Healthcare Excellence Canada

Excellence en santé Canada

Improving the Care of Older Adults

Promising Practices for Supporting Long-Term Care Provider Resilience

What we heard

This report was commissioned by Healthcare Excellence Canada but researched and produced by the Translating Research in Elder Care Group at the University of Alberta, (Carole Estabrooks, Scientific Director).

Authors

Sandra Young PhD RN CAPM CPHQ is a casual faculty member with the University of Alberta Faculty of Nursing and TREC.

Don McLeod, B.S.W., MA is a consultant working in the public sector and has been supporting TREC as a facilitator and engagement specialist. He has worked in eldercare for 30 years in a variety of roles including on the executive team of a large not for profit seniors organization based in Calgary.

Christina Weise, MPA is the Principal of Weise Insights Ltd and an Advisor to TREC.

Carole Estabrooks, CM, PhD, RN, FRSC, FCAHS, FAAN, FCAN, is a Professor in the Faculty of Nursing and has an adjunct appointment in the School of Public Health at the University of Alberta. She is a Tier 1 Canada Research Chair in Knowledge Translation and the Scientific Director of Translating Research in Elder Care Group.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) is an organization with a relentless focus on improving healthcare, with – and for – everyone in Canada. Launched in March 2021 from the amalgamation of the Canadian Patient Safety Institute and the Canadian Foundation for Healthcare Improvement, Healthcare Excellence Canada has greater capacity to support partners to turn proven innovations into widespread and lasting improvement in patient safety and all the dimensions of healthcare excellence. We believe in the power of people and evidence and know that by connecting them, we can achieve the best healthcare in the world. HEC is an independent, not-for-profit charity funded primarily by Health Canada.

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Table of Contents

Executive Summary

The impact of the COVID-19 pandemic on the those who live and work in long-term care, and their families, is profound. During the crisis, the leadership of Long-Term Care (LTC) homes worked tirelessly to support their staff, while researchers began to describe the lived experience of staff, and evaluate tools aimed at improving staff resilience.

This report describes what we heard during semi-structured interviews conducted with leaders and researchers of LTC homes. Our focus was to learn about the work underway targeting provider mental health and well-being. Our goal was to identify promising practices that may promote personal resilience, team cohesion, and organizational learning which may be used by both policy makers and managers.

Active and visible leadership, overcoming staffing challenges, team effectiveness strategies, cultivating psychological safety, staff recognition and participation in improvement initiatives, as well as providing staff education and wellness programming; were all themes derived from interviews with LTC leaders. The researchers we interviewed were evaluating the effects of moral injury prevention toolkits, staff recognition by the family of people living in LTC psychologically safe workplace cultures, staffing mix scheduling tools, reflection rooms, stress management techniques, staff driven improvement projects, as well as coaching and peer-to-peer support for managers. Recommendations for future research and programming are presented based on these findings.

Background

Not since the 1918 flu pandemic, has the world seen a healthcare crisis on the order of the COVID-19 pandemic. The severity of the effect of this virus on the people living in LTC, families, providers, staff, and administrators, across the LTC sector, has been pervasive. As healthcare providers, we strive for the best experience for people living in LTC, but when the unexpected occurs we can take some solace in knowing we tried our best, with a view to continuously improving and learning. Yet the pandemic presented challenging circumstances for the staff when working severely short with overwhelming workloads, coupled with the fear of infecting their own families at home, or the people living in LTC led to significant distress. Although the medium and long-term impact of this prolonged distress is yet to be determined, we can anticipate ongoing and sometimes severe challenges with burnout and significant effects on mental health and well-being, or in some instances, psychological growth for many staff. Our goal was to identify promising practices that may foster personal resilience, team cohesion, and organizational learning that will assist LTC managers through the longer term impacts the pandemic may have had on their staff.

Methods

We undertook a two-pronged approach, with one of our team members conducting semi-structured interviews with 13 LTC leaders in seven provinces and territories across Canada (Appendix A), while the other team member conducted semi-structured interviews with seven researchers and five knowledge brokers in four provinces (Appendix B), who are currently measuring the effect of interventions aimed at improving the mental health of LTC staff. We also contacted 17 additional researchers in the LTC field, who declined to participate as they did not have any current or past research relevant to the mental health and resilience of care aides. Our interview questions probed for initiatives and processes that have been put in place to support staff in LTC, with a particular focus on care aides.

The term care aide is used throughout this report, recognizing that unregulated provider titles and roles vary across provinces (personal support worker, nursing assistant, orderly, healthcare aide). In the report that follows we present the interview themes and promising practices that are currently being implemented at LTC sites across the country, followed by recommendations for future program development.

What We Heard

Theme 1: Visible Leadership

The leadership from a facility in Saskatchewan spoke to a leadership mantra called 'Stay up and show up!' referencing the professionalism and resiliency the leadership team chose to uphold and project to their staff. Similarly, the leadership team from Nova Scotia talked about

> *"…showing up continually in scrubs to work on the floors whenever needed and we were always visible and accessible. We ensured we had 24 hour on call support for all shifts and on every weekend, with leaders in the building ...."*

Interviewees from New Brunswick shared, "*our DOC [Director of Care] is always on the floor, she is visible and approachable and is always listening ... then brings things back to the leadership team.*" The leadership team from Alberta agreed, stating, "*staff shouldn't have to look for us or hunt us down.*" In British Columbia (BC) and Quebec (QC) leaders spoke about 'walking the talk' –

> *"…we realized early on that we needed to make a clear statement that the safety of residents and staff was our most important priority. Of course, we said this, but we had to demonstrate it" (BC), "managers will show up in scrubs on the unit doing whatever is necessary to help. Managers went beyond the call of duty to do whatever it took, including showing up on weekends or evening shifts. Our goal was to always have someone on the unit to support them" (QC).*

Another team demonstrated authentic leadership via 'From the Heart' videos. They conveyed their vulnerability and empathy with messages like "you are not alone" and "we are here for you." These sentiments were received as genuine when followed up by managers being available and helping 'on the floor.'

Most of the leaders we interviewed talked about a commitment to being present and meeting frequently to strategize ways to support their staff. All emphasized the importance of frequent, layered, and transparent communication, using a multitude of strategies.

> *"We met with every staff group, every day, for eight months. We shared updates about changing protocols, managed resident concerns, and took time to ask how they were*

doing… This face-to-face time with staff was essential to being clear and providing the support and reassurance that staff needed."

Other leaders described an 'open door policy,' making themselves available for discussions with staff. One Director of Care from BC regularly scheduled 15-minute blocks of time with care aides to raise their ideas, or to simply talk through their experiences in a confidential setting. Leadership from a facility in Nova Scotia encouraged staff to share their stories, yielding compassion and empathy across the teams.

The senior leadership team we interviewed from Yukon found the pandemic offered an opportunity to pull forward their "Four Rules for Leadership" developed in a leadership retreat a year prior to the pandemic. These four rules are: be generous with praise, information, and feedback; ask genuine and curious questions; model a calm and wise approach; and delegate intentionally. These rules of leadership are similar to the three questions posed in the paper "Through the Eyes of the Workforce" (7) addressing how to cultivate a high reliability culture: 1) Am I treated with dignity and respect by everyone? 2) Do I have what I need so I can make a contribution that gives meaning to my life? 3) Am I recognized and thanked for what I do?

Visible, deliberate and supportive leadership is a foundation and critical success factor for all the initiatives and activities described in the remainder of the report. If leadership is not supportive, it just doesn't work.

Theme 2: Team Effectiveness

Many of the leadership teams have implemented “regular check-in conversations” with their staff. The Saskatchewan group held multiple huddles with the team not only providing timely updates, but also asking “What are your scared of? What do you need help with?” These skills are similar to the Institute of Healthcare Improvement (12) “What Matters to You’ conversation guide for cultivating ‘Joy in Work.’

The leadership team from Nova Scotia is using the True Colors™ tool (10) to learn how to better relate and collaborate with team members based on information related to their personality and preferred communication styles. This tool helps individuals to understand themselves and others based on personality types. By understanding our personalities, we can better communicate as a team. The group from Nova Scotia emphasized the value in keeping a well-functioning team together during stressful times, to promote team communication and peer to peer support.

Psychological Safety

Most of the leaders explained they were moving away from a traditional hierarchical approach to reporting structures and performance management, towards adhering to the principles of a ‘just culture’ with appropriate accountability. Formal discipline processes are being replaced with opportunities for learning. *“We are always asking staff, ‘what have you learned from this’ and ‘what would you do differently?’ Creating a learning culture as part of our daily practice”* Staff are encouraged to ‘speak-up’ to keep people living in LTC and each other safe.

The team from Yukon reported conducting regular debriefing sessions, with peer-to-peer support around grief and loss.

> *“We invite staff to contribute to an open goodbye letter where staff express their feelings and pay tribute to the residents who have died. Our goal is to create safe spaces for staff to express feelings and to share this in small groups.”*

They note they are *"…experiencing some hesitancy from care aides to be engaged in groups like this."* This is congruent with recent interviews conducted in Alberta regarding the impact of COVID-19 on the care aide experience, where the majority of the care aides sought spiritual, family or peer support, rather than attending structured sessions, formal groups, or professional counselling.

The Director of Care from New Brunswick asks care aides what they would like communicated to the board while preparing her board report. During COVID they explained,

> *"they go home every day worried that we haven't made a difference or done enough... 'we see everything the Board and leadership team are doing for us, and the residents'…and it is making these challenges a lot more bearable."*

Diversity, inclusivity and cultural competence are being embraced at specific homes. For example, one site flies *"…three new flags outside our building: the United Nations flag, the Gay Pride flag and the Transgender Pride flag. We try to be inclusive, internally and always in the community."*

Promoting autonomy and allowing staff to fulfill the full scope of their roles contributes to a healthy and productive workforce (7). A leadership team in BC is empowering care aides to organize care processes like bathing, and to lead decision making related to break coverage.

> *They team up to manage more complex situations and ensure care aides with more resident knowledge are there to support the process… having more autonomy to plan their own schedule and to make decisions and change roles/responsibilities provides care aides with a greater sense of control over their shifts and more energy to do the work in the way that makes sense to them.*

Staffing

Staffing shortages and challenges primarily due to 'one work site' policies increased workload for all LTC staff across the country. Creative solutions to staffing challenges were sought through applying for grants to fund more staff, as well as offering partial shifts to add hours for as many staff as possible. Although all leaders we interviewed spoke to the difficulties in scheduling due the one work site policy, the leadership team from BC realized greater continuity of care for people living in LTC with their ingenuity in staffing models.

Recognition

Another key dimension of the IHI 'Joy in Work' framework is meaningful recognition of staff. All the leadership teams we interviewed stated that the most meaningful feedback for staff comes from the residents and families themselves. One leadership team in our sample reached out to family members to invite them to share comments and stories about the staff who had been working so hard during the pandemic.

> *"The response was amazing as we received over five hundred responses…These were beautifully written notes with stories, poems and examples of what a difference the staff were making in their loved one lives."*

The leadership team collated these submissions and published them as gifts for the staff.

Education

Additional support for staff was the delivery of education related to pandemic response best practice, and also how to care for each other through the pandemic. Table-top simulations created safe learning environments to not only plan for outbreaks, but shaped shared mental models of roles and goals should an outbreak occur. Many sites contracted subject matter experts in mental health who delivered provider and train the trainer education in mental health, grief and loss, burnout and resilience. The leaders we connected with from New Brunswick emphasized the value-add of a dedicated educator offering 'just-in time learning' that was integrated into the workflow for the staff.

Huddles for timely updates were used by most the sites. Many sites discussed increasing the frequency of huddles, and a few highlighted opportunities for all staff to lead huddles, including of care aides. Huddles were not only a way to impart information, but to open a forum for staff input. Huddles have now replaced didactic staff meetings in two of the sites. This bidirectional exchange is also evident in the site we approached in New Brunswick.

> *"Our DOC holds nursing practice meetings monthly which include care aides. These regular meetings provide an opportunity to discuss current and new care practices. We can introduce changes and also explore what issues staff are having and share what practices are working."*

Some leadership teams have instituted mandatory education. For example, the team in the Yukon requires anyone in a supervisory role completes the 'Working Minds' training. This course prepares supervisors to

> *"…recognize how people show up at work when they are well, and when they are not, and what the indicators are for staff under stress. The program provides supervisors with strategies to support staff, and the knowledge to refer staff to other resources… This was begun early in the pandemic but will be expanded post-pandemic."*

This organization has also established a palliative care resource team who design and deliver webinars around *"…issues such as selfcare, resiliency, vicarious trauma and compassion fatigue."*

At Eden Care Communities in Regina, up to eight hours of grief and loss training was offered to all managers, who were then equipped to effectively support their teams and recognize the signs of staff who may be at risk.

> *"She didn't know what was 'wrong,' usually she was able to handle resident concerns but for some reason she just couldn't do it anymore. Because of the training, her manager had a language and a process to support the care aide. This resource and approach will be a valuable part of our training and support going forward."*

Wellness programs

Many sites had established wellness programs prior to the pandemic, and there has been a commitment to maintain these programs, with modifications and appropriate restrictions. For example, leadership from a home in Nova Scotia described building an on-site home gym with personalized training. This site had a particularly unique focus on healthy workplace initiatives like learn to run, stair challenges, annual health fairs, and a total health index with 87 percent of staff participating in individualized assessments. This innovative team also engaged the residents in a mobility project to 'walk across Canada.'

The leadership in Nova Scotia highlighted the importance of honoring vacation time.

> *"Once we were stabilized, we made sure staff were able to get two days off at time, and then limited …vacations. We committed this year to [a minimum] of two-week vacations from June to September."*

Conversely, the leadership team from Quebec cited their unique circumstance when

> *"Quebec enforced new laws for long-term care which included requiring staff to be available full time … and cancelling all vacation and leave days. All of this led to staff burnout …some staff left because the rules became too much which put more pressure on remaining staff."*

Several leaders underlined a renewed attention on fostering provider mental health. *"Our biggest focus in the past year in our work to support staff is to make mental health a priority and be very clear that it is ok to talk about it."* A leadership team from BC funded nursing leadership courses through Safe Care BC, focused on workplace health and safety. They found that the collaborative skills the leaders gained contributed to *"…giving the care aides a voice."* Whereas some leadership teams referred staff to formalized Employee Assistance Programs, social workers, spiritual care providers, coaches, or external consultants. The team in Alberta found *"… it was more effective and staff were more responsive, when internal people were convening debriefing sessions rather than bringing in outside support".* Due to the renewed focus on mental health, one Alberta organization was participating in three research studies describing mental health in LTC staff.

Evaluation and Measurement

Formalized means of evaluating methods to support staff had been undertaken by a limited number of the sites. Most homes were consumed with responding to COVID and did not have time to evaluate the interventions.

- Some continue standardized surveys under Accreditation Canada, the former Canadian Patient Safety Institute, and in the west the Translating Research in Elder Care program's routinely administered surveys (www.trecresearch.ca), while others regularly distribute local surveys with plans to administer post-COVID.
- Educational sessions provided to staff about how to manage through the pandemic have been reported as "well attended" and "well received."
- One Alberta team reported a 50 percent increase in individualized meetings with staff hosted by spiritual care and social workers. "They raised everything from family issues, domestic abuse, depression, anxiety and stress."

- Standardized measures such as staff sick-time, Worker's Compensation claims, overtime, retention, and absenteeism were monitored by most facilities.
- Subjectively many of the teams interviewed described greater team cohesiveness.

Interventions

Many tactics, interventions and programs are perceived to be positively influencing the psychological health and safety of LTC staff, although formal evaluation efforts have been largely missing. The following promising practices were reported by the leaders we interviewed and have been implemented at their sites, during times of limited resources and capacity for planning, and in the face of unparalleled working conditions. The future holds even greater potential for meaningful support especially for provider mental health in LTC.

Changing a culture

- Process Improvement Teams
- Change campaigns
- Huddles
- Trust building - leadership 'walking the talk' and demonstrating to staff 'they had their backs'
- Meaningful recognition
- 'Learning Culture,', 'Quality and Safety Culture,' 'Improvement Culture,' 'valuing clinical quality improvement rather than quality assurance'

Leadership

- Modeling resilience
- Transparency
- Accessibility to staff
- Providing direct care
- Restructuring to reduce the number of direct reports

Education

- Table-top simulations
- Dealing with grief and loss
- Resiliency skills

Communication

- Debriefing with the care team
- Distributing iPads to staff to respond in real time about ‘how was your day?’
- Access to an internal organization intranet
- Use of social media to fan out information
- Emails and text messaging
- Posters
- Videos from leadership
- Applications (Apps) to facilitate more direct and immediate communication with staff
- ‘Fire-side chats’ with senior leaders and the CEO

Support (mental health and well-being)

- Employee Assistance Programs
- Recognize Mental Health week
- Guest speakers on mental health, burnout, and resilience
- Clinical psychologist, coach, spiritual care and social workers
- Initiating yoga and mindfulness classes
- Starting meetings with expressions of gratitude
- Gym memberships converted to on site home gyms

Recognition (celebrations, ceremonies, tangible supports and tokens of appreciation)

- Showcasing the work of the team on local news channels
- Food trucks, barbeques, fruit, ice cream, popsicles, granola bars, free coffee and ‘treats’
- Expanding nursing week to be inclusive of all staff
- Self-care gift packages for staff
- Daily photos of ‘everyday heroes’
- Paid meals and accommodation in hotels during the first wave
- Gift cards and prize draws
- T-shirts: ‘Together we are strong’
- Water bottles
- Personalized thank-you cards
- Coffee cards
- Staff led parades
- Personal Protective Equipment (PPE) provided to staff and their families for their use outside of the facility
- Access to COVDI-19 testing
- Paid sick time with or without symptoms, and with negative testing results, for mental health and physical exhaustion
- Working collaboratively with community partners. For example, shopping hours at grocery stores dedicated to staff
- Healthcare ‘hero’ bells and pots and pans at 7:00 pm in the first wave
- Blessing of hands ceremonies
- Healing circle ceremonies

Learning from the Researchers

In LTC, significant distress was experienced by staff when the care they needed and wanted to provide was not possible. These situations included when people living in LTC were isolated in their rooms during outbreaks and kept away from family, had no interaction with other people living in LTC, or when having none or limiting the number of people permitted to be with a person at the end of their lives. Dr. Bonnie Lashewicz from the University of Calgary is exploring support of mental health and the prevention of moral injury in LTC staff, to inform the design of a mental health support/moral injury prevention toolkit.

Family Councils of Ontario led an initiative called TLC for LTC. It is a collaborative campaign designed to thank LTC staff for their efforts throughout the pandemic and raise awareness of the importance of their mental health and well-being. An activity, published on their website, provides families with ideas for recognizing team members.

The Psychological Health and Safety in Long-Term Care Advisory Committee in Ontario is working with a group of 20 homes, that applied to participate, to create a psychologically safe workplace culture and protect mental health. They are leading the adoption of the National Standard of Canada for Psychological Health and Safety (9) in the Workplace across a many LTC homes in Ontario.

Staff shortages and scheduling were a major challenge identified by LTC leaders during the pandemic, especially over the course of the first wave. Dr. Farinaz Havaei from the University of British Columbia is currently adapting a tool for scheduling in the emergency department to the LTC context. The Synergy Tool (13) is an evidence-based tool that can be applied in real-time allowing staff to collaboratively and objectively quantify their patient's care needs, thereby informing staff mix decision making and reducing staff shortages.

When staff are engaged in influencing meaningful change, rather than feeling like change is happening to them, they are more creative and productive. Working with Dr. Sienna Caspar from the University of Lethbridge, a center in Alberta pointed to the success of Process Improvement Teams to train and empower staff, and specifically care aides, to drive improvement in care processes. *Application of the Feasible Sustainable Culture Change Initiative* or FASCCI model (2) has generated a more person-centric experience for residents during their meals. Currently Dr. Caspar's team is reporting galvanizing effects on the team, and reduction of distress in the staff who are involved in the participative decision making involved in collaborating on a PIT.

Mindfulness based stress reduction practices through movement and meditation are gaining popularity with participants, while demonstrating positive effects in a growing body of evidence. Tracy Cocks and Tita Angangco from the Centre for Mindfulness Studies offered an abbreviated and modified version of the traditional eight-week Mindfulness Based Stress Reduction/Mindfulness Based Cognitive Therapy curriculum, with 20-minute guided practices outside of the course. The program was offered to health care workers in Toronto and supported by the United Way of Toronto. A key factor contributing to success was not only leadership sponsorship, but leadership co-participation in the course. Evaluations showed improved coping skills and emotional regulation. The Centre is seeking partners and funding to modify this program to the needs of LTC staff and have published evidence of the benefits of Mindfulness-Based Cognitive Therapy with people with dementia and their caregivers (1).

Reflective practices are also showing promise relative to managing grief. Many LTC staff endured the loss of people living in LTC who were beloved and long-time members of the community. Dr Jane Kuepfner, a specialist in spirituality and aging, recounted the need for grief related rituals, honoring spiritual practices, and supporting transitions following the death of a resident during the pandemic. She notes that not all spiritual resources are religious; they can include stories, music, meditation, connection with nature, and sharing a meal. This is the basis for Reflection Rooms (8), installed in 33 settings in five provinces across Canada, as places designated for storytelling and reading stories about the experience of dying, allowing for “death-discussing and death-accepting.”

Dr. Carole Estabrooks and the Translating Research in Elder Care (TREC) team, through their research, have identified and evaluated strategies to support managers in making and evaluating change, and to support care aides to lead improvement initiatives. Both address quality of work life. This team is currently leading the implementation and evaluation of a strategy intended to assist care aides to develop knowledge and skills to manage acute and chronic stress. This strategy is two pronged, with an education and body-oriented component (a structured breathing technique). They are also launching initiatives to support care aides caring for older adults with histories of psychological trauma, and conducting early work to support people living in LTC who have experienced psychological trauma. Their Improving Nursing Home Care through Feedback on PerfoRMance Data (INFORM) (3) initiative was a successful intervention to support managers of care units to improve performance by improving modifiable elements of their care units. It included workshops, coaching and peer-to-peer support. The Safer Care for Older Persons (in residential) Environments (SCOPE) (3,4,5,11) intervention, supported and empowered care aides to the lead an improvement intervention on their units. It

included an emphasis on developing the leadership skills of care aides and a leadership section for managers and sponsors to facilitate supporting this kind of change.

Summary and Observations

The interviews with researchers and DOCs identified a number of common themes which may assist homes facing the effects of the pandemic on those who live and work in LTC, and their families. These are the common themes:

1. Active, accessible, and authentic leadership combined with participative decision making, are key to generating high functioning teams.

2. A lens towards continuously improving and learning as a team can change traditional hierarchical organizational cultures, into more just and trusting organizational cultures.

3. Greater and meaningful participation in decision making about care leads to a sense of meaning and purpose and subsequently, improved resident experience.

4. Safe and supportive options for sharing and discussing personal and professional experiences with trusted peers was a prime outlet for staff. Formal debriefing and peer-to-peer support groups may be promising practices to leverage this pattern.

5. Just in time education, huddles, webinars and courses designed to not only prepare staff to respond to the pandemic, but to learn about how to compassionately care for themselves and others resonated with staff and leaders.

The experience of caring for people living in LTC and staff during the pandemic was highly consistent among the leaders we interviewed. Throughout the pandemic, these leaders tested and tried a multitude of interventions aimed at supporting their staff. There is a need for research dedicated to understanding and evaluating strategies that support care aides and other staff in LTC which may be effective in promoting mental health, wellness and resilience. Evaluation is key to confidence in an evidence base that will inform the best promising practices that then undergo wider implementation with evaluation.

The relatively small response from the research community is indicative of the lack of attention that has been focused on developing and evaluating strategies to improve working conditions and work life in LTC homes in Canada. This is an essential component of building a strong evidence base and that evidence base is critical to wide spread implementation efforts, that

when evaluated enable LTC homes and organizations to make informed decisions about adoption.

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Appendix A

A. Interviewee Organizations

Province	Organization
British Columbia	Tabor Village, Abbotsford
British Columbia	Oak Bay Health Care Society, Victoria
Alberta	Brenda Strafford Foundation, Calgary
Alberta	Sherwood Care, Sherwood Park
Saskatchewan	Eden Care Communities, Regina
Quebec	CHSLD, Montreal
Nova Scotia	Glen Havens Manor, New Glasgow
New Brunswick	Rexton Lyons Nursing Home
Yukon	Copper Ridge Place, Thomson Centre, Whistle Bend Place, Whitehorse; McDonald Lodge, Dawson City

B. Researchers interviewed

Name	Organization
Sienna Caspar	Associate Professor, Therapeutic Recreation Faculty of Health Sciences University of Lethbridge
Kate Dupuis	Schlegel Innovation Leader in Arts and Aging Schlegel-UW Research Institute for Aging

Carole Estabrooks	Scientific Director, Translating Research in Elder Care Professor, Faculty of Nursing University of Alberta
Farinaz Havaei	Assistant Professor School of Nursing University of British Columbia
Bonnie M. Lashewicz	Associate Professor Community Health Sciences University of Calgary
Jane Kuepfner	Schlegel Specialist in Spirituality and Aging Schlegel-UW Research Institute for Aging
Peter Norton	Professor Emeritus Family Medicine, University of Calgary

C. Intervention Specialists/Knowledge Brokers Interviewed

Name	Organization
Tita Angangco	Co-Founder and Member, Board of Directors Centre for Mindfulness Studies
Susan Brown	Director of Research Coordination and Research-Practice Integration Schlegel-UW Research Institute for Aging
Tracy Cocks	Director, Community Programs Centre for Mindfulness Studies
Scott Mitchell	Knowledge Broker Schlegel-UW Research Institute for Aging