natural setting; therefore, the research for this study was conducted onsite at the healthcare organization. According to Creswell, qualitative researchers look for involvement of their participants in data collection and seek to build rapport and credibility with the individuals in the study. In the present study the attendance of the researcher at various quality of work life activities not only helped to determine how the activities are organized and the nature of staff participation, it also enabled the researcher to build rapport with some of the study participants. Qualitative researchers also reflect on their personal beliefs and experiences and how they guide the study. Sensitizing concepts, referring to the concepts or categories that analysts bring to the data, provide the researcher with a general direction in which to look for data (Patton, 2002). This study was influenced by the sensitizing concepts that emerged from the review of the literature, namely work stress, quality of care, leisure as a means of coping, and organizational culture. Experiential data derived from previous employment in the health care sector also helped to guide the study.

Conceptual Framework

This study was guided by the conceptual framework of phenomenology and attempted to understand social phenomena from the participant's own perspective (Patton, 2002). Phenomenology asks the question, "What is the meaning, structure, and essence of the lived experience of this phenomenon for these people?" (Patton, 2002, p.104). It is concerned with exploring the lived experiences of the participants and

seeking multiple realities and viewpoints. Phenomenology also helps to identify human experiences concerning a phenomenon as described by participants in a study (Creswell, 2003).

Using a phenomenological approach involves discovering how people experience some phenomenon by capturing how they perceive, describe, remember, and make sense of it. Conducting in-depth interviews with people who have direct, first hand experience with the phenomenon of interest is believed to be the most effective way to gather such data (Patton, 2002). Patton also emphasizes the importance of participant observation to phenomenological research as he suggests one way to know what another person experiences is to experience it for ourselves.

Consistent with the phenomenological approach, this research attempted to understand if a relationship might exist between quality of work life initiatives and perceived quality of care from the participant's point of view. Therefore, the qualitative design of this study helped foster an understanding of each participant's unique experience through in-depth interviews. It also provided an understanding of the phenomenon being researched through direct, first hand experience and participant observation.

Selection of Participants

Participants for this study consisted of staff employed in the various health disciplines that comprise the Health Care Team in Aging and Veterans' Care. Members of the Health Care Team include all staff directly responsible for providing care to the residents. Purposeful selection was used to select staff members who had first hand experience with the phenomenon of interest. Therefore, only staff members who

participated in quality of work life initiatives offered within the facility were contacted to participate in the study.

The Health Care Team in Aging and Veterans' Care is comprised of the following disciplines:

- Nurses – with approximately 600 staff
- Recreation Therapy – 20 staff
- Creative Arts – 15 staff
- Occupational Therapy – 9 staff
- Physiotherapy – 8 staff
- Clinical Nutrition – 4 staff
- Social Work – 3 staff
- Speech Pathology – 3 staff
- Audiology – 3 staff
- Communications Disorder Assistant – 1 staff

Having representation from the various health disciplines directly responsible for providing care was important to help determine if working conditions were experienced and perceived differently by staff from various health disciplines. It also highlighted any differences that existed in the experience of quality of work life initiatives by healthcare discipline.

Members of the Health Care Team were invited to participate in this study via email with an information consent letter that outlined the purpose of the research (see Appendix B – Information Consent Letter). Since the recruitment process involved a

request for voluntary participation, it was difficult to accurately predict the number of staff who would participate in this study and from which disciplines they would come. In the end, thirteen participants from various disciplines agreed to participate.

Data Collection

Data collection consisted of individual interviews and participant observation. Interviews provide an opportunity for detailed investigation of each individual's personal perspective and for an in-depth understanding of the personal context within which the research phenomenon is found (Creswell, 2003). Interviews were conducted using a semi-structured interview guide which served to guide but not govern the discussion (see Appendix A- Sample Interview Guide). Questions were open-ended in order to provide participants with the opportunity to fully explain their experiences.

Researcher attendance at some of the quality of work life initiatives helped in establishing rapport with the participants prior to the commencement of the interviews. It also provided useful data through participant observation and allowed for more insight into the nature of the experience of quality of work life initiatives for the participants.

Each interview was conducted in a private area at the healthcare organization and the location was often chosen by the participant. Interviews generally lasted one hour, were tape recorded, and transcribed verbatim. Participants were made aware of the recording and transcribing procedures prior to their involvement with the study. After the interviews memos and notes were written about questions, impressions, and feelings I had during the interviews.

Naturalistic participant observation (Patton, 2002) took place during selected quality of work life activities. This type of observation was useful in gaining a better

understanding of the quality of work life initiatives and how they were being received by the staff members who attended. Observation was directed toward, but not limited to, such things as who attended regularly, the amount of interaction between participants, the level of engagement in the activity, and evidence of enjoyment with the activity. Observation notes were documented immediately following my attendance at each quality of work life initiatives.

In order to maintain the confidentiality of all recorded material, appropriate safeguards were taken to ensure that this material is protected in accordance with ethical policies and procedures. At the conclusion of the interview participants were asked to sign a consent form giving permission to be contacted for follow-up verification of the transcription and interpretation of the data. The anonymity of each participant was protected by referring to each participant only as a healthcare professional and assigning each participant with a number.

Analysis

The data from this study was systematically gathered and analyzed using a grounded theory approach (Strauss & Corbin, 1998). Strauss and Corbin explain that grounded theory involves using multiple stages of data collection and the refinement and interrelationship of categories of information. It derives meaning through the identification of emerging categories that are grounded in the views of the participants. Grounded theory begins with a basic description of the data. It then moves to conceptual ordering in which data get organized into categories. Theorizing happens when ideas and concepts get formulated into a logical, systematic, and explanatory scheme.

Grounded theory offers coding procedures as a framework for providing standardization and rigor to the analytic process (Strauss & Corbin, 1998). In this study, the analysis of the transcribed data followed the coding procedure using open, axial, and selective coding. Coding is referred to by Strauss and Corbin as representing the operations in which data are broken down, conceptualized, and put back together in new ways. Open coding involved the identification of categories or themes that emerge from the first interview and continued with new categories being added in subsequent interviews. The second step involved the use of axial coding, which included a more in-depth examination of the emerging themes and the identification of additional information that led to further themes being developed. Once the major themes were identified, selective coding was used. This stage of the analysis involved a search for connections between themes that led to theory building.

Throughout the coding process I used the constant comparative method (Lofland & Lofland, 1995). According to Patton (2002), comparative analysis constitutes a central feature of grounded theory development. Therefore, each participant transcript was compared with the other transcripts and codes and categories were compared with each other. Negative cases were also analyzed (Kirby & McKenna, 1989) against existing themes to affirm and ensure the relevance of themes and patterns. Direct quotes were used to illustrate the themes.

Establishing Trustworthiness and Credibility

According to Lincoln and Guba (1985), there are several ways to increase the likelihood that credible and trustworthy findings and interpretations emerge from qualitative research. Triangulation, which involves using multiple sources of data

collection to verify or justify a theme, is one way of enhancing trustworthiness and credibility (Creswell, 2003). However, Richardson (2000) offers the notion of crystallization to support the idea that data can be considered from many perspectives. This idea is also supported by other authors in qualitative research (Denzin & Lincoln, 2000; Janesick, 2000). Crystallization recognizes that any given approach to study the social world as a fact of life has many facets. The crystal "combines symmetry and substance with an infinite variety of shapes, substances, transmutations, multi-dimensionalities, and angles of approach. Crystals grow, change and alter, but are not amorphous" (Richardson, 2000: 934). Crystallization provides us with a complex, deep, but completely partial understanding of the topic. We have rich data that reflect different angles at different points in time and from different perspectives.

If we move beyond triangulation towards crystallization, Richardson (2000) suggests that our research be evaluated on the basis of substantive contribution and asks whether it contributes to our understanding of social life. This study aimed to enhance our understanding of the participants' working lives with respect to quality of work life initiatives and the provision of quality care. Richardson also offers reflexivity and impact as evaluative measures for research. A reflexive journal was used throughout the study in order for me to reflect on and document my beliefs, feelings, and emotions. Any thoughts or questions that surfaced regarding new research directions and practices were also documented. Finally, Richardson evaluates research on its expression of reality and asks whether the text provides an embodied sense of lived experience. This study was designed to capture the participants' lived experiences through the use of both naturalistic participant observation and in-depth, open ended interviews. In keeping with the tenets

of crystallization, recognition is given to the notion that only a partial understanding of the phenomenon can be obtained from this study and this understanding is reflected from many different perspectives.

CHAPTER FOUR

FINDINGS

The findings from thirteen interviews conducted with healthcare professionals at a long term care facility that specializes in Aging and Veterans Care are presented in this chapter. Before presenting the findings a foundation will be laid which will provide an overview of the commonalities and uniqueness of each of the individual participants based on demographic information. In interpreting the findings, this backdrop may help the reader better understand the context of the participants' lived experiences and reflections.

Description of Participants

All thirteen participants work in disciplines that provide direct care to the residents who live in the facility. Included in this study are participants from physiotherapy, occupational therapy, recreation therapy, music therapy, audiology, social work, nursing, clinical nutrition, and chaplaincy. Eleven of the participants are female and two are male. Ten participants work full time and three participants work part time. All participants have post-secondary education and specialized training in their respective disciplines. There is some variation with respect to years worked at this organization, with length of service ranging from one year to twenty-six years. However, there is recognition of longevity reflected in years worked, as more than half of the participants have been with this organization for more than ten years.

The age range for participants is between mid-twenties and mid-fifties. The majority of participants are either married or in a common law relationship and three participants are single or divorced. All but three of the participants have children which, as they explained, can influence the amount of time they spend on domestic work. Hours spent on domestic work in a typical week ranged from as little as three hours per week to as much as fifty hours per week, with the majority of participants indicating that they spend between ten and twenty hours each week on domestic work. Time spent commuting to and from work ranged from one to ten hours per week. Participants acknowledged that the time they spend each week on paid work, domestic work, and commuting dictates how much time they have left over for leisure pursuits. Time spent engaged in leisure pursuits ranged from two hours to twenty-one hours in a typical week.

In reporting the findings, each participant will simply be referred to as a healthcare professional and assigned a number to protect participants' anonymity. While confidentiality is important in any study, it is particularly critical in this case since some of the participants were initially reluctant to have their interview audio-taped and during the interview they entrusted me with sensitive information that they had not intended be publicly revealed. I suspect that some of this information, if not handled judiciously, could impact and perhaps even strain working relationships between several participants and their coworkers and supervisors.

The findings presented in this chapter begin to address the research questions that were laid out in chapter one. Specifically, the findings describe how participants experience their work environment in terms of stress, work load, time pressure, and work life balance. The findings also highlight the nature of their experiences with QOWL

initiatives and the perceived connection between QOWL initiatives and leisure. The chapter concludes with an overview of how participants describe their provision of quality care, including the rewards, challenges, and indicators associated with care provision.

Sources of Stress

Although sources of stress varied among the participants, each of the participants acknowledged that they experienced some degree of stress throughout their work day. In most cases the participants referred to the types of stress inherent in their jobs before the topic of stress was actually explored in the interview. When asked specifically about stress during their work day, only two participants initially responded by saying that stress was not a common factor or a concern in their jobs. However, as the discussion ensued, both of these participants also described specific aspects of their jobs that were frequently stress-inducing.

Many of the stressors identified by the participants seem to be typically associated with work in a health care setting. Stressors associated with time pressure, work demands, and caring for people who are often chronically ill have commonly been linked to the nature of work in healthcare settings and specifically to work within long term care settings (Cohen-Mansfield, 1995; Hannan et al.,2001; Schaefer & Moos, 1993). Stressors connected with time pressure and work demands are reflected in participants' comments that describe the challenges of accomplishing the basic requirements of the job and feeling that work never gets finished.

> I feel at the end of the day I feel I have so much more to do. And I never ever, ever walk out, feeling like I'm done. I walk out thinking, someone's going to hate

> me if I get killed on the highway going home and they have to come in here to clean my desk. (Healthcare Professional # 11)
>
> Sometimes it feels like I'm a top and everything is spinning and it just keeps getting faster and faster (Healthcare Professional # 2)
>
> It's the time pressure, you have so many people to see and so little time to do it and you know that there's even more that you could be doing if you had the time. Like you just deal with what absolutely has to be done because people need things as opposed to really taking the time to do things and expand your role and do things differently or do research or do all the other things that you'd like to do. (Healthcare Professional # 9)
>
> At the moment, there are a lot of expectations; there are a lot of education sessions to go to. Right now it's a stressful time because I don't even feel like I can get even the basic needs done of my job, like I'm feeling stressed out. (Healthcare Professional #10)

Caring for people who are chronically ill brings with it a certain degree of emotional stress. Understandably, as staff work so closely with residents they can become emotionally attached. This attachment may be stressful for staff as residents' conditions deteriorate or as residents die.

> I think it's stressful because basically you're dealing with people who are chronically ill. That is the biggest thing. And I sometimes feel that I am on the frontline of it. (Healthcare Professional # 3)
>
> It can be emotional, very emotional. Because I find myself working on a floor that is end stage. When I say end stage, it's the level of care, it is that the patients have to be fed. They have to be fed a certain type of food. And sometimes you see their pictures, you see these were just young nice fellows, you know. And it's emotional. And no matter what anyone says, you do get attached. Yes, you do get attached. So I, sometimes I have a little problem, I get emotional. (Healthcare Professional # 4)
>
> But sometimes things that are of big emotional content, I mean there are lots of people that die here and you know, or have terrible things happen and it's not so easy just to compartmentalize in your brain because the images keep coming. (Healthcare Professional # 1)

Interactions with family members can also be stress inducing. As family members encounter their own stressful experiences associated with the placement of a loved one in a long term care facility, these stressors may carry over in their interactions with staff. The quotes below illustrate the challenges that staff may encounter as they deal with family members who are concerned about the care their loved ones may be receiving:

> One of the biggest challenges of providing care, especially patient focused care, is if you are on a unit as debilitated as mine, um and it's challenging mentally as well, is basically families. You have a lot of interaction with families, and we do understand that, you know, they want to be there. They maybe lived with someone for many, many years, you know some of them 30, 40, or 50 years. And they are now living without them and it's hard to learn to live without someone. Then they come in and some young, chipper girl or guy comes in and "good morning, we are just going to give a wash, can you just excuse me". Their defence system just goes up right away. Then they feel like okay, nobody here cares about my husband or my wife, nobody here cares. (Healthcare Professional # 5)

> I mean it's not just a bad day, it's, you're dealing with really sick people and you're dealing with stressful families and stressed families.
> (Healthcare Professional # 9)

Other types of stressors identified by the participants varied among the participants and relate to the nature of their relationship with their manager and co-workers. Managers can add to the stress of certain individuals if it is perceived that they are giving unequal or preferential treatment to certain staff, are imposing changes without soliciting input from staff, and are exerting too much control over circumstances that directly affect staff. These issues will be discussed further in the next chapter.

Although not a common concern, some participants identified co-workers as a source of stress. Coworkers can add to one another's stress if they cannot be relied on to carry out their tasks or when tension and conflict exist between groups who work closely together.

> So stress for me is to have to rely on colleagues and they don't follow through. I think that can be a stress and especially if it's out of my hands and then you're sort of, you're stuck there and you can't, you need them to do something and they're not following through. (Healthcare Professional # 12)

> I feel terribly stressed and it's because of two things. The first one is that I work with a small group where there are a lot of personality clashes and often there is a total lack of respect. (Healthcare Professional # 6)

Depending on the position that the participants hold and to what degree they must work interdependently with other staff, there may be certain stressors associated with the time and effort required to work collaboratively and coordinate work schedules. For example, it is necessary for nursing staff to be replaced in order to ensure adequate coverage on the unit when staff are either sick or on holidays. Therefore, nurses can find it stressful having to work around other people's schedules in order to secure time off for such things as family vacations.

> So for me to get that now, I have to negotiate with my peers to get all those days changed and who will work for me and all of that. Yeah, it's a stress. It's a stress, because I can't make a decision with my sisters who are out of town, who are in the States, to do anything because I have to verify with everyone at work. It's work and there's no care about life. It's all quality of work life. (Healthcare Professional # 4)

Coping with Stress

Coping strategies vary from participant to participant, but they often involve some form of past-time that is personally enjoyable or rewarding to the individual. Participants described spending time socializing, engaging in physical activity, and spending quality time with family members in order to take their minds off work and its accompanying stressors. Furthermore, participants seem to select experiences that will provide them with an element of escape, both mentally and physically, from the demands of work. Iwasaki and Mannell (2000) refer to this type of escape-orientated strategy as leisure

palliative coping, in which leisure provides a temporary escape from stressful events in people's lives.

> I think I've learned more or less to walk away from work at the end of the day. Physical activity is good for me. I walk or go skating or whatever I can do. That's a good way to get me down to earth again or whatever.
> (Healthcare Professional # 1)

> I like sports. Even on TV. I watch only sports on TV. It's the only thing that is both entertaining and true. And when I leave work, I leave work. I don't take it home with me. So when I'm at home I am able to let go of some of my work stress. (Healthcare Professional # 8)

> I try do to things that make me feel good, just maybe going out to a bar, having a few drinks, letting loose with friends. That's a good thing. Like just letting loose and doing things that are so totally not what I'm doing in my professional life. (Healthcare Professional # 3)

> I hang with my friends, I do a lot of stuff, I get out, like you know, when I have free time to myself, I have time to go out with my friends and you know just hang out, and do things with my family. (Healthcare Professional # 13)

> Just walking my dog or something like that, taking my mind off it completely. But you know what, I'm pretty good, I find by the time I've driven home I've had a chance to unwind a bit. I start to think, really, how important is it? You let little things sometimes get to you through the day. (Healthcare Professional # 7)

The relationship between work stress and job inefficiency and between leisure and stress reduction has undoubtedly directed healthcare decision-makers' attention toward the use of leisure as a way of addressing work related stress (Ellis & Richardson, 1991; Smith, Everly, & Haight, 1990). This, in turn, has resulted in the establishment of QOWL initiatives at many organizations within recent years.

Quality of Work Life Initiatives

The quality of work life (QOWL) initiatives offered at this organization are designed to help improve work life for employees. These initiatives fall under four main categories labelled as social and recognition, wellness, awards, and a category called other (see Table 1). Table 1 provides examples of the types of initiatives that are commonly offered to employees as part of the comprehensive QOWL program.

Table 1 – Summary List of Corporate Quality of Work Life Initiatives

Social & Recognition	Wellness	Awards	Other
• Golf Tournament • Fall Staff BBQ • Talent Show • Casino Rama • Ski Day • Holiday Campus Parties • Volunteer Recognition Dinners • Service Award Celebrations • 25 year Club BBQ • Nursing Week • Health Discipline's Awareness Weeks • Women's Health Day • Community Fair • Department Recognition Programs • Professional Association	• Restorative Lunch Breaks • Random Acts of Restoration • Sunny Gym • Fit Walk Program • Nutrition Classes • Weight Watchers • Smoking Cessation • Heart Healthy Classes • Stress Reduction	• Schulich Awards • Peter Ellis Award • Peter Boyd Awards • Nursing Education Awards • Practice Base Research Awards • Inter-Education Clinical Supervision Recognition Awards	• Leadership Development Program • Orientation • Career and learning Centres • Organizational Development Pathways to Learning workshops • Institute for Health Improvement • Creche Daycare • Leadership Days

Initial Lack of Awareness of QOWL Initiatives

When I initially asked about the QOWL initiatives, many participants responded by saying that there is nothing, or next to nothing, happening within the organization around quality of work life. There is a definite separation in the minds of the participants between the programs and special events that are being scheduled for staff and the realization that these programs are considered to be QOWL initiatives. Their responses are more of a reflection of a lack of awareness with how the initiatives are categorized and why they are provided than they are a reflection of a lack of awareness about the programs themselves. Communication does seem to be an issue since for the most part each participant felt that they receive adequate communication about the QOWL initiatives and events through regular email correspondence, but in fact they did not recognize the events are something offered to enhance work life balance.

> There's not a lot. I mean we have a Christmas party, but that's only once a year. (Healthcare Professional # 7)

> I'm not really aware of a lot of programs. There's the restorative lunch. I think I went over to that one time when it first started just to see what it was all about. I know they had one recently. (Healthcare Professional # 1)

> Yeah, to be honest, I'm not familiar with anything. (Healthcare Professional # 3)

> We don't know about them. And I say 'we' because I don't ever remember hearing any one of the staff that I work with going to one of those. (Healthcare Professional # 5)

Restorative Lunch Breaks and On-site Gym

It was interesting to note that when participants were able to identify particular QOWL initiatives, they were quick to mention both the Restorative Lunch Breaks and the on-site gym. Since the Restorative Lunch Breaks are promoted specifically as a QOWL initiative, participants may be more inclined to think of these lunches in terms of

enhancing their quality of work life. Most participants have attended at least one of the Restorative Lunch Breaks; therefore they may be more familiar with these particular initiatives compared to some of the others. Although attendance at Restorative Lunch Breaks seems relatively common among participants, many admitted that getting to the gym located on site is something that happens far less frequently.

> You know, when you mention that, the first thing that comes to mind are those lunches that are put on by the recreation department….Restorative Lunch Breaks, yeah. I attended all of their sessions and I find them very helpful. And then there is a gym and I used that regularly last year but all throughout the winter I haven't gone to the gym. That's all that I can think of. (Healthcare Professional # 8)

> Um, the first thing that comes to mind, and probably the only thing that comes to mind are the recreation therapy restorative lunch breaks. Those have been really good. I've enjoyed almost all of them, and they are an hour and you go and you know, and they usually have interesting topics and it's an hour for you to get away. What else do they have? They have exercise I know, like they have the gym and stuff. (Healthcare Professional # 13)

> I'm usually aware of what they are because the emails come across my desk. I know about the Recreation Therapy ones, the Restorative Lunch Breaks. I know about the gym that's just downstairs – but do you think that I can get there? (Healthcare Professional # 2)

Throughout the course of the interviews, it became apparent that participants were also aware of many of the other QOWL initiatives, such as the annual ski day, golf tournament, the staff barbeques, and Christmas parties. For the most part, these programs were familiar but not particularly convenient for the participants. Many participants found it either difficult or unappealing to participate in such programs because participation would intrude on their personal time and this time is valued as time to be spent away from work and time spent with their families and friends.

> I know myself, I at times can't attend things that are on certain days or in the evening just because of the fact that I just don't have enough day care at those times or because I commute for a distance. I mean drive all the way home, pick up the kids and then meet my husband and, like we actually get home at the same time and then for me to drive all the way back, it's just too hard. (Healthcare Professional # 12)

> If something that's going to be on my day off, it's really not, I find it very difficult to come in because that's my time off. Most of the time it doesn't fit in to my time for my work. So it's a little problem these days. (Healthcare Professional # 4)

> For some people who start late, they can probably do it in the morning or do it after work but I have to run home, so staying to do anything, whether it's something fun or whatever, after work is kind of out of the question. (Healthcare Professional # 9)

> I am not one to leave my house on a non-work day just to come to (the organization) for something. Maybe if it was like something that was worthwhile to me, that was planned outside of my outside of my working day, and I felt that it was something literally for our staff, but also from (the organization), you know what I mean, that they are giving back. (Healthcare Professional # 5)

Deterred by Cost

The cost associated with some of the QOWL initiatives seems to be a deterrent for people to attend. Participants indicated that they are not only reluctant to spend the money on organizational activities, they also felt discouraged by the idea that the organization seemed not to value the work they do sufficiently to plan such events as a way to acknowledge and appreciate staff. After I attended the annual Christmas party for staff in Aging and Veteran's Care, I reflected in my journal about how the cost of an initiative can negatively impact how it might be perceived by staff.

> Oh, that's why we didn't go, because you had to buy tickets. We were all like are you kidding me? For all the work we do and we still got to buy our tickets? No way. Actually I don't think anyone of us went. Put it this way, if (the organization) is going to do something for us, do it for us. (Healthcare Professional # 5)

> No, because we usually do a department one and I don't really choose to spend money twice. You know I would choose to do one social thing that is going to cost me my money. (Healthcare Professional # 10)

Relatively few Aging and Veteran's Care staff were in attendance at the Christmas party compared to the number of staff who work in this area. For at least some of the study participants with whom I spoke, cost seemed to be the biggest disincentive for not attending. The following participant who attended the Christmas party also expressed disapproval with the fact that there was a charge associated with this activity:

> Let's go back to the staff Christmas party. You were charged I think $25 to attend. I felt that was really poor. A lot of people felt that that was not, that it was insulting….It was too much money and we should not be charged. I did a bit of research around with other organizations. This subject is a bit of a hot potato. I found that in a lot of organizations, people really don't think there should be a cost. They see it almost as the organization owes them and it should be like a thank you. (Healthcare Professional #11)

Informal Social Opportunities

Consistent among participants is the idea that informal get-togethers for staff that are either organized by managers or by the staff themselves go a long way to improving quality of work life. These type of programs are credited with not only having the potential to foster connections and relationship building among staff, they also seem to signify to staff that their managers are appreciative of the work they do by their willingness to either plan something for the staff or by taking the time to attend something that is planned by the staff.

> Often on the units too there will be a celebration for some reason or you'll have a staff meeting that everybody gets together and the unit manager may buy your lunch and show appreciation in that way and thank you for coming to the staff meeting or they'll have special initiatives. So the unit manager often has control of the quality of life. (Healthcare Professional # 1)

> I'll tell you what is really great are those kinds of impromptu occasions when they have lunches on the floors. Those are fabulous. It's a special occasion for a staff. Maybe they happen maybe three times a year and I think it's such a nice way to get to mix with some of the other staff. (Healthcare Professional #11)

> And to get together also if we have like a birthday for one of the staff or if there's anything, even a death of a staff member….It's usually organized by the staff and (the organization) has been very kind….Helping to plan, letting us have time off for that, bringing extra staff, bringing in snacks and so forth, and even being present at it. (Healthcare Professional # 4)

QOWL Initiatives as Leisure

Participants vary as to whether they consider their experiences with the QOWL initiatives to be leisure experiences. For some, if the initiative is one in which they choose to participate and they derive a certain amount of enjoyment from it, then it is considered to be leisure regardless of the context in which it takes place.

> Yes, because it's doing something for my own enjoyment. I'm doing it because I want to do it. I'm not mandated to do this; I'm choosing to do this. (Healthcare Professional # 10)

> Yes, I think I would because it's something that I really enjoy doing and I choose to do it. (Healthcare Professional # 6)

Others however, feel that anything that happens during their work day, no matter how enjoyable, is merely a break from work and not a leisure experience.

> It's a break but I wouldn't really call it leisure, I consider leisure to be doing something that you enjoy and that is relaxing. So when it's only a little bit of time and then it's back to work and then you're going to get behind because you've gone to that, I wouldn't call it leisure. (Healthcare Professional # 7)

It seems that even though people acknowledge that these QOWL initiatives are both enjoyable and freely chosen, because they participate in them during the work day, they are reluctant to think of their experiences at these initiatives as being leisure experiences. However, some admit it is like leisure to the extent that the essence of the program is unrelated to the components of their job.

> Yes, I think so. I am trying think of what else I would consider it as. As long as it's a topic is outside of (my discipline) or something like that so it's not something I am working with everyday. Because you know it's my job right, so like its…if it's just related to patient care or stuff related to (my discipline) than that's not leisure, I don't care how engaging it is.
> (Healthcare Professional # 13)

> It's part leisure, it's part work, I guess. It's working in that it happens during the work day. It's leisure in that it's an activity that is completely different to what I have been doing before; it's unrelated to my job here. It's also leisure in that it's not something I have to do. I can just sit and relax and enjoy the break.
> (Healthcare Professional # 11)

For some, the experience with the QOWL initiatives is hindered by the fact that they have to return to work when it is over. Participation in an activity, particularly an activity that is pleasurable, makes the idea of returning to work more daunting and staying motivated throughout the day more difficult. Returning to work after an initiative can be especially challenging when the work piles up and they fall farther behind as a result of taking time away from their tasks to participate in the initiative.

> Sometimes when I'm feeling unmotivated and go to an event and I had a great time then I don't want to go back to work because that's work and I was just having such a great time. Or like if they have something outside in the summer, it's like I don't want to go back inside now. (Healthcare Professional # 6)

> Sometimes I find after those things that you don't want to go back to work. You know because you've gotten, it's like your brain goes in a certain direction and when you stop, it's harder to get back. Like every time we've had a luncheon, it's really hard to then go from that mode back in to working. Whereas when you work right through, I find it easier. (Healthcare Professional # 9)

Regardless of whether or not participants choose to participate in certain QOWL initiatives, some expressed gratitude that these types of opportunities are offered and are available if they wish to participate.

> The fact that it is there makes me feel good because if I do want to do something, there is something to do. It's nice to know that it's there, because if I do want to take them up on that offer, and do the yoga or what ever, it's there and I can do it, so I like knowing that it's there as opposed to it not being there at all. (Healthcare Professional # 13)

Work Life Balance

Individual assessments of the extent to which people feel they achieve work life balance vary in accordance with circumstances that are external to work, such as family and domestic responsibilities and time spent commuting. As the participants' demographic information suggests, there is also some variation in time spent on leisure pursuits, domestic work, and commuting to and from work that may be used to help explain variations in work life balance. For the most part, participants seem to be able to separate their home life from their work life and recognize the importance of having a balance between the two domains.

> It's very important because my family is more important than my job. This is just my opinion, but I don' t think you're a good human if you don't take care of your family and yourself before you give yourself to somebody else. (Healthcare Professional #10)

> First of all, when the day ends I go, like I don't take it home. You know, like it's over. In the past I used to take things home. I'd bring it in the house with me and then I'd bring it back out with me in the morning. Now I may take home an article to read or something so I do some work but it's minimal. (Healthcare Professional # 2)

> Well, for me work life balance means that I have enough time through the week. I've always been the type of person that I can go home and not take work stuff with me. (Healthcare Professional # 6)

> I think it means that I don't go home and think about work. I have other activities you know, I can be with my family. When I'm home I'm not checking my email and my voice mail all the time….I have a dog that has to be walked and I have children that have their own issues. (Healthcare Professional # 7)

> With regards to like work and home, I am one of those people that I can separate the two. I can be miserable at home, and I will come to work and I am happy and chipper and my regular self, and vice versa. (Healthcare Professional # 13)

Work life balance also seems to be influenced, in part, by work status with respect to the designation of full or part time work. Not surprisingly, staff who work part-time indicate a greater satisfaction with their work life balance than staff who work full-time and juggle family responsibilities in addition to their full-time work.

> It's even better that I'm part-time just because you're able to take them to whatever special interest that they have and being able to spend time with, my youngest is still at home so it's nice being able to spend time with them and get involved with their schools. (Healthcare Professional # 12)

> And I do work part-time. So if I leave at 11:30 and I'm with my kids for the rest of the afternoon, you don't really have a lot of time to worry about work. (Healthcare Professional # 9)

There seems to be certain benefits for the organization in having part-time staff, at least from the perspective from some part-time staff members. Although full-time work seems to be the norm, it seems part-time work can also bring with it certain advantages for employers. One of the participants highlights these advantages as she describes part-timers as being less inclined to burn out and more apt to return to work feeling well rested.

> Even though I work part-time hours, when I am here, I am a hundred percent here. I do feel that there can be a really good advantage of working part-time. I think that part-time people feel a lot less burnt out at the end of the week. I don't walk out of here feeling spent and after a three day weekend, I feel rested and I'm ready to come back to work on Monday. I find that I'm really looking forward to it. So I did struggle with the attitude toward part-time, but I don't feel that any more (Healthcare Professional # 11)

Autonomy on the Job

With the exception of nursing staff, each participant referred to having opportunities within their working day to act autonomously and assume responsibility for the way their day is structured. This was evident from the first point of contact with the participants when the interviews were being scheduled. It was most challenging to recruit and arrange time to meet with nursing staff because they work interdependently and have a certain degree of inflexibility in their work schedules. In the end, one nurse who was identified as a potential participant and who was willing to participate could not find the time to set aside for the interview. Another potential participant expressed an interest in the study but indicated that there would be no opportunity to meet with me during her work schedule because she was already too pressed for time to complete her everyday work.

The two nurses who eventually participated in the study did so on their own time. I arranged to meet one participant during her lunch break and the other participant during her supper break. Even with these interviews being arranged during their break time, it was clear that in order for both participants to set aside this time to meet they had to coordinate some of their duties with other staff on their nursing units.

Each of the participants I interviewed from other healthcare disciplines seemed able to coordinate their time to accommodate meeting for the interview with minimal disruption in their day and no need for coordination with any other staff. These participants, however, also seemed pressed for time, which was evident by the number of disruptions that occurred in the middle of interviews because participants had to respond to phone calls or attend to residents.

The capacity to act autonomously also seems to carry over to other aspects of the participants' work day. For example, their attendance at non-work related functions, such as the QOWL initiatives, does not require the approval of their manager. In fact, in many cases, staff do not have to inform their managers of their plan to attend one of these initiatives when they choose to attend.

> Well, I organize my day so I am able to go to these things. I really don't need to tell her. She would support it though. That is my sense.
> (Healthcare Professional # 8)

> We don't even talk about it. I just go…I'm not dependent on her. I don't have to say, "Is it okay?" (Healthcare Professional # 11)

> It's pretty much up to me. So if I decide I want to go to things, I can go.
> (Healthcare Professional # 7)

It seems safe to say that with job autonomy comes job responsibility. Therefore, participants who have discussed acting autonomously also expressed feeling responsible for the amount of work that they get accomplished during their work day. It seems the more responsibility people assume for their own productivity, the less inclined they are to take the full time allotted for their lunch or breaks. It is for this reason, perhaps, that it might be difficult for them to justify taking time away from job related duties to attend such non-work task related functions as QOWL initiatives.

> It's that I know that I'm not going to enjoy a lunch when I know I have stuff that has to get done. So I'm going to feel better if I get this stuff done and then when I leave I won't feel so stressed. (Healthcare Professional # 10)

> So for that, leaving the floor, I'm going to have to dedicate my assignment to other staff that are just as busy. So it is a busy floor. I would really love to go to tell you the truth, but it's too much rush in getting there.
> (Healthcare Professional # 4)

> So these things are nice but sometimes you just get to the point where you just want to get through your day because your day is busy enough.
> (Healthcare Professional # 7)

> If I'm going to go to a Restorative Lunch break, for example, to relax and regenerate, well if I have to forgo doing some work things to do that then I don't find it relaxing. Instead of being able to relax later I'm going to be rushing my butt off to get things done. And if I don't do it today I'll have to do it tomorrow and then I'll be rushing or I know things won't get done. (Healthcare Professional # 6)

Moreover, the responsibility that participants assume for their jobs seems to manifest itself in their demonstrated commitment to working through breaks and lunch hours to ensure that they keep on top of their work tasks. In fact, working through lunch seems to be so prevalent that one participant actually came up with the phrase, "eating aldesko" to describe the act of eating lunch while sitting at one's desk getting caught up on work related activities.

> So what I do is I eat lunch "aldesko"….I turn on the computer and respond to e-mail or start getting into the documentation. (Healthcare Professional # 11)

Although the phenomenon of "eating aldesko" was only described by one participant, most of the other participants explained that working through lunch and skipping their breaks as something that is fairly common place.

> I probably only take my lunch two out of five days. So I usually work though lunch because it's busy. (Healthcare Professional # 10)

> So often my lunch consists of making phone calls, making arrangements, working on things on the internet, going to see residents and addressing questions that they have. (Healthcare Professional # 12)

> I try to get lunch but sometimes I eat at my desk when I'm really behind. (Healthcare Professional # 7)

> Sometimes I do "Infomed" during lunch. A lot of the time I might read or just sit and check my email. (Healthcare Professional # 8)

The Provision of Quality Care

The experience of providing care to the residents was generally described by the participants as a source of pleasure. Most staff recounted interactions with residents based on respect and dignity and described the process of developing close relationships with residents through their provision of care.

> So I get really close to patients, they know about me, I know about them. They know my life story, I know their life story and I try and make every visit personal. (Healthcare Professional # 13)

> It's a huge thing to me. It's emotional you know; dealing with very, extraordinary people who have done extraordinary things. It's taking the time to get to know the patient and to get to know his family and I like to be a part of it. I feel honoured to be a part of their lives. (Healthcare Professional # 11)

Among the challenges to providing care that were highlighted, many of them are separate and distinct from the actual interactions with residents. These challenges, for the most part, are linked to the sources of stress identified earlier in this chapter as time pressure, work demands, and working relationships that involve an element of conflict.

> I guess the challenge I find is when I'm being pulled in too many different directions. When I don't feel that I have the time it takes to develop relationships with the residents. Having residents feel comfortable around you and trust you, it takes time. When there is too much to do, this is what is lacking. (Healthcare Professional # 8)

> If I'm not happy, it's because of a lack of time that I haven't been able to see someone who might need the interaction and time because I have to be somewhere else at the same time. So I don't always have the time to direct the approach. (Healthcare Professional # 12)

Some participants also identify certain interactions with residents to be challenging if they deemed particular residents to be verbally abusive or confrontational.

> And we have to be open-minded, non-judgmental in things that may be said or done, right? To know that you may be called, for six mornings straight, you may be called a (derogatory term). (Healthcare Professional # 4)

> I find it particularly hard, even if I had a fairly good day, dealing with patients who are very angry. (Healthcare Professional # 3)
>
> If a patient is abusive, which is one of the high stresses, it can be difficult. (Healthcare Professional # 11)

When asked how they can tell if they are providing quality care, participants were quite consistent in their answers and they generally believe that the best validation they receive comes from the residents and their families. Participants explained that residents offer a great deal of feedback when it comes to the care they receive. Furthermore, participants believe that it is the residents who are in the best position to judge the type of care they receive.

> I receive plenty of cards from family members and from residents thanking me for what I have done. Those are reminders; they remind me that I am making a difference. I get many verbal thank-you's too, so is nice to be recognized for the work that you do. It makes you feel good that they appreciate what you do. (Healthcare Professional # 8)
>
> So they're like, they'll tell you, like I mean they tell you that they are happy, they tell you "oh thank you, even just thank you for talking to me. You brightened my day, or I feel so good when I leave here, I feel more energetic, and I feel". So they tell me, and that's what I base most of my stuff on. (Healthcare Professional # 13)

Summary

Work within a healthcare setting can be challenging and stressful as well as personally rewarding and satisfying. This section has laid the foundation and painted a picture of the types of stressors experienced by healthcare staff and the ways in which staff might choose to cope with work related stress. It also described the nature of staff experiences with respect to both QOWL initiatives and the care they feel that they extend to residents. This provides background information that helped to develop, understand,

and interpret the five emergent themes that focus on the connections between the participants' overall QOWL and their provision of quality care.

CHAPTER FIVE

EMERGENT THEMES ON QOWL AND PROVISION OF QUALITY CARE

The following five themes emerged from this study:

1) Work Demands Impact on Care Provision
2) Manager Relations
3) Professionalism
4) Social Support Networks
5) Need for Restoration, Humour, and Balance

These themes collectively capture the nature of the healthcare working environment as it is described by the study participants. These themes also present the reader with a depiction of the factors that can influence QOWL in this particular healthcare setting. Through the explanation of themes the reader will begin to understand how work demands and manager relations can affect QOWL and can, in turn, have a perceived impact on care provision. The reader will also discover how a sense of professionalism can bring with it an ability to overcome adverse working conditions in order for staff to offer top quality care indicative of professions that place a high value on resident quality of life. The influence that QOWL initiatives can have on QOWL will also become evident as the themes unfold. QOWL initiatives are credited with fostering social support networks and providing opportunities for restoration, humour, and balance. Study participants point to the presence of social support and the realization of restoration and balance as contributing to both to an enhanced working environment and the overall improvement of care provision.

Theme # 1: Work Demands Impact on Care Provision

The findings suggest that there is a belief that some tasks take up too much time and detract from the more important functions of the job, which are considered to be spending time with and caring for the residents. As was evident in the previous chapter, staff can experience stress resulting from time pressure and work demands when they feel they are being pulled in too many different directions and there are too many things to juggle during their work day. Direct contact with residents and the opportunity to provide quality care is one of the most rewarding aspects of the job as indicated by all participants. Therefore, when the time spent providing care is minimized in order to accommodate various other work demands, participants begin to view these work demands as unwelcome intrusions that detract from resident care.

Increased Documentation

Consistent among participants is the feeling that documentation demands are continuously increasing. Furthermore, the push to document things that are unrelated to resident care with workload measurement tools such as "Infomed" has created resistance to documentation. For the most part, the type of information collected, even if it is resident related information (collected through MDS), is perceived as being beneficial to the organization's administration and of little benefit to healthcare professionals and how they do their jobs. In fact, it appears that time spent tracking how staff spend their time pulls them away from the areas where they feel they should be devoting their time, such as providing patient focused care.

> Documentation is a pain in the neck and while it might be useful for the organization, it doesn't feel all that useful to me. Maybe if I was tracking only patient data, but there are so many other things that we have to track, like involving how we spend our time. (Healthcare Professional # 11)

> They keep adding more and more paper work for us to do, like there's more documenting. I find doing that difficult at the best of times. (Healthcare Professional # 6)

> Don't make us find an extra 20 minutes in our day to fill out sheets and fill out work load sheets. We have been filling them out for many, many years, and nobody has even looked at them. (Healthcare Professional # 5)

> And the MDS, like the new forms, they keep bringing out new things to keep track of, but they don't realize that all of this takes time and then you have less time to actually see people. And if you don't see the people, then you have less to chart on and then they think our numbers are so down and ask, "Why aren't you seeing more people?" It's a vicious cycle. (Healthcare Professional # 9)

> There are a couple of main challenges. The first one is documentation. Everything you do you have to document and that is taking time away from being with the residents. The other challenge is time – time to provide quality care. (Healthcare Professional # 2)

> As you'll hear when you interview more people here, we have Infomed statistics, we have MDS reporting to do, we have a database with charts, and now there's a new brochure charting where it's in people's actual charts (Healthcare Professional # 6)

It is important to note that the documentation that is expected of staff, such as Infomed and MDS, are forms of documentation mandated by governing bodies for all long term care facilities in Canada. Furthermore, at the time this study was being conducted, the organization was in the process of revamping their documentation process in order to make it less time consuming and more efficient for staff to complete.

Selective Focusing

As described in the literature, nurses working within the constraints of insufficient time find it difficult to consistently provide quality of care to all of their patients. This

challenge can lead to the adoption of a process called selective focusing, in which nurses engage in self focusing, need focusing, patient focusing, or quality focusing (Williams, 1998). The level of focusing chosen often depends on the time available and the amount of stress experienced. The following quotes describe the type of situations in which insufficient time coupled with work demands can cause staff to focus on the needs of one resident, as in patient focusing, to the possible exclusion of other residents.

> There are things that you want to do but because a patient may be sick, you know. So, number one, you have to spend most of the time with the one who is sick. So you are a little bit stressed because that other one is calling to you and wants the care. So that can be a little challenging, or stressful, you know. Stressful, yeah, because you're trying to do everything. You're still satisfied…..Because the other one that you did not do maybe all of the other little things, but you still provided safety. They weren't at risk. You may not have given them the bath that they wanted, but they were fed and they were clean and, as I said, they were safe. (Healthcare Professional # 4)

> So it's like, "I can't give you an hour today, because of mister so and so". Or I have this guy here that's really sick, so I may spend a little bit more time with him, but that means that I have to compromise someone else's care. If we had an extra body it wouldn't be that bad. (Healthcare Professional # 5)

In circumstances such as the ones described above, it could be argued that although other residents are not deemed to be at risk, denying certain aspects of their care puts into question the quality of care they may be receiving. Similarly health professions describe working with residents who can require so much of their time that the care of other residents is sometimes impacted.

> Again it's time and when there is some unexpected issue with a resident and it absorbs all of your time. And I feel that is an issue with me here. There are people who can take up a lot of your time. The people I feel guilty about here are the quiet ones who don't always get that extra attention. And it's very easy to kind of shaft them in order to deal with the ones who complain, right. (Healthcare Professional # 11)

> Often things get stressful because there's someone that needs me to take care of something and it's even like walking down the halls and you're stopped by someone that needs something addressed. Well it's great for that interaction for them but it puts you behind getting other things done.
> (Healthcare Professional # 12

Staff/ Resident Ratio Concerns

Participants feel that the goal of providing quality of care could be more attainable if the ratio of staff to residents was more favourable and enabled them to have more meaningful interactions with residents. Issues around size of resident caseloads seem to be related to some of the previously expressed concerns associated with time pressures and work demands. The more residents that each healthcare professional is responsible for, the less capable they feel of providing individualized care in a manner that is conducive to patient focused care.

> There's a target, there's what our school told us we should do ethically. There's, um, there's what our manager feels comfortable about, there's what we can physically handle and logically handle, and then there's, you know what we need for our Infomed stats to look good on paper. So there are many different pushes and pulls here about what size of a caseload to have. (Healthcare Professional # 6)

> It means I think that I sometimes don't spend the time I'd like to with the people I do see, that I'm being called away to another area. If I could create my own job, I would have maybe half the residents. I'd be responsible for half the residents that I'm responsible for. And I would think I would have better quality of time with those residents. It's just impossible when you have so many people to keep an eye on. (Healthcare Professional # 1)

> I feel like we're sort of sell outs because we're too concerned with the numbers and everything. That's not what good therapy is. There is not enough time for reflective practice so I often feel conflicted. (Healthcare Professional # 6)

Seeking Diversity within the Work Day

Interestingly, despite the concern expressed by participants over the degree to which time pressures and work demands can impact the provision of care, participants also seem to welcome opportunities to diversify their jobs in order to create a sense of balance during their work day. Work tasks that provide participants with a change of focus and give them some variety seem to help make work much more satisfying.

> As long as I am not doing 100% patient care and there is something else in my day, whether it's some sort of research or it's attending one of those quality of work life things, or even doing documentation, as crazy as that may sound. For me, as long as I am doing something that kind of balances my day so it's not all strictly patient care, I'm happy and I feel good. (Healthcare Professional # 13)

> But it's also a balance within the work day of doing things that have to be done that I don't necessarily enjoy doing and doing those things that I like to do. So I try and make a balance there. So if I have to sit and do my statistics for a long time, then I'll go and see a patient and do something more pleasurable and then I'll go back and do statistics again. (Healthcare Professional # 1)

> Well, I guess it means that I do good projects that I'm interested in where I can be creative and I can express myself. Things that give me satisfaction. So I like to be creative in my work. (Healthcare Professional # 2)

The quote below describes how special projects can provide the impetus for staff to temporarily change the way they work and think because these tasks are separate and distinct from ordinary work functions. In this way, diversified work provides certain challenges that participants can find exhilarating.

> It's when you take on something extraordinary. I mean extraordinary in the sense that it's not ordinary. Because it is something out of the ordinary, you need to be able to work harder at it; you need to think more about it.
> (Healthcare Professional # 11)

The difference between work tasks that are perceived to detract from providing quality care and work tasks that are perceived to provide a sense of job fulfillment can perhaps be explained by the element of choice. When staff feel time pressures and work

demands are largely out of their control, they are more apt to take a negative view of the impact they can have on the way care is provided. However, when staff are able to work autonomously and have some choice, as when they have the opportunity to engage in special projects or to infuse some variety into their work day, they report feeling very positive about the experience. These projects, although seemingly no less intrusive in providing direct care to the residents, are valued by staff when they are projects that are chosen by the staff and present opportunities for greater flexibility, creativity, and self fulfillment.

Theme #2: Manager Relations

Discontentment

It seems that relationships between staff and their managers can be best described in terms of a continuum of the manager's level of direct involvement with the professional practices of the healthcare professionals they oversee. At one end of the continuum, there are managers who directly involve themselves with professional practice and through their decisions and actions have a significant impact on the quality of work life for staff who are under their charge. At the other end of the continuum, there are managers who remain largely disconnected from professional practice unless there is an issue or a concern that arises that requires them to intervene. Through their limited involvement with staff who report to them, they may also be impacting quality of work life for those individuals.

Despite the fact that many of the participants indicate being able to work autonomously when it comes to how they schedule their day, they also explain how the decisions and actions of their managers can play a significant role in influencing the

atmosphere of the particular setting in which they work. The situation that was most consistently described by participants can be characterized as one of unrest and low morale. In many cases, it is the managers who are seen as critical to work related problems.

> I work with a small group where there are a lot of personality clashes and often there is a total lack of respect. Well, things with co-workers have never been good. So I think that's when you have to blame the manager.
> (Healthcare Professional # 6)

> But there are managers; their Human Resource file is this thick because they are so abusive to their staff. For years, they've been treating people so bad that their staff go off on sick leave and nothing is done about that. That is a message loud and clear to your staff, we don't care about your quality of work life. So that is very demoralizing to staff. (Healthcare Professional # 9)

> We used to do more things as a department and now people aren't as content in their jobs really. People don't want to socialize, you know, there's a lot of unrest so to speak….Um, well, it's due to the manager, right?
> (Healthcare Professional # 10)

> We have a professional practice leader but my understanding is that she is only to deal with issues of professional practice whereas my manager is supposed to resolve conflicts and I have a conflict with my manager. I would like managers, especially my manager, be accountable for how they act and treat all of their employees. (Healthcare Professional # 3)

While some of the participants readily shared their concerns about the lack of cohesion that exists among staff, others were hesitant to talk about their concerns on tape. However, the comments they provided also suggest that managers are believed to be at the centre of the problem when it comes to low staff morale. Perhaps, their reluctance to elaborate on this issue stems from a fear that if their identities are revealed, these particular comments may cause even more friction between certain managers and staff.

> You know what? It (the staff Christmas party) has also become political. I don't think you need to waste time to go to that. That's my opinion. I've just seen that

> kind of decline in accommodating staff that kind of way. That's why I feel, but it's nothing that I can indicate for the tape. (Healthcare Professional # 4)

> And, yeah, they have their barbeques and whatnot. We have like, if you want to, you can go can go to like, the Christmas dinner or New Years Ball, but our unit doesn't really participate in stuff like that just because the morale on our unit is so low. I don't know, maybe I shouldn't elaborate on that part. (Healthcare Professional # 5)

For some participants, the discontentment with managers comes from a perception that some managers' treatment of their employees is characterized by inflexibility and inequality.

Inflexibility

Managers, as well as the organization's administration, are perceived as being inflexible when it comes to accommodating working hours, requests for part-time work, and access to educational opportunities. This perceived inflexibility translates into a decreased quality of work life for some participants. Some participants are looking for a greater work life balance through a reduction in work hours. Other participants indicate that their quality of work life would be enhanced through greater access to courses and other educational opportunities.

> You know, with jobs changing and different hours, and being expected to be flexible. You know, they used to talk about quality of work life as being really important and now it seems they are taking it away. Instead of saying you know, if people want to work part-time we'll see what we can do, now it's don't even ask to work part-time because it's considered a huge privilege and it's not going to happen for any new staff. (Healthcare Professional # 10)

> Yeah, I asked if I could job share. I know others who have asked as well and the answer has been no. And I think for a place that hires mostly women they should be more open to things like that because I wouldn't leave it….So with something like that they should look at the whole picture of what actually makes people happy, rather than just offering things that they think will make people happy. Listen to what people have to say and then you wouldn't have us so burnt out. (Healthcare Professional # 7)

> Oh her (manager) definition of quality of work life is according to her. So whenever it's convenient for her, whenever it suits her, she will allow you to do something. Like I come in early and I'm afraid to leave, like I normally come in at 8:00 or sometimes I come in at 7:30, I'm afraid to leave until 4:00 even though I should be leaving at 3:30 (Healthcare Professional # 3)

> Managers can do whatever they want without rationale; they don't have to give rationale. They can just say, "This is the way we want it." And so certain (staff) have a lot of leeway in their hours of work or what kind of courses they can go on and how they can spend their day. And others have no flexibility. And it's all at the discretion of the manager. So if there's a personality conflict or if there's issues, there is nobody to go to to support you. (Healthcare Professional # 9)

> Personally I would prefer her to be a bit more flexible around things involving education for us to be able to attend. That's quality of work life, right? I mean it's all work related. So with that the organization benefits. I mean professionally speaking; it's good for (the organization). So if she was supportive of that type of thing it would be better. The way it is now doesn't make me want to stay. (Healthcare Professional # 2)

Inequality

Some participants suggest that managers can be unequal in their treatment of certain staff. This disparity is believed to impact quality of work life and is attributed to the decline in staff morale. Inequality is considered to occur in two types of circumstances. First, certain managers are believed to be giving unequal treatment to staff who work in the same working unit or discipline, resulting in better schedules and other privileges. Next, individual staff can be treated differently from other staff, either within their own discipline or separate disciplines, depending on which manager they report to and how these managers vary from one another. Both of the situations described result in staff feeling that a certain degree of unfairness, and even favouritism, exists.

> There are some really close relationships with managers, like friendships. Which isn't really, you know staff shouldn't see that. That's wrong, you know, to see friendships with managers. And there's special considerations given to some people and not to others. I just think there needs to be more consideration given; you've got so many people doing a good job. There needs to be some sort of

> equality in it. You don't want to make somebody feel bad, which is exactly what ends up happening. (Healthcare Professional # 10)
>
> I think it depends, because I know people who have wanted to go part time, and they weren't able to. I think it all depends on your manager. (Healthcare Professional # 13)
>
> Basically with program management there are different managers and everybody reports to a manager. So depending on your manager, you're treated certain ways. So you could have you know, three OTs, three rec therapists, three physios all being treated completely different from their own colleagues. So and that's not right. You are at the mercy of that person. (Healthcare Professional # 9)

Disconnection

As previously mentioned, at the opposite end of the continuum from managers who directly involve themselves in matters of professional practice are those managers who only concern themselves with practice when problematic circumstances arise. Although this type of hands off approach does not seem to be met with as much criticism or resistance as the alternate approach, there is a clear indication that it results in some participants feeling disconnected from their managers. This disconnection brings with it the potential that staff will perhaps end up feeling isolated within their work environment and unsupported when it comes to matters of professional practice.

> Unless I'm having a great deal of trouble with a patient and she has come in then she is not usually involved. My supervisor is not someone that I see regularly. My supervisor oversees a lot of different staff in different professions so she is not involved with things so closely in our profession. (Healthcare Professional # 11)
>
> Yeah generally they've got too many people and they probably don't even notice your feelings. But I think there is a role there for them to do that. I think they should. I mean, they should provide regular forums to see if all is well or to ask how things can be. (Healthcare Professional # 1)
>
> With like managers, it's generally only if there is stuff not happening, that's when I'll hear from them. Like I said, the residents are pretty vocal. I mean I don't know if they pass it on to the managers, but we don't get that back.

(Healthcare Professional # 13)

Lack of Recognition

The study participants appear to have a need for recognition for a job well done or for some expression of appreciation for their years of service. However, they admit that the recognition that they are seeking is not forthcoming from their managers.

> There are many days that we stay beyond 3:30 and stay until 4 o'clock or 4:15 just to get that chart in order, just to have it put into the computer so that the patients can have the best care possible. And it's taken in stride and nobody recognizes it. We can tell our manager but it just gets brushed off. It's like, "you guys take long breaks anyways". So you know, we are not appreciated and it sucks. (Healthcare Professional # 5)

> What I'd like to hear from my boss is that you're doing a really good job, not a thank you for doing this on certain things, but just to one day, "You know what? You're really doing a good job." (Healthcare Professional # 3)

> But I think we could do more in terms of giving positive feedback….I think sometimes we only hear the bad stuff and seldom do we hear about the things we do really well. (Healthcare Professional # 11)

Furthermore, formal recognition events designed to show appreciation to staff for their years of service to the organization were criticized by participants for missing the mark.

> We just need somebody to tell us how great we are doing. My (co-worker) has worked her for over (several) years, and for his (milestone) year they gave him a choice of a watch, a clock, or a grill (and he hasn't) gotten yet. That was about six months ago. (Healthcare Professional # 5)

> Let me tell you about recognition. So I went for my (number) year dinner and you receive a gift. All the senior management stood at one side talking to themselves. They had a drink of wine and stayed with themselves. The invitation came from the CEO and I was rather excited about going to it. You know (number) years is a long time to spend at a job. And he's not even there. And then they all sit at their nice little round table and have a nice dinner and they get up because they have to hand out the gifts. So they hand out the gifts and I get an empty box because they didn't receive my order. And it takes four months to actually receive my watch

> which is the worst quality you could have ever imagined. So that's what happens at the (number) year recognition event (Healthcare Professional # 10)

Avoidance of Care

Regardless of the reason for the tension that exists between certain staff and their managers, the consequence of having staff who are either discontented or disconnected can be a lessening of the quality care provided to the residents. It is understandably challenging for staff who are feeling stressed out and demoralized to be in a frame of mind that is conducive to providing quality care to the residents. Therefore, it should be of little surprise to discover that tenuous relationships between staff and their managers can result in the inability of staff to carry out the aspects of their job that require them to be both focused and positive, as is the case when it comes to providing quality care to the residents.

> But we have a co-worker, she is stressed out and she hates her manager, she doesn't want to work on the unit, she just doesn't want to be here. (Healthcare Professional # 13)

> If I had sort of a terribly stressful day due to her (manager), I may avoid patients or I may avoid particular patients that I've had a confrontation with in the past. I may not want to visit with them as long as I really think I should. (Healthcare Professional # 3)

> This isn't me, but I know of a co-worker who has been brought down so far by the manager that you just can't leave your office. You know, you just can't go out there and talk to them (residents) because you feel too low. And that's happened to a few people. They find it hard to go and work with residents when they feel as bad as they do about themselves and their job. (Healthcare Professional # 10)

Theme # 3: Professionalism

Professional Identity

The healthcare professionals who participated in this study work on an interdisciplinary healthcare team and bring a particular skill set to the team through their education and experience. For many, their role on this healthcare team, along with their specialized knowledge and training, helps to shape their identity as professionals. It appears that their strong affiliation with their particular discipline helps them to feel both competent and confident in their roles.

> But my main focus now is I'm a practitioner, I'm a (healthcare professional) and I will do things that I think are right. (Healthcare Professional # 3)

> I feel as an employee in this setting, it's different from being in an acute care hospital, in this setting you have your professional job but you're also part of the team. (Healthcare Professional # 1)

> The majority of us have worked in many, many different institutions, and we carry that experience with us. So we bring that experience here and it's just fantastic to see us at work. (Healthcare Professional # 5)

> I have a job. I have a career that's very important and the work I do is important and people rely on it. But I'm more than just a (healthcare professional) that works at (this organization). (Healthcare Professional # 9)

It seems that the professional identity some participants have is so important that they begin to feel isolated when they are not able to work as closely as they would like with their professional counterparts. The quote below illustrates that when participants do not feel connected with others from their healthcare discipline they might begin to feel as though they no longer have a professional voice:

> But for the rest of us, that's how they really want it because it's like a divide and conquer thing. We've lost our voice as professionals. And we try and have committees where we can get together all the different disciplines and talk about

> our common issues because we all have the same issues. But even those, they don't end up being that kind of a forum. (Healthcare Professional # 9)

As healthcare professionals establish their professional identities, they are perhaps more apt to feel that they bring certain skills to the workplace. They also believe that the skills they have to offer will translate into better quality care for the residents with whom they work. In this sense, they establish themselves as the experts of the particular kind of care that they are providing.

> So I enjoy the assessment process that goes on and learning if there is any way that they can be helped by my specialty. (Healthcare Professional #1)

> I think if anything that I try really hard to respect whoever it is that I'm working with, remembering their dignity….. And I think that I'm, like I'm happy with my approach. (Healthcare Professional # 12)

> (It) makes me feel that I give professional care. And I think that all the professionalism that I've been taught, really I could be taught it but you also have to have a sense of doing this job. (Healthcare Professional #3)

Professionals Rise Above Adversity

As professionals, participants describe the responsibility they have to not let adverse working conditions impact the care they are there to provide. Therefore, they feel that they must overcome adversity and be professional enough to find ways to meet the residents' care needs and enhance the residents' quality of life, even if their own quality of work life is being threatened.

> I don't think we will let changes affect the end result that we do for our clients. It's more the day-to-day aggravation. It's our quality of life….because we work twice as hard or do whatever, overcompensate as much as we have to in order to get things done. (Healthcare Professional #9)

> I think it is my own responsibility to do whatever I can in that way. I have to be professional enough to not let other things get in the way of meeting the residents' needs. (Healthcare Professional #6)

> I don't think it's the residents that suffer because they're number one. Things for the residents happen and nothing is going to interfere with that. (Healthcare Professional # 10)

Professionals View Residents as #1 Priority

Valuing the residents is a vital aspect of being a healthcare professional in a long term care facility. The belief that the needs of the residents are a top priority seemed to resonate with each of the participants. Therefore, it should come as no surprise to learn that participants consider providing quality care as their primary focus and they believe the care they provide is top quality.

> The patients are important right this minute. One good thing about this unit that I love being a part of is that we are damn good (healthcare professionals). And I say that because we are passionate about what we do, I mean when it comes to patient care, that our patients are taken care of, getting our work done, getting it so everybody is happy, and making sure that everything is sort of tip top. (Healthcare Professional # 5)

> I'm at that point now where my main focus is my patients and their quality of life. (Healthcare Professional # 3)

> Like I enjoy working with the residents so having good relationships with the family members and then, you know when you, it can justify to me why I put myself through it all. Why I struggle and why am I not working somewhere else. Well, it's because I enjoy the people I'm working with and the people I'm here for. That's why we're here. (Healthcare Professional # 9)

> I enjoy it. I feel very comfortable with the residents. I enjoy being with them. I feel good when there is something I can do to make their lives a little better. It is very positive for me. (Healthcare Professional # 8)
> Sometimes I think I would like to do more for more people. But the quality that each person is getting at the bedside is the same. And that's really what we're here for. (Healthcare Professional # 9)

> I think that I provide good care, because I actually put my patients first. Every patient that comes in, I try to get to know each patient, like they are not patients to me, a lot of them I consider friends. (Healthcare Professional # 13)

Theme # 4: Social Support Networks

Breaking Down Barriers and Bridging Disciplines

It seems that one of the most valued aspects of QOWL initiatives and other informal social engagements is that they provide opportunities for staff to interact socially. Participants explain that opportunities to get together socially help to foster relationship-building among staff. As these relationships are strengthened through social interactions, coworkers develop a sense of trust for one another which they feel translates into improved working conditions. Without such opportunities, it seems social interactions between health disciplines would seldom occur since working in a large facility can make it difficult for staff from different disciplines to meet others with whom they do not closely work. Therefore, activities that are designed to promote socialization seem to be the best way to break down any barriers that might exist and help contribute to a more unified healthcare team.

> It makes a big difference if you can get employees from various disciplines together in a setting that's not necessarily crisis intervention or you know problems at work. That you can get them there to get to know each other and socialize….And it helps you see the broader picture of where you work. It gives you a feeling that you're part of a larger, group effort and that you're not just battling on your own. (Healthcare Professional # 1)

> And then going on to the unit the next day and nurses know who you are and they greet you with a smile and then you have something to talk to them about, something other than work stuff. I find that really improves working relationships among staff (Healthcare Professional # 11)

> It's the social component, you know, when I went out with them (co-workers) and played with them. Now when I see them at work it's not just 'Hi, how are you?' It also helps with the trusting relationship because now I know this person better and I can share stories even in the work place. That to me is very - it energizes me you know – energizes the spirit. And, you know, and then the working environment is different. It's 'Oh, I'm going back to work and I'm going to see people that I had a conversation with last night'…. I think staff would still do their work professionally but I think when there is a relationship, when there is

> some kind of social, personal, trusting relationship, there is more to work than just business and just saying, 'Hi, how are you?'(Healthcare Professional # 8)

> I appreciate that it is a mix of age and professions and culture. And I think when you can get together socially; all kinds of barriers come down. And I really think it's very, very enjoyable. You see, I don't have the opportunity to interact that much with say the nurses, so it's wonderful to be able to do that. I think it's good also to get away from the organization and interact with each other socially. (Healthcare Professional # 11)

> But it's more that you've sort of known that person and known the discipline that they're in but now you have a better sense of who they are. So afterwards you're more apt to say hello in the hallways and ask them about their day. (Healthcare Professional # 12)

Working as a Team

In a long term care environment where healthcare professionals work on interdisciplinary teams, the importance of effective team work can not be overstated. The following quotes not only reflect a strong affiliation to the healthcare team to which they belong, they also reflect a certain amount of personal gratification that comes from team cohesion.

> I have amazing colleagues. I have amazing people who work on the team. They give me the quality of life for me to keep going in my work. (Healthcare Professional # 3)

> Working together, team work, and communication. When there's team cohesiveness and people are working together then your day is smoother and your day is happier. (Healthcare professional # 7)

> The newer professionals, they bring their experience, they bring their knowledge, special knowledge to the team, and it's fantastic to see us at work. (Healthcare Professional # 5)

In addition to the personal gratification that participants derive from working as interconnected team members, there also seems to be an acknowledgement of the carry over value that this team work brings to the residents by way of improved care provision.

As the quote below illustrates, quality of care is often enhanced through effective team work:

> We work as a team. And from that we're able to meet the standards. We're able to meet the residents' expectations. We're able to demonstrate the philosophy of (the organization). So working together as a team has made it very, very effective to patient care as to what the organization is expecting of us.
> (Healthcare Professional # 4)

Supportive Relationships

As previously discussed, there are many different stressors associated with working in healthcare settings. These stressors can sometimes make it difficult for healthcare professionals to achieve or sustain a desired quality of work life. The relationships that staff members develop with one another are viewed as sources of strength, particularly in times of increased stress. Participants explain that when they are able to seek support from coworkers, they begin to feel that they are not alone with the difficulties they encounter in the workplace. For some participants, receiving support and encouragement from coworkers enables them to rise above adversity and find ways to persevere when work situations become particularly challenging.

> Well there are people that I can talk to, where we can go to our office and vent. Or we can talk to other team members that go through the same things and they're there and they know what's going on, so whatever it is. If it is patient related or boss related, there are people you can talk to. (Healthcare Professional # 9)

> Like I know if other staff say, "Oh you know, I had the same problem with Mr. Smith". So it's good to know that you're not alone in the difficulties that you're facing. (Healthcare Professional # 12)

> Certainly if I have a problem with a particular resident and I can't sort out what to do or how to deal with it, my coworkers are great resources. Also just to vent, just to say what I've done, have I done the right things, can I do anything more, something like that. (Healthcare Professional # 1)

> You know it's just the opportunity for mutual sharing. If I didn't have the people here at work that I have to speak with and vent to – people who I know are genuine people, then I would have been gone long ago.
> (Healthcare Professional # 3)

> The people I work with, I have been working with a lot of them for like five, six, seven years so a lot of them I would consider friends, where some of the other people that don't necessarily put themselves out there and aren't accessible, I consider them co-workers. It's just like "hi, bye" but other people I will go out of my way, to stop chat or even to go to if I was like stressed about something, or whatever, so I would feel obviously more comfortable to go to somebody like that than someone I don't really spend any time with except talking about work.
> (Healthcare Professional # 13)

> Oh yes, as I say they impact my work, if I'm having a difficult day, the other staff will come and assist, yes….We get a lot of support from each other, you know.
> (Healthcare Professional # 4)

Source of Recognition

Earlier in this chapter, it was noted that coworkers feel they can not always rely on their managers to provide them with the recognition that they are often seeking. However, it seems that coworkers might be able to fill the need for recognition when they take time to recognize and appreciate one another.

> The residents and their families tell you. They tell you flat out. It's the residents that you and it's your immediate staff. I also think you get a lot from your co-workers and I think it's really meaningful from your coworkers. (Healthcare Professional # 10)

> One of my co-workers and some of the staff on the unit put together a little biography of me and submitted it. And I got the award. It carried me for a long time. What it signified was huge in my mind. When people take the time to recognize the thing that you're doing, it gives you a rush that is unbelievable. Those kinds of things are huge. I think they can be huge factors. We all need to be told that we're appreciated. (Healthcare Professional # 11)

Theme # 5: Need for Restoration, Humour, and Balance

Participants admit that they often skip breaks, work through their lunches, and have little time in the day for anything other than work related tasks. Despite this, however, they also recognize the need to instil balance in their work day and to have an opportunity to experience some sort of restoration. When left up to the individual, the quest for balance and restoration often gets pushed aside in favour of attempts to be more productive.

Feeling Re-Energized and Rejuvenated

When participants can find the time in their hectic work day to attend QOWL initiatives, they explain that they return to work feeling re-energized and rejuvenated. Participants further explain that without such opportunities, they may begin to lose their focus midway through their work day. More than just quick energizers that fade soon after participation, QOWL initiatives that occur during the work day, such as the RLB, are credited with providing a feeling of rejuvenation that will often stay with participants throughout the rest of their day. This feeling, in turn, helps staff to be more attentive in their jobs and provide more personal attention to residents.

> I feel energized, yeah, especially after the restorative lunch breaks when they've had really terrific speakers. It lasts me longer on those days I can tell you, it does. They had a fellow; I forget his name, a fellow who is a wheelchair athlete. And you really felt that if he can do what he did then the small tasks we have to do in our day are certainly manageable. So, I do feel I get something from that, and it's a few things, it is talk related and it's the opportunity to interact with some of the other staff. (Healthcare Professional # 11)

> Yeah, after I go back to work and I'm visiting with the residents, I find the energy stays and it helps me as far as my work goes. I am more attentive, more focused and I think I bring this when I visit with the residents….Personally, to me it re-energizes me. I find them relaxing and re-energizing. Recently at a RLB, we had a motivational speaker and it inspired my work and what I do. It helped me to assess my own performance, you know, how I do my job. And I talked about that

> speaker with the veterans. It reminded me about what is important. To me, relationships with the residents and with the other staff, that is what is important. (Healthcare Professional # 8)
>
> You know what I find when I go to things like that, that keep me awake, I actually go back to work feeling more energized than I than I usually do. Sometimes after lunch I end up feeling really, really tired and kind of like I am running out of steam by the time lunch is over. I can barely keep my eyes open. And going to something like this, where it is active, and you know you are interested in what they are saying, you know it kind of wakes you up, so I come back feeling more energized, which helps me get through the rest of the day. (Healthcare Professional #13)
>
> It's just being able to sit back and listen and the person can be entertaining but I also like learn something new. For me, if there's anything I miss about finishing school is that I miss the courses and just listening and learning something new from someone who's very enthusiastic about what their topic is. And especially if the speaker's good, then that's nice too. I find that life here can get really hectic so it's just nice to sit back and relax. (Healthcare Professional # 12)

Finding Humour in the Day

In a workplace that is commonly characterized as being fast paced, demanding, and filled with stress it may be difficult to find the time to share a laugh among those with whom you work. However, it is because of this fast paced, demanding, and stressful environment that the participants feel the need to be able to find humour during their day. It seems that when staff are able to share a laugh with their coworkers, they are reminded to not take things so seriously. As humour becomes more a part of the work day, it is expected that work related stress will start to dissipate. Therefore, the use of humour seems to provide participants with an effective coping strategy in order to deal with work related stress. Opportunities for humour can be found during QOWL initiatives. Some of these initiatives, such as the RLB's, incorporate humour through the use of a motivational speaker or stand up comedian. With other initiatives, the element of humour is less overt,

but it can be present when staff are able to take time out and stop to share a laugh together.

> Like when (the comedian) came it was just funny, like for an hour we just sat and laughed. You know it gives you some humour in your day and if you've been having a bad day, that's nice. Any time where you can kind of sit back in work and just laugh like that, that's nice. (Healthcare Professional #9)

> You know, just being able to have a laugh in the hallway with some of the people I work with. It's nice to be able to stop and talk to someone and have a laugh in the hallway without having to worry about who's watching.
> (Healthcare Professional # 7)

> It's the humour, the finding the humour within your day. Everyone needs to be reminded of that, not to take life so seriously. (Healthcare Professional # 10)

> I've been to the Restorative Lunch Breaks and I appreciate humour, things that involve humour or if I'm going to get something out of it, like education wise. (Healthcare Professional # 6)

Balance

It seems that one of the most significant benefits that can be provided by the QOWL initiatives is that they give participants a reason to take time away from work and enjoy their breaks. As previously mentioned, without a reason to take a break, which can be provided from participating in a QOWL initiative, many staff will deliberately choose to work through their breaks and lunches. These choices can result in staff ignoring their personal need for balance. Therefore, it seems that it may be necessary for some participants to be supported, and perhaps even encouraged, to take a break in order to discover a sense of balance during their work day.

> I think balance within the work day can come from some of these initiatives because they force you, you know they give you a reason to take your break. I think it could be encouraged more, for people to not work through their lunch hour. (Healthcare Professional #10)

> Well I find my lunch hour is very precious so I don't give it up easily, but like I said, I do need a better balance so I try to go to things. I liked the experience of golfing, it was a lot of fun. (Healthcare Professional # 2)

Summary

The five themes described in this chapter captured the many factors that can influence QOWL and the provision of quality of care within a healthcare organization. The first theme, *Work Demands Impact on Care Provision*, highlighted the pressures associated with documentation, the apparent need for selective focusing, and concerns around staff/resident ratios. The second theme, *Manager Relations*, described the effects of staff feeling either discontented or disconnected from their managers. The third theme, *Professionalism*, suggested that a strong professional identity, coupled with skills and competence, brings with it a resilient workforce that places a high value on quality care provision. The fourth theme, *Social Support Networks*, emphasized the importance of socializing to team work and relationship-building among staff. The fifth theme, *The Need for Restoration, Humour, and Balance,* captured the value of rejuvenation for staff who often feel overextended during their work day. A more in-depth examination of the themes will be provided in the final chapter.

CHAPTER SIX

DISCUSSION

Working conditions and the factors affecting QOWL for staff working in the health care sector have received considerable attention in recent years (Koehoorn, Lowe, Rondeau, Schellenberg, & Wager, 2002; Ellis, 2002), but the idea that QOWL initiatives containing elements of recreation and leisure can have a potential impact on QOWL for this group and perhaps even quality of care has been virtually unexplored. This study examined both QOWL initiatives and perceptions of quality of care using an inductive, grounded theory approach.

The purpose of this study was to examine the experiences of both QOWL and quality of care from the perspectives of staff members who comprise the healthcare team and who provide direct care to the residents in Aging and Veteran's Care. The findings from this study support previous findings which suggest that contending with stressful situations in the workplace is a common occurrence for health care professionals (Callaghan, Tak-Ying & Wyatt, 2000; Jinks & Daniels, 1999). These findings also extend the conceptual framework of QOWL beyond the notions of stress, work load, and time pressure dealt with in previous research. The interpretive nature of this study allowed the exploration of the extent to which participants experience stress during their work day, their perceptions of participating in QOWL initiatives, and the rewards and challenges of providing quality care to long term care residents in a large, fast paced healthcare setting.

The discussion in this chapter will begin by reflecting on the themes and how they relate to each other. It will also explore how these findings relate to previous research, including the extent to which these findings support and are consistent with previous

research. Significance and limitations of the study will also be discussed and consideration will be given to suggestions for future research.

Responding to the Research Questions

Before engaging in a deeper examination of the themes, it is important to re-visit the research questions that guided this study. As stated in chapter one, this study was designed to address the following questions:

6) How do staff members experience their work environment in terms of stress, work load, time pressure, and work-life balance?
7) What is the experience of staff relative to QOWL initiatives?
8) How do staff members perceive their managers in relation to supporting their involvement in QOWL initiatives?
9) What role can leisure play in helping to shape QOWL initiatives that aim to reduce work related stress and promote work-life balance?
10) What is the perception of staff regarding the quality of care they provide and to what extent do they feel it is influenced by QOWL initiatives?

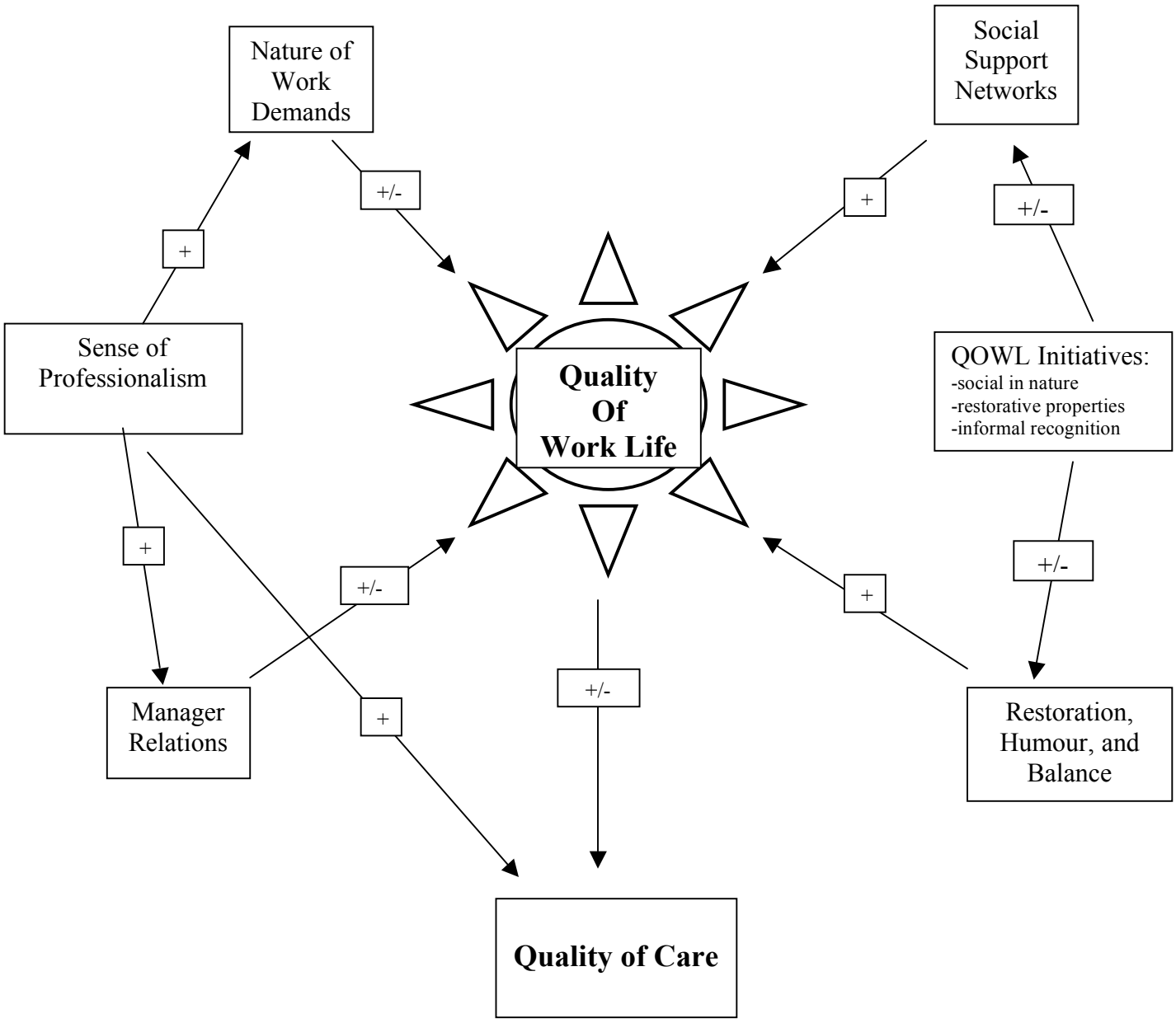
Each theme that has been presented helps to illuminate certain aspects of the above questions. For example, while addressing the first research question, it was discovered that the work environment can be characterized as one in which work demands are often time consumptive and stress inducing. Through responding to the second research question, the data helped to reveal that QOWL initiatives can provide staff with much needed opportunities for restoration, humour, and balance during their work day. These initiatives also promote occasions for staff to socialize and establish

connections and relationships with their co-workers. With response to the third research question findings indicated that not only can managers be perceived as non-supportive of QOWL initiatives; they can also impact QOWL on a broader scale through some of their decisions and actions that impact the working environment. Findings that respond to the fourth research question suggest that the recuperative and restorative properties that are often associated with leisure can help shape QOWL initiatives and help staff attain benefits linked with socializing and finding balance during their work day.

Some insight into staff perceptions of the care they provide was evident throughout each of the themes. Staff identified some of the ways that work demands have impacted the care they are able to provide. They also pointed to tensions that can exist with managers as possibly influencing the level of care they provide. At the same time, the sense of professionalism shared by staff was perceived as fostering an ability to overcome stressful or adverse working conditions in order to provide quality care. The establishment of social support networks translated into improved working relationships that positively affect care provision. Finally, as the needs for restoration, humour, and balance get addressed, staff described being more attentive in their jobs and able to provide more personal care to residents.

The diagram below (see Figure 1) depicts the relationship between the five key concepts and how they are perceived to impact both QOWL and the provision of quality care.

Figure 1


Nature of Work Demands
Social Support Networks
+/-
+
+
+/-
Sense of Professionalism
Quality Of Work Life
QOWL Initiatives:
-social in nature
-restorative properties
-informal recognition
+
+/-
+/-
+
+
+/-
Manager Relations
Restoration, Humour, and Balance
Quality of Care

Bridging the Themes: The Paradoxical Nature of Work in Healthcare

The themes that emerged from this study reflect the paradoxical nature of work within a healthcare setting. The participants all expressed concerns about work demands and time pressures and indicated that these factors can detract from the provision of care. However, the participants' desire and willingness to take on extra projects over and above their regular work functions suggest that any additional time spent engaged in tasks deemed to be personally rewarding is not generally perceived as an impediment to care. It may be that participants perceive time spent engaged in special tasks and research projects as contributing to their professional growth and sense of accomplishment. Moreover, they may see this as a way to regain a sense of control over their work and find a balance during their work day. Perhaps when participants feel more balanced and fulfilled with their jobs, they begin to feel better and the standard of care they are providing.

The paradoxical nature of work is also evident in the participants' descriptions of the care they provide. Their descriptions reflect the notion that, as professionals, they can rise above adversity in their work day to ensure residents' care needs are being met. There is also an acknowledgement that the residents are valued as a top priority and the quality of care being provided reflects the significance placed on resident needs. However, despite the assertion that professionals can rise above adversity to provide quality care, participants describe situations where a perceived decrease in their own quality of work life can also lead to a perceived sense of lessening care. Perhaps in situations where quality of work life is being compromised, participants feel less optimistic about their role in care provision. Therefore, it may not necessarily be a matter of diminution of care, but rather a decreased feeling of enthusiasm and self assurance in

their role as care providers. In other words, staff may be doing a good job when it comes to providing care, they just may not feel as though they are doing a good job during stressful times when they feel their quality of work life is being jeopardized.

Another paradox of work in healthcare exists in the expressed need for balance and restoration during the work day. When left up to the individual to schedule and prioritize their own work day, it seems there is a low priority placed on taking time away from work and finding opportunities for rejuvenation. Participants explain that they deliberately and frequently skip their breaks and work through their lunches. However, the need to find balance and restoration in the work day was readily expressed by participants. Therefore, QOWL initiatives can be a welcome rationale for staff to take time away from work and enjoy a much needed break. Since they are professionals, the participants likely feel a deep sense of commitment to the work they do and working through breaks and lunches may be their way of demonstrating this commitment. It is also plausible that as they gain more job autonomy, participants feel more responsible for their individual work practices and therefore feel the need to work longer and harder to get their work done. However, as they begin to feel overworked and time pressured, participants have a need for support and encouragement in their attempts to find balance and restoration. QOWL initiatives seem to signify to the participants that it is okay to take a break and get recharged.

The themes discussed here suggest that there are aspects to the work that can have either a detrimental impact on QOWL or can contribute to enhancement of QOWL. Detriments include a stressful, fast paced work environment, a lack of support and recognition from managers, and demanding work schedules. At the same time,

participants identify factors inherent to their jobs that provide them with a sense of pleasure and fulfillment. For example, they explain how interesting work projects, supportive co-workers, opportunities to re-energize and rejuvenate, and the recognition they receive from residents and families play an important role in enhancing their overall QOWL.

The intersection of the themes with Patient Focused Care

In addressing staffs' perceptions of the quality of care they extend to residents and whether, in their view, this is affected by the QOWL initiatives, it is necessary to consider the emergent themes in relation to the philosophy of care espoused by the organization. Patient focused care (PFC) has been integral to nursing practice at this organization since 1995 when it was established as core to nursing philosophy and standards (Spee, Chua, & Nose, 2001). Since then, other health care disciplines have embraced this philosophy through the PFC courses that are continuously being offered (Mitchell, Closson, Coulis, Flint, & Gray, 2000). Some research has been carried out at this organization to better understand healthcare practice in relation to the tenants of PFC. Specifically, the Recreation Therapy Professional Group participated in an action research project aimed at understanding their assessment process from the perspective of both the patient and the therapist in order to discover the ways the assessment process was congruent with PFC (Hornibrook, Pedlar & Haasen, 2001).

Guided by Parse's theory of human becoming (Parse, 1996), PFC calls for a change in values, beliefs, and actions of all staff. PFC suggests that quality of care will improve if professionals relinquish control and facilitate patient and family involvement in discussion of options and choices about care (Mitchell, Closson, Coulis, Flint, & Gray,

2000). Therefore, patients are encouraged to become the directors of their own care and ultimately of their own health.

Rather than approaching care with information on a person's functional and psychosocial abilities and limitations, PFC encourages health care staff to uncover the meanings, values, hopes, and dreams revealed by individuals in their personal health descriptions (Mitchell, 1990). When health care staff begin to view a patient as a person to be with rather than a problem to be solved, their care recommendations start to reflect what the individual actually wants in terms of healthcare (Mitchell, 1992).

It is useful to look at the findings of this study in relation to PFC because at the root of PFC lies the ability of healthcare staff to be present, to listen, and to explore options for care with their patients. On the one hand, it seems questionable whether healthcare staff who are feeling overextended with respect to workload and who are finding it necessary to work through their breaks just to stay on top of everyday work tasks can find the time required to uncover the meanings, values, hopes, and dreams described by Mitchell (1990). On the other hand, the idea that staff are receptive, and often eager, to undertake research initiatives has undoubtedly led to the facility wide adoption of the PFC philosophy in the first place.

Another potential impediment to practicing PFC may be the professional identity that some healthcare staff seem to firmly hold. Perhaps the more healthcare staff believe that they have specialized skills and knowledge that are necessary for care provision, the more inclined they will be to feel as though they are the drivers and the experts of care. The stronger the professional identity, the more difficult it may be for professionals to relinquish control over the care that is being provided. Yet, the idea that the residents in

Aging and Veteran's Care are valued and considered to be a top priority might provide the impetus for healthcare staff to direct their approach towards establishing a better rapport with residents and a deeper understanding of individual care wishes.

Social Capital in the Workplace

Social capital has become a popular topic in recent years and researchers are increasingly interested in its linkages with health (Lochner, Kawachi, & Kennedy, 1999; Kawachi, Kennedy, & Glass, 1999). Although it is commonly assumed that social capital influences health, relatively few studies have examined this idea within the context of the workplace. However, some researchers maintain that social capital is an important contributor to both QOWL and employee health. Veenstra (2000), for example, found frequency of socialization with coworkers to be positively related to overall health. Requena (2003) used the dimensions of trust, social relations, commitment, communication, and influence to measure social capital in the workplace and discovered that higher levels of social capital can lead to greater levels of satisfaction and quality of life at work. Liukkonen et al. (2004) also investigated social capital as a workplace characteristic that can potentially affect employee health and determined that a high level of social capital existed for people who had a high level of co-worker support. Their findings indicated that high levels of social capital were associated with better self-rated health for employees.

Although not explicitly examined in this study, the idea that social capital in the workplace is linked to employee health can help to further understand the findings. The importance of social support networks to staff members is a prominent theme of this study. Participants describe trust and social connections as an integral part of the

relationships they have with their coworkers. They also explain how these factors enhance their QOWL and overall work satisfaction.

Central to the theme of social support networks is the idea that participants value the supportive relationships they have at work. These relationships are especially helpful in times of increased stress and adversity. In their study, Garrett and McDaniel (2001) found that social networks in the workplace are significant during times of change and uncertainty in the work environment. They concluded that a supportive work environment can protect staff against stress and burnout.

It has previously been noted that job stress and burnout have a negative impact on the health and well-being of healthcare staff (Callaghan, Tak-Ying & Wyatt, 2000; Jinks & Daniels, 1999; Ellis, 2002; Haggstrom et al., 2004). However, Liukkonen et al. (2004) have found that there can be a strong association between co-worker support and good self-rated health. The association between the presence of support networks and health is further supported in the present study, as the social support received from co-workers is being readily acknowledged by participants as a contributor to their QOWL. Participants acknowledge QOWL initiatives as opportunities to break down the barriers that exist between disciplines and broaden the connections they have with others on the Healthcare Team. The bridging of healthcare disciplines and strengthening of co-worker relationships that are based on trust and support that develop when staff are presented with occasions to socialize in an environment that is not strictly work centered. Furthermore, through the strengthening of such co-worker relationships, staff can become the recipients of acts of recognition that stem from staff showing their appreciation for one another. Such findings suggest that social capital acquired through the exchange of

trust, social support, and shared appreciation among co-workers may indeed be crucial to the health and well-being of healthcare staff.

Significance

The findings in this study are significant in that they provide insight into the complexity of work in healthcare settings. Furthermore, they show that there are many factors that can potentially impact the QOWL for healthcare staff. This study also supports the idea that the well-being of the healthcare workforce merits serious consideration by healthcare decision-makers. Each of the themes presented in this study can have practical implications when it comes to finding ways of enhancing QOWL for healthcare staff.

The first theme, *Work Demands Impact Care Provision*, is important because it addresses concerns that staff may have about being pulled in too many different directions. These concerns, they feel, subsequently impact the quality of care they are able to provide. Although certain work demands will naturally accompany work in the healthcare sector, healthcare decision-makers should be especially aware of the time pressures placed on staff and the potential impact this might have on care provision.

The second theme highlights the notion that manager relations can be characterized by discontentment and disconnection. It is not uncommon for tenuous relationships to exist between healthcare staff and their managers as a result of changes and restructuring that culminate in the downsizing or merging of departments and the redesigning of roles and responsibilities (Blau, Bolus, Carolan, Kramer, Mahoney, Jette, & Beal, 2002). However, issues of inequality, inflexibility, and insufficient recognition may be deserving of special attention. It seems there may also be a need to look more

closely at the issue of disconnection associated with manager relations that was found in this study. When managers are responsible for the supervision of staff from various disciplines, staff may end up feeling as though they are not receiving adequate support when it comes to matters of professional practice.

The third theme, *Professionalism*, describes the professional identity espoused by many of the staff who feel both closely connected with their disciplines and skilled and competent enough to provide quality care. Since, as the findings suggest, a sense of professionalism can bring with it a strong commitment to resident care and an ability to rise above adversity in the workplace, perhaps this is an aspect of staff development that should continue to be nurtured. There is danger however, that the concept of professionalism can be misconstrued, making it seemingly contradictory to the tenets of PFC. For this reason it is necessary to look at the idea of professionalism more closely.

If professional practice is grounded in technical rationality, which interprets problems as being solvable through the systematic application of scientific methods (Schön, 1983; Miller & Pedlar, 2006), professionals may start to see themselves as the drivers and experts of care. As such, they may be inclined to exert too much of their power and control over care provision. If, however, professionals are guided by self-reflective practice, they are better able to respond to the unique and unexpected challenges of their work and view these uncertainties as opportunities to learn and grow (Miller & Pedlar, 2006). As Sylvester (2005) argues, to view professionalism as merely the pursuit of power and expertise is to ignore the traditional understanding of professionalism as being based on virtue and integrity. According to Sylvester, in its truest sense, professionalism involves the pursuit of excellence and devotion to the public

good. Therefore, rather than considering the idea of professionalism as being counter to the PFC philosophy, it should perhaps be considered a requisite for practicing PFC.

The fourth theme, *Social Support Networks*, highlights the importance placed on opportunities for social interaction for staff. Among the benefits associated with socializing are breaking down barriers and bridging disciplinary boundaries, encouraging team work, and nurturing supportive staff relationships. Considering that the frequency of socializing with coworkers can be positively related to overall health (Veenstra, 2000) it may be wise for healthcare decision-makers to further promote socializing as a way to enhance the well-being of the healthcare workforce.

The final theme outlines the need for balance and restoration and suggests that staff are searching for opportunities which will enable them to feel reenergized and rejuvenated and provide them with a sense of balance during their workday. This finding raises two interesting issues that healthcare decision-makers may find useful to consider. First, previous research has shown that employees will often challenge and even reject the role their employer plays as a guardian of their wellness (McGillivray, 2005). However, findings from this study suggest that employees may actually rely on their employer to promote and provide opportunities that will enhance wellness. Second, McGillivary's data also suggest that organizations often discount more passive and collective leisure forms in favour of active leisure, especially in the form of health and fitness. The findings of this study lend support to idea that QOWL initiatives which are designed to provide employees with balance and restoration may be worthy of greater attention. In fact, Trenberth, Dewe, and Walkey (1993) go as far as suggesting organizations committed to promoting employee health and well-being should consider

the benefits of providing recuperative and therapeutic opportunities in a similar manner to providing opportunities for employees to engage in social, physical and health related activities.

In addition to the significance found by considering some of the practical implications that flow from each of the themes, this study is also significant in that it advances the notion of leisure as a means of coping with stress, in particular, work related stress. It has been determined that perceived leisure freedom can interact with life stress in a manner consistent with its being a buffer against the negative influence of life stress on general health (Coleman, 1993). Leisure has also been found to enhance mood and facilitate palliative coping and companionship, which can significantly reduce work related stress and improve mental health (Iwasaki, Mannell, Smale, & Butcher, 2002). This study contributes to the body of literature focusing on the connection between leisure and stress because it shows leisure's influence on QOWL initiatives can provide staff with opportunities to build social support networks and find balance and restoration in their work day. Such experiences can help guard against the effects of stressful conditions in the workplace.

Recommendations for Future QOWL Initiatives

It is clear from this study that QOWL initiatives can provide staff with experiences that are conducive to improving their overall quality of work life. It is also clear that quality of work life can contribute to the perceived enhancement of the quality of care that is provided by staff. Since quality of work life and quality of care are key organizational priorities, several recommendations can be offered to help with the future development of QOWL initiatives.

The most popular QOWL initiatives share the following characteristics: 1) they provide an opportunity for staff to interact socially with other members of the Health Care Team, 2) they address staff needs for restoration, humour, and balance, and 3) they reflect the organization's appreciation for the work staff accomplish. This information suggests that future initiatives will be most effective if they are planned with these specific goals in mind.

It seems there are two types of initiatives that are offered to staff. The first type of initiatives are those that fall under the categories of social and recognition, wellness, awards, and 'other'. The initiatives that are most appreciated by staff are those that are scheduled during the work day and are provided at no cost to participants. Conversely, initiatives with an associated cost may not only deter participants but they also send the message that staff are not being sufficiently recognized by the organization.

The second type of initiatives offered are the informal initiatives that are organized on an ad hoc basis by staff or their managers. These initiatives seem to be more symbolic in nature and send staff the message that managers value the work they do. Such initiatives usually take the form of staff lunches and impromptu celebrations to acknowledge special occasions.

It is worth restating that in a typical work day staff do not make time for activities that are restorative, rather they regularly work through their lunches and breaks. QOWL initiatives, however, can provide staff with a reason to take a break from their work in order to get rejuvenated. A lack of balance within the work day may suggest a need for greater promotion of the intended benefits of QOWL initiatives and for more support and encouragement to be extended to staff in their efforts to participate.

Limitations and Future Directions

It is important to note the limitations that influenced the design of this study and those that were recognized during the process of data collection. By recognizing the limitations, future direction for research can be suggested. With the interpretive nature of this study the findings cannot be generalized to represent the larger healthcare workforce, nor was that the intention of the study. Even among the thirteen healthcare participants some divergent meanings, experiences, and motivations were found. An example of this divergence was demonstrated through individual assessments of work life balance and how it varied in accordance with family responsibilities, time spent commuting to and from work, and whether participants worked full time or part time. Another example of how meanings and experiences differed among participants became evident through the discussion of whether they considered QOWL initiatives to be leisure. For some, the elements of choice and enjoyment seemed to define leisure experiences and therefore they felt that leisure could, in fact, be experienced during the work day. For others, leisure and work were independent; therefore, for these participants, leisure could never be experienced in the context of work.

This study suggests the complexity of work in a healthcare setting and the factors that can impact the QOWL for healthcare staff. The present study, though, was limited to the experiences of staff from one healthcare organization who participated in this study. Although not the central purpose, this study revealed some the rewards and challenges of care provision and demonstrated the impact QOWL initiatives are perceived to have of quality of care. Clearly, there would be a benefit for future research to look more closely at the nature of the relationship between QOWL and quality of care by involving the recipients of care as study participants.

In terms of broader implications, by revealing the paradoxical nature of work within a healthcare setting, this study emphasizes the importance of context for understanding the QOWL experience for staff and the need to look at the many elements present in a healthcare organization that can influence QOWL for healthcare staff. It is important, for example, to not only understand experiences with QOWL initiatives, but also to understand how stress, work life balance, job autonomy, work demands, and relationships with managers and co-workers can all play a role when it comes to impacting QOWL.

In many ways, the findings of this study provide support for previous research on workplace stress in the healthcare sector including such issues as resident-related stressors, the nature and volume of work, management styles, and nature of the general work environment (Callaghan, Tak-Ying & Wyatt, 2000; Jinks & Daniels, 1999). The findings also support the idea that work stressors can adversely affect QOWL for healthcare staff and have a potentially negative impact on quality of care that is being provided (Cohen-Mansfield, 1995; Hannan, Norman, & Redfern, 2001). There is also evidence in this study for the use of selective focusing, described by Williams (1998) as a process used by nurses to cope with the difficulties they encounter in their daily work. In the present study, however, selective focusing is not specific to nursing staff; rather it is also described by other participants who are working within the confines of insufficient time to provide care to chronically ill residents.

This study highlights some similarities between the benefits derived from leisure used as a form of coping with work related stress and the benefits attributed to the QOWL initiatives. For example, a study by Iwasaki, Mackay, and Mactavish (2005)

revealed that leisure can be used as an effective way to cope with work-related stress through strategies involving socializing through leisure and leisure-generated social support, deflecting stress-inducing thoughts through leisure, feeling rejuvenated through leisure, and finding humour and laughter through leisure. Although the participants in this study varied with respect to whether or not they considered QOWL initiatives to be leisure, they described ways in which the QOWL initiatives provided them with opportunities for socializing, feeling re-energized and rejuvenated, and finding an element of humour in their work day.

Although previous research into QOWL for staff working in healthcare has primarily focused on nursing staff, the present study suggests that other healthcare professionals working within the long term care environment may share similar experiences with nurses in terms of contributors and detractors of QOWL. For example, stressors related to work demands, time pressures, and management style did not seem to be more or less significant for the other healthcare professionals than they were for the nurses who were interviewed for this study. Moreover, the rewards and challenges associated with providing resident care were similarly described by all participants, regardless of their affiliated health discipline.

Factors that seemed to set nurses apart from the other participants in this study are autonomy on the job and flexibility within the work day. As described in the previous chapter, nurses do not have the same degree of job autonomy as other healthcare professionals because they must work interdependently with one another to provide resident care. There are also unique challenges associated with working in a profession that provides round the clock care, especially when the peak times for care often coincide

with the breaks and lunch hours of other healthcare staff and consequently end up being the times when QOWL initiatives are planned. Since lack of job autonomy and lack of flexibility can be unique sources of stress for nurses, it may be worth taking a closer at these elements in particular when examining the stressors experienced by the healthcare staff and drawing comparisons between the various disciplines that comprise the healthcare workforce.

Summary and Conclusion

This study provided an in-depth look into the working lives of staff in a healthcare organization. It helped to illuminate some of the stressors associated with working in a fast paced, constantly changing environment where work demands and time pressures are ever present. This study also demonstrated that QOWL should not only be researched in terms of initiatives designed to improve work life for employees. Rather, there are potentially many factors that can impact QOWL for healthcare employees, including the challenges they are faced with during the work day and the nature of the relationships they have with their managers and co-workers. QOWL initiatives, however, can also provide certain positive experiences for staff, especially when they promote the opportunity to socialize and build connections with co-workers and help to fulfill employee needs for restoration, humour, and balance.

Connections between QOWL and the provision of quality care also became apparent through this study. If staff feel their QOWL is being jeopardized they also believe their provision of care may be compromised. However, positive influences on QOWL, which can be provided through QOWL initiatives, can leave staff feeling more confident and encouraged about the care they provide. Relevant to the association

between QOWL and quality of care is the idea that professionalism lends itself to the provision of quality care. Commitment to professionalism can transcend the detrimental forces that impact both QOWL and quality of care.

This study would not have been possible without the willingness of the healthcare organization's administration to open its doors and invite the research to be conducted. I am truly thankful for the opportunity this afforded me. I am also appreciative of the organization's commitment and readiness to search for ways to improve working conditions for employees. In fact, after sharing some of my preliminary findings with several of the administrative staff, I learned that many of these findings are in line with the current thinking within the organization and several advances are already underway to address some of the concerns found in this study. For example, as healthcare organizations face changing technologies that can sometimes make documentation burdensome and problematic, this organization is in the process of searching for ways to make documentation less time consuming and more efficient for staff to complete. It is expected that this change will subsequently lead to less work demands being placed on staff and more time being allotted to direct care provision.

As important as the cooperation of the organization was to this study, much of the credit goes to the thirteen participants who volunteered their time and shared their thoughts and experiences. I can not express how grateful I am that each participant was willing to be forthcoming and share their experiences with me so readily. The richness of the data collected contributed to the depth of the study and for this I am extremely appreciative. I would also like to take this time to commend each of the participants for their commitment to professionalism and their dedication to providing residents with

quality care despite the challenges they may be faced with. As evidenced by the longevity of tenure described in chapter four, a feeling of professionalism can bring with it a longstanding commitment to the organization. This commitment can perhaps be seen as stemming from a sense of pride that is associated with working in a well renowned and respected healthcare organization.

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APPENDIX A – SAMPLE INTERVIEW GUIDE

1. Can you tell me what a typical work day is like for you?
    - What might you do during your lunch break or the other breaks you have throughout the day?
2. What can you tell me about the QOWL initiatives happening here?
    - Why do you think they are offered?
    - Do you feel they are necessary?
    - Why or why not?
    - How do you think information about QOWL initiatives can be effectively communicated to staff?
3. Which of the QOWL programs have you attended?
    - Why?
    - What was that experience like for you?
    - Does this experience carry over to the rest of your day (back on the unit)?
4. Would this experience be considered leisure for you?
    - Why or why not?
5. Has your experience with the QOWL initiatives impacted your relationship with other staff in your department?
    - What can you tell me about that?
6. Has your experience with QOWL initiatives impacted your relationship with staff from the other health disciplines?
    - What can you tell me about that?
7. How do you feel your manager views QOWL initiatives?
    - In what ways does he/she support you in participating in these initiatives?
    - What do you feel your manager's role is when it comes to QOWL initiatives?
    - What role do you have in improving quality of work life here?
8. Previous research has suggested that healthcare staff can experience a great deal of work stress related to resident health, work overload, and time pressure. What does stress look like for you?
9. Can you describe some of the ways you usually cope with stress?
10. What does work-life balance mean to you?
    - How easy is it for you to achieve work-life balance?
    - What do you think could be changed to improve your work-life balance?
11. Can you tell me about any experiences you have at work that you feel help alleviate stress or contribute to a better work-life balance?
12. What can you tell me about your experience of providing care to the residents?
    - How do you feel about the care you provide?
    - What challenges, if any, are there in providing care?
13. Are there some days when you feel that providing quality care is more difficult?
    - What do you attribute to this?
    - How do you feel when this happens?
    - Can you describe ways in which your co-workers support you with this?
    - Can you describe ways in which your supervisor supports you with this?
14. Do you think the QOWL initiatives have impacted the care you provide to the residents?
    - Can you tell me about any particular situations?
    - What sorts of things tell you that you are providing quality care?

APPENDIX B – INFORMATION CONSENT LETTER

Date

Dear _____

I am contacting you to invite you to participate in research about the quality of work life initiatives happening within your healthcare organization. I am a Master of Arts student in Recreation and Leisure Studies at the University of Waterloo under the supervision of Dr. Alison Pedlar. This research will be used for the fulfillment of my degree requirements.

The purpose of this study is to explore staff experiences of quality of work life initiatives. As a member of the Health Care Team, your participation in this study will be valuable and greatly appreciated. As a participant, you will be asked questions pertaining to your work environment, provision of care, and your experiences during the quality of work life initiatives you have attended.

Participation in this study is voluntary. It will involve an interview of approximately one hour in length to take place in a mutually agreed upon location. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences. With your permission, the interview will be audiotape –recorded to facilitate collection of information, and later transcribed for analysis. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation. I may also invite you to participate in a follow up focus group with other members of the Health Care Team. All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study, however, with your permission anonymous quotes may be used. All data collected from this study, including audiotapes, written transcripts, and consent forms will be locked in my office for security.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about your participation, please contact me at (519) 888-4567 ext. 3894 or by email at dbfortun@ahsmail.uwaterloo.ca. You can also contact my supervisor, Dr. Alison Pedlar, at (519) 888-4567 ext. 3758 or email apedlar@healthy.uwaterloo.ca.

I would like to assure you that this study has been reviewed and received ethics clearance through the Office of Research Ethics at the University of Waterloo and the Research Ethics Board at your organization. However, the final decision about participation is yours. If you have any comments or concerns resulting from your participation in this study, please contact the Director, Office of Research Ethics at (519) 888-4567 ext. 6005.

Thank you for your consideration in becoming a participant for this study. I very much look forward to speaking with you and thank you in advance for your assistance in this project.

Sincerely,

Darla Fortune
M.A. Candidate
Recreation and Leisure Studies, University of Waterloo

CONSENT FORM

I have read the information presented in the information letter about a study being conducted by Darla Fortune of the Department of Recreation and Leisure Studies at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be tape recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous.

I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

This project has been reviewed by, and received ethics clearance through, the Office of Research Ethics at the University of Waterloo. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Director, Office of Research Ethics at (519) 888-4567 ext. 6005.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

☐YES ☐NO

I agree to have my interview tape recorded.

☐YES ☐NO

I agree to the use of anonymous quotations in any thesis or publication that comes of this research.

☐YES ☐NO

Participant Name: _____ (Please print)

Participant Signature: _____

Witness Name: _____ (Please print)

Witness Signature: _____

Date: _____