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Facilitated reflection meetings as a relational approach to problem-solving within long-term care facilities

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ABSTRACT

Care workers have valuable knowledge to contribute to the improvement of their work environments. Yet incorporating their perspectives into organizational decision-making within long-term care facilities (LTCFs) has been an ongoing challenge. In this article we investigate a promising practice that brought workers and management together in weekly and bimonthly facilitated reflection meetings to identify and resolve problems. Drawing on observations as well as individual and group interviews, we sought to understand whether and how this intervention worked from the perspective of participants. Our study found that one of the main achievements was creating a safe space for workers to speak honestly. They felt heard and treated with respect. In this context, they were willing to surface concerns, failures, and problems for collective deliberation and action. The inclusion of a range of occupational groups ensured that the solutions developed were sensitive to context, including organizational and occupational realities. While the outcomes of the process were impressive, this paper highlights the relational work that created trust, respect, and a spirit of collaboration. We suggest that such facilitated reflection processes may serve as an important strategy to improve the organization of work in LTCFs, one that is particularly well-suited to the dynamic and relational nature of care.

Introduction

This paper contributes to a line of inquiry seeking to improve the work conditions in long-term care facilities (LTCFs), which is intimately linked to the quality of care residents receive (Eaton, 2000; Estabrooks et al., 2020). Working conditions in North American LTCFs have been of long-standing concern. Research has shown them to be routinely understaffed and under-resourced (Harrington et al., 2012), with aides struggling to provide adequate bodily care and unlikely to find time to offer social, emotional, and spiritual support (Gubrium, 1997; Hung & Chaudhury, 2011; Rodriquez, 2014). Institutional constraints and a focus on economic efficiency demand highly regimented work environments (Foner, 1994; Molinari & Pratt, 2021), with care workers having to manage tensions between managerial requirements and the immediate individual needs of residents. Hierarchies are also pervasive, authorizing top-down styles of communication and silencing care aides, whose knowledge and perspectives are excluded from decision-making (Diamond, 1992; Gubrium, 1997; Kontos, Miller, & Mitchell, 2010). Under such conditions, care is frequently rushed, sometimes provoking aggression from residents, tensions among coworkers, and high levels of burnout and turnover (Braedley, Owusu, Przednowek, & Armstrong, 2017; Chamberlain et al., 2017).

Seeking to encourage staff engagement and improve work organization, a British Columbia Health Authority developed the Partnerships in Person Centred Care (PPCA) initiative that provided structured opportunities for care workers and managers to come together and discuss their work. The process involved ongoing weekly reflection meetings. These meetings were guided by a facilitator and provided a regular forum for dialogue, deliberation, and problem-solving. Longer facilitated reflection meetings were convened every 2 months to address more complex challenges. The facilitated reflection process revealed problems, both big and small, and supported collectively developed solutions that have been implemented within participating facilities.

In this paper, we present the results of a qualitative study that sought

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to understand whether and how this facilitated reflection process worked from the perspective of participants. Our study found that staff and managers experienced the process as a unique intervention that made a real difference. Our study also revealed that there was far more to these meetings than bringing staff together to discuss their work – although that alone was an achievement, given work pace in LTCFs. Specifically, we discovered that considerable relational work was required to create a context for workplace innovation. We use the terms “relational labor” or “relational work” to refer to the skills that ensure good relationships characterized by reciprocity, trust, and mutual understanding (Fletcher, 1999). Relational labor is skilled and complex. In the facilitated reflection process we studied, relational work was needed to foster a communicative environment where staff felt safe to speak and reveal problems. Relational labor was also required to move from anger and blame to respect and understanding. And relational work was required for staff to listen to one another in order to fully understand the complexity of the problems they were striving to resolve. Relational work also contributed to cultivating distributed accountability among the staff when enacting solutions.

By attending to this relational labor, we contribute to the growing body of research that recognizes the centrality of relationships to care work in the long-term care (LTC) sector. This research has shown how relationships between staff and residents are essential for coordinating work among colleagues (Gittell, Weinberg, Pfefferle, & Bishop, 2008) as well as coming to understand the needs and preferences of residents (Sutherland, 2020). Research also indicates that organizational and policy mechanisms play an important role in fostering conditions for relatedness (Diamond, 1992; Eckenwiler, 2012), such as ensuring adequate staffing, consistent shift allocations, and preventing practices that can harm relationships such as contracting out (Ponder, Longhurst, & McGregor, 2020). Prior studies also demonstrate that good relationships among staff matter for the quality of care provided (Foner, 1994; Keady & Nolan, 2013). As we show in this paper, facilitated reflection meetings can nurture relationships among staff and, in the process, improve care work. In what follows, we review the recent research on reflection meetings in the LTC sector before describing the PPCA process and presenting the results of our study.

Background

We situate our paper within an interdisciplinary body of research that recognizes the importance of collective deliberation and problem-solving among LTCF staff as a promising means to improve the quality of work and care. We use the concept of “reflection meetings,” borrowing from research in the Swedish context (Banerjee & Braedley, 2016), to name these opportunities for staff to come together, identify problems, share knowledge, and devise solutions.

Reflection meetings may be informal or formal. They may be little more than brief moments seized within the flow of work. Yet despite this brevity, they are essential for staff to coordinate with their colleagues and respond to the predictably unpredictable nature of care work (c.f. Anderson et al., 2005; Gittell et al., 2008). Or they may be formalized meetings, organized and scheduled as part of a quality improvement process, and even facilitated, as was the intervention we studied (see also Vikström & Johansson, 2019). They may bring together a single occupation group or they may bring together an interdisciplinary team, involving a range of occupational groups, such as the moral case deliberation sessions organized by van der Dam et al. (2011). The thread running through these different meetings is that they pull staff together to talk about their work, identify problems, and collaboratively solve them.

Unfortunately, the conditions of work in the LTC sector do not support reflection. The legacy of neoliberal austerity measures in North America has resulted in insufficient staffing (Armstrong & Armstrong, 2020), requiring workers to rush basic care, leaving little, if any, time to pause, reflect, and dialogue. The privatization of staff, through contracting out or relying on temporary workers to fill gaps, also impedes problem-solving, resulting in staff who are not familiar with their colleagues nor the residents they are caring for and have limited commitment to the workplace (Ponder et al., 2020). Such harsh working conditions can also lead to distress, disrespect and burnout among care workers (Braedley, Owusu, Przednowek, & Armstrong, 2017), rendering respectful deliberation unlikely.

Furthermore, neoliberal managerialism has framed opportunities for conversation and relationship building as inefficient and wasteful (Rankin & Campbell, 2006). Shift overlaps, for instance, which have traditionally served as a chance for incoming staff to confer with outgoing staff, are often eliminated or replaced by technology. Neoliberal managerialism has also exacerbated occupational hierarchies, and structured opportunities for communication tend to be top-down, reflecting a command-and-control style of management (Baines & van den Broek, 2017). In a telling institutional ethnography mapping communication flows with LTCFs, Caspar, Ratner, Phinney, & MacKinnon, 2016 discovered a dearth of two-way conversation. Rather, communication flowed in one direction – from the top down – reflecting concerns of management and privileging clinical information. Upward flows of communication, for instance from care aides to licensed practical nurses (LPNs), only happened informally, if at all. Care aides had to resort to communicating “on the fly,” interrupting busy nurses and risking being reprimanded. The study also found the only structured forms of two-way communication were the bath and bowel lists. This suggests the organization of communication continues to support the assertion Gubrium (1997) made nearly a quarter century ago that the job of care aides consists largely of bed-and-body work. Such findings, as Caspar, Ratner, Phinney, & MacKinnon, 2016 conclude, help explain why care aides continue to feel “underappreciated, disrespected, and dismissed” (p13).

Recognizing the limited opportunity for reflection, some researchers have turned to participatory research methods to disrupt work routines and create space for dialogue. One such intervention used a series of facilitated meetings to discuss new guidelines for dementia care (Vikström & Johansson, 2019). These reflection sessions brought staff – mainly care aides but also occupational therapists and managers – together to discuss their work in relation to the new guidelines. Collectively, staff identified areas of weakness. Then, over an additional ten facilitated meetings, they sought to remedy these shortcomings. Subsequent interviews demonstrated that the facilitated reflection process enabled staff to adapt and improve their work. These meetings also transformed the unit’s culture. Being able to discuss their work with their colleagues afforded staff members a better understanding of how their individual duties fit within the collective project of the LTCF. The process thus generated a sense of shared responsibility. As one participant observed: “we have changed from being isolated islands of individuals to become one unit” (2764).

As the above example indicates, another thread that runs through the research on reflection and problem-solving is that the effectiveness of this approach relies on the quality of relationships among staff. This is the case for both informal and formal reflection meetings. Indeed, informal meetings to organize and coordinate work are particularly dependent on the quality of the relationship between staff (Gittell et al., 2008). As Caspar, Ratner, Phinney, & MacKinnon, 2016 observe, without trust and respect, care aides will not approach their colleagues, and much less management, to share new information. While formal meetings have the advantage of requiring staff to gather, whether the ensuing discussions are productive depends significantly on the relational competence of leaders to facilitate open dialogue (Corazzini et al., 2013).

Although relational practices are essential to good care, attention to the relational dimensions of long-term care work have been slow to develop, with care continuing to be thought of as manual labor or task-based body-work (Day, 2013). This narrow understanding of work devalues the skills and ways of knowing that are required to cultivate good

relationships. The problem is not confined to the LTC context. Writing about work in a white-collar managerial context, Fletcher (1998) notes that relational work is gendered and therefore neglected. “Real work,” she argues, follows masculine rules that are bound up with the “instrumental values of rationality, abstraction and linearity” (175) and with normative assumptions that bind power to autonomy and weakness to interdependence. Relational work violates these rules and is, therefore, “disappeared.” In other words, rather than being perceived as real work, relational labor is reconstructed: as a gendered attribute (e.g., something women naturally do well), a personality trait (e.g., someone who is friendly), or, worse, a liability (e.g., a talkative, inefficient person). This failure to appreciate relational labor hampers productivity and harms those skilled in relational practice. Advocating for a feminist reimagining of work, Fletcher observes that relational work needs to be named, valued, and supported. Thus, in this paper, we take seriously the relational work that staff continually pointed to as essential in making the facilitated reflection process not only enjoyable, but innovative and effective.

The facilitated reflection process

The PPCA has been instituted in nine of the Health Authority’s (HAs) residential care homes. The HA is one of the largest of five in British Columbia, responsible for organizing and delivering publicly funded health care to nearly two million people.

The reflection process unfolds over several steps. The first step involves ongoing, weekly reflection meetings, open to all direct care staff except management. These weekly meetings are facilitated, with the intention of encouraging staff to express and clarify their main concerns. In the second step, the manager is included. The facilitator continues to orchestrate the conversation, ensuring staff are heard. In the third step, facilitation is taken over by the manager, although the meetings still follow the staff’s agenda. Meetings run anywhere from 20 to 40 min, concluding with action items.

While weekly reflection meetings provide an ongoing opportunity to discuss staff concerns, some problems required more time to address. The fourth step involves the formation of “team meetings,” which convene approximately every 2 months. These include workers from all occupational groups (e.g., care aides, care-coordinators, managers and allied health professionals). Participation is voluntary, though staff are paid to attend and substitute workers are arranged to ensure resident care is not disrupted. The team meetings are facilitated and run for approximately 4 h. Together, the weekly and team reflection process address a variety of problems, resulting in the development of procedures to enhance workplace safety and care delivery which we describe below.

Methods

This study adopted an interpretive descriptive design (Thorne, Kirkham, & MacDonald-Emes, 1997) to learn whether and how the facilitated reflection process worked from the perspective of participants. Interpretive description is a qualitative approach developed for use in health care settings. It aims to learn from individual cases in order to develop lessons that can then guide future action. Our methods included the use of observation as well as group and individual interviews to learn about the reflection process from the perspective of participants.

Ethics approval for the study was obtained from the Research Ethics Boards at both York University and the Health Authority. Permission to observe meetings was obtained in advance from the facility manager. Additionally, we provided an explanation of the project at the start of each meeting and requested permission from participants to observe. Prior to each group and individual interview, a signed consent form was obtained from all participants.

Data collection

We began by observing weekly and team meetings to develop a familiarity with the PPCA meetings’ format and content. These meetings were not audio recorded but field notes were taken and used to guide the development of interview questions. After observing several meetings, a preliminary interview protocol was developed and used to guide group interviews. Group interviews were typically held immediately after the meetings we observed and included all members present at the meeting (except managers) and those who had to report for duty. This strategy enabled us to explore issues that came up during our observations. We excluded management from group interviews to encourage open communication among workers. Some of the questions we asked included: Can you tell me what the PPCA does? What benefits does it have? What is essential for these benefits to be achieved? What are the main challenges with the PPCA? Are these necessary for the process or could they be avoided? If so, how?

We conducted separate interviews with management (e.g., facility managers and health authority leadership) as well as with some workers who wished to participate but could not attend the group interviews. Questions were similar to those noted above, though with management we also sought to explore whether the process challenged their authority and/or transformed their leadership style.

It became evident early in data collection that the reflection process evolved with practice. We therefore made sure to observe meetings at various stages, from meetings in facilities where the reflection process was in its infancy (e.g., we observed the very first weekly meeting) as well as observing meetings where the process was well-established (e.g., had been running for three or more years). We found meetings at the early stages were qualitatively different (e.g., there was more emotional venting) and we explored these differences through our interviews with participants. This process of adjusting study design as analysis proceeds is a feature of interpretive design and other forms of qualitative research such as grounded theory (Charmaz, 2017; Thorne et al., 1997).

In total, we observed five weekly and five team meetings. We conducted 11 individual and eight group interviews with a total of 52 participants. The individual and group interviews ranged from 30 to 120 min, were audio recorded, and then transcribed verbatim. While we did not collect demographic information beyond occupation and gender, our sample included 23 health care assistants (HCAs), 11 registered nurses (RNs), six facility managers and senior leadership, six licensed practical nurses (LPNs), and five allied health professionals, as well as one facilitator. Reflecting the gendered nature of the LTC sector, all were women except for two HCAs and one RN.

Analysis

Following the tenets of interpretive description, we began our analysis with broad questions rather than minute coding that may overwhelm and distract from the big picture (Thorne et al., 1997). The analysis was initially guided by the questions of “what is the PPCA doing?” “what are we learning?” The first author listened to the audio recordings, took notes, and shared the developing analysis with the coauthors who were either present during the interviews or listened to the recordings. It was clear the reflection process was perceived to work from the perspective of participants. It was the “real deal,” as they often said. Interrogating the data as to *how* the reflection process worked identified patterns around respectful communication and collective deliberation. The first author then coded the data transcripts, attending to those factors that contributed to the quality of communication and problem-solving, enabling a more nuanced picture to emerge.

The developing analysis was refined through discussion among coauthors, repeated engagements with the data, and the presentation of our initial conceptualizations back to participants. For instance, the coding of the transcripts revealed that the communication was consistently described as “respectful.” Further interviews and coding indicated

that respect had a very specific meaning. Respect was understood to signify empathy and the consideration of different points of view. This analysis brought our attention to the relational work the facilitator did to create room for staff to speak and to also model active listening, which was captured in the field notes and interview transcripts. Working in this way, we developed an understanding of the factors contributing to the reflection process's effectiveness as well as some of its challenges, which we describe below.

Finally, we note that we employed multiple strategies to ensure the trustworthiness of the data collection and analysis (Shenton, 2004). These included studying meetings at various stages of the process, post-interview debriefs, ongoing discussions among researchers, negative case analysis, and presentations back to participants. In the presentation of our analysis below we ensure anonymity by identifying quotes with pseudonyms and an alphanumeric code referencing group interview (GI) or interview (I). We note the participants' occupation where possible.

Results

Our overarching finding was that the PPCA produced a unique context for creative problem-solving, wherein staff felt safe to speak and were able to identify and resolve problems collectively. In presenting our analysis of how the process worked, we distinguish between the context of communication and the content of these meetings. Thus, the first three themes describe how the process supported safe, authentic communication where staff felt heard. The next two themes focus on problems-solving, particularly the need to develop trust in their capacity for innovation and their ability to fully explore problems. These themes are inter-related and their linkages are depicted in Fig. 1. We also observed that relational work was essential throughout the process. As such, we do not confine relational labor to an individual theme but endeavor to note it throughout. We conclude this section by presenting some of the challenges identified by participants.

Creating an authentic communicative environment

All participants reported that the conversation in the reflection meetings was uniquely respectful and honest. This differed substantially from the day-to-day culture in some units where workers did not speak across occupational divides, felt afraid to voice their opinions, or were not listened to. According to leadership, the PPCA opened a space for conversation. "*One of the benefits [of the PPCA] is that it cracks open an opportunity to have a conversation that might not have existed in some sites because of the culture of the units*" (HA leadership, I1). Or in the words of Brenda, a care coordinator (GI1): "*What the PPCA had done is went to the managers and said: Guys you've got to listen to your staff. You're not listening. And they [the managers] said to us, well you've got to speak up.*"

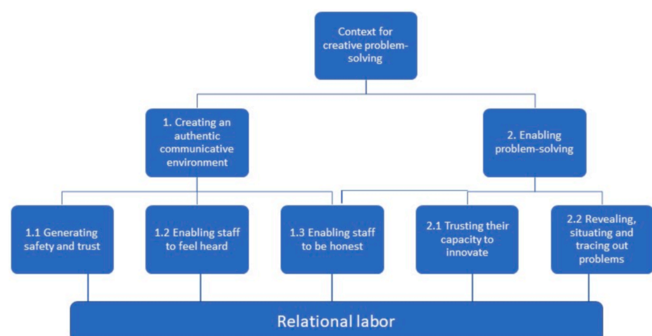

Fig. 1. Inter-related themes.

Generating safety and trust

While workplace culture was not uniform across the health authority or even in individual facilities, staff were generally afraid to speak openly. "*What happened before [the reflection process],*" as Brenda (care coordinator, GI1) put it, "*was the frontline staff were scared to speak their mind because they felt 'I'm dead if I speak out'.*" Workplace hierarchies contributed to this silencing, as Jackie (manager, I4) described:

> Some of my leadership staff are very hierarchical in their thinking and that has been a struggle. My [resident care coordinator] is very much medical model, very much the army model, where there's always been a hierarchy: "You do what I say because I've got more education than you," or "I'm better than you are," or "I'm more important than you are, because my name has got a bunch of initials behind it" and "I'm a nurse and you're just a care aide."

The reflection process disrupted this dynamic and created a sense of safety. Regardless of their position, staff felt they could speak openly, voice criticisms and concerns, and admit to failures and misgivings without reprisals:

> I felt it was made clear [what was said] stays in the room. I felt comfortable that I could say anything to anybody. (Lucinda, HCA, GI4).

> Now we are not afraid to talk. We know we have a support. We have somebody who will listen to us and say: "Here you can talk. We'll make sure that your concerns are going to be listened to." (Harpreet, RN, GI2)

The perceived safety of the reflection process was attributed to several factors. Most significant was the presence of the facilitator, "*What the facilitator did was made the managers promise there were no repercussions for us speaking out*" (Brenda, care coordinator, GI1). The facilitator noted that she had the backing of health authority leadership, thus managers could not so easily dismiss her requests. Further, she was familiar to the care staff because of her previous job as the health and safety educator. This familiarity created trust, as did the fact that she did not work directly for the facility manager but was employed by the health authority. At times she noted she had to earn the trust of staff, and in such cases, one strategy she used was to identify informal leaders and work to gain their trust as a means of opening up the conversation.

The exclusion of managers during the initial sessions also contributed to the perception of safety. Indeed, there was considerable venting in the sessions prior to the inclusion of managers. For many staff, this was the first time they could openly speak their mind. And they did. According to the facilitator, venting was a necessary step. It was particularly important, she observed, in those facilities where staff had longstanding and unexpressed grievances. Still, there came a point when she needed to corral their emotions. A key task for her was to assist staff in translating their anger into actionable requests. As she put it, her work was to "*pull the meeting forward*" by "*pick[ing] out the issues and making sure we talk about them.*"

Despite the opportunity for staff to vent before managers were included, several of the managers recalled their first meetings being emotionally charged:

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

Nevertheless, managers came to value the reflection process because it allowed them to hear staff, something they all said they were

committed to. The process also built trust. Letting staff into their world, helping staff understand the constraints managers labored under as well as their commitment to both staff and residents contributed to gaining the respect of their staff. Working together to solve difficult problems also helped humanize managers and further built trust. Thus, Heather, quoted above, who reported feeling attacked, observed that after several meetings:

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

Enabling staff to feel heard

In addition to feeling safe, staff felt heard. Care aides reported feeling understood, some for the first time. But care aides were not the only ones that were heard. Managers and nurses described similar experiences. Indeed, the interdisciplinary openness of these meetings was a key factor in changing the context of communication, rupturing occupational silos. The reflection process "*gets everyone going a different direction than we are kind of used to*," explained Roberta, a health care aid (GI1). Nurses, care aides, LPNs, physiotherapists, managers, and others shared their perspectives. In doing so, points of convergence as well as differences (e.g., competing interests and responsibilities) were revealed. The sharing of perspectives also created understanding and dissipated anger: "*We can see their point of view. They will explain to us why they do certain things,"* said Daisy (HCA, I10). *"When I understand why they do something, it's oka*y."

The facilitator played an important role in enabling staff to be heard. She modeled active listening, pausing or slowing the conversation as needed, containing staff with strong personalities, as well as paraphrasing and asking questions for clarification. When required, she also spurred hesitant staff to speak: *"I had somebody pull me aside and say, 'This is what happened. I'm terrified to bring it up'. I said '[Be courageous]. Bring it up.' She did. And it was really good." (Facilitator, I8).*

The facilitator also sought out divergent perspectives, treating them not as problems but as opportunities to develop a fuller picture of the issue at hand. Indeed, several leaders observed that these meetings were characterized by a more holistic approach to knowledge, one wherein the governing assumption was that all staff members had something valuable to contribute: *"Everybody's got a piece of information about this whole,"* observed Jackie (manager, I4). *"Everybody has a piece of wisdom in terms of care, and a way to make the workplace safer."*

Another oft noted reason staff felt heard was because their concerns set the agenda. This was a key feature of the reflection process and differed from other meetings, where the agenda was determined in advance by leadership or educators. As Paula, a care coordinator (GI3), explained:

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

Perhaps not surprisingly, giving staff a chance to speak and be heard left them feeling respected. When asked what staff meant by respect, we found it was bound up with empathy and understanding. Respect was a product of the relational work of stepping into the world of another person. As Daisy (HCA, I10) explained: "*Listen. Try to understand where people are coming from…. Have empathy for one another. That, to me, is respect."*

Enabling staff to be honest

Relational work also enabled staff to be vocal and honest in these meetings. Lack of regular communication – particularly across occupational groups – contributed to animosity, especially in cases where the motivation behind a colleague's behavior was not understood. The reflection process provided a forum to address such resentments. This work was described as "*pulling back the curtains,"(Jennifer, recreation therapist, I12), "stripping the varnish," (Mona, HCA, G1) "getting rid of crap*" *(Joanna, manager, I7)*. These metaphors conveyed the need to move beyond surface collegiality and reveal the sometimes ugly truth. "*What the PPCA has done*," Marta (care coordinator, GI8) remarked, "*was brought us to the table…and said, 'okay, here you are. This is our laundry. We have to wash it' [laughter]*."

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

Given the opportunity to speak and be heard, it is not surprising that many of the participants reported an enhanced sense of self-worth. According to Roberta (HCA, I9) the process "*has started to make people feel more valued at what they do."* Participation also contributed to aides' confidence, as Roberta (HCA, I9) added: *"It has helped me come out of my shell and helped me to dialogue better."* These transformations played out beyond the meetings. For instance, several managers remarked that participants were more likely to speak up on the unit. Or as Daisy, a care aide (I10), observed: "*It's made me not so afraid to go talk to the bosses and [have] lots more communication."*

In sum, the relational work that generated a safe space for staff to speak honestly and feel heard was essential to establishing a context in which problem-solving could begin. *"Where we would just fly off the handle,"* observed Jada (HCA, GI4)," *people are listening to what is being discussed. There is conversation happening to understand what is being brought forth.*" Another HCA (GI1) put the effects of this relational effort bluntly: "*When all the other crap is aside, you can actually look at what you are here for."*

Enabling problem-solving

From participants' perspectives, the reflection process stood out from other meetings because it solved problems that mattered to staff. "Most of the meetings that we've attended in the past, nothing gets resolved, so it's a waste of time" (HCA, GI5). One aide likened the process to a "steam powered engine" that channeled frustration into forward motion (fieldnotes). We provide a partial list of problems that were identified and resolved during the meetings we observed in Table 1.

Trusting their capacity to innovate

Participants told us that an important part of the process was learning to trust their ability to work through problems and develop solutions together. Participants in the well-established reflection meetings we observed understood the process and moved comparatively quickly from problem identification to analysis then to proposed solutions. Newer groups, however, lacked this confidence and participants could get frustrated. Sometimes they would express frustration when understanding the problem seemed to be taking too long or when proposed solutions did not work. As the facilitator described:

Table 1
A partial list of concerns addressed through the reflection process.

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

> At the initial stages of the PPCA work, the teams really struggle with this idea of developing solutions to problems for which they think there are no solutions. As the teams mature, they realize that they're able to come up with a solution and try the solution out.

Several practical measures contributed to building trust in the process's ability to solve problems. For instance, the publication of the meeting minutes on bulletin boards throughout the facility made the accomplishments of the process visible. Staff could see that new practices and policies were a direct result of the reflection process. Action items also mattered. These were produced at the end of each meeting and allocated responsibility for the completion of tasks. They not only served to distribute the workload and further engaged staff in the problem-solving process but they acted as concrete indications that staffs' concerns were being heard. By following up on the status of action items from previous meetings, forward movement was visible and barriers could be identified and addressed. As Paula, a care coordinator (GI3), observed:

> I listen and I hear them and at the end of the day when we have an action plan I ask them if the action plan is suitable to what they want. [I ask if there is] anybody wanting to help or sometimes I'll delegate things and they're good with it because it's all been their idea and it's all been what they wanted to talk about.

Not all problems could be resolved. For instance, we observed that some solutions were too expensive or would violate labor laws or patients' confidentiality. In these cases, ensuring a clear understanding as to why the problem could not be rectified helped maintain the processes' credibility. However, in most meetings we observed, solutions were found or the process of problem-solving continued. Proposed solutions were treated in an experimental fashion. They were to be implemented and, if they did not work, the team would again *"hit the drawing board" (Facilitator, I8)*. Confidence in this experimental approach came with practice: *"If the solution doesn't work the first few rounds, eventually, folks get the idea to be looking for ways to address issues that are unique and comprised of a team effort" (Facilitator, I8)*.

If the proposed solution worked, they would be instituted as facility or unit policy. The "work-plan" was one such example. It was a document responding to HCAs' frustration that their knowledge was being ignored by nurses. The document created a place for aides to record significant observations about residents. It was visible on the nurses' station and nurses were required to initial each entry after reading it. "*The built-in accountability of the work plan,"* according to Marta, (care coordinator, GI8):

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

Another way trust in their problem-solving capacity was developed was by bringing in members from other reflection meetings to share their experience. This was often done to address similar problems and thus created opportunities for inspiration and knowledge sharing. We witnessed several instances where participants shared solutions developed in their unit. Some interventions, such as the work plan, were thereby adopted by several facilities. We also saw one instance where the facilitator was asked to solicit staff input on a health authority policy initiative. Most participants welcomed the chance to engage in policy development, but the research team wondered during a post-observation debrief whether using reflection meetings as 'ready-made' opportunities to obtain staff feedback could become a means of slipping into a top-down agenda.

Revealing, situating and tracing out problems

In addition to cultivating trust in their capacity to problem-solve, participants' ability to design solutions was supported by a spirit of compassionate inquiry. The safety of the communicative environment supported staff in revealing mistakes, failures, risky routines, and other such practices that they would normally hide for fear of reprisal. In so doing, the conversation surfaced many problems. In one meeting we observed, dayshift workers admitted they were being helped by their nightshift colleagues who would wake residents early to get them dressed and ready for breakfast. This practice was justified as a work-around to address staffing shortages, but it was also recognized as poor care. None but the few staff involved knew this was going on, and without the safety of the reflection process, it would have remained hidden. In another meeting, HCAs revealed that two person lifts were routinely performed singlehandedly, putting the safety of workers and residents alike at risk. In some cases, workers had been reprimanded multiple times and training sessions attended, yet the practice persisted. It did so because, as the HCAs revealed, lack of knowledge was not the problem: they were afraid to ask for help.

Additionally, honest speaking and respectful listening allowed staff to trace out the complexities of problems in a process Krishna, (manager, I2) referred to as a "*root cause analysis*" and the facilitator likened to "*peeling back layers of an onion.*" The presence of staff from different occupations was crucial, as many problems were embedded in various occupational and organizational routines. To offer an example of the complexity of seemingly straightforward problems, we witnessed a HCA voice her concern that a male resident was taking too much time to get ready in the mornings. HCAs were frustrated because they were being blamed for falling behind schedule. The care coordinator said she'd look into this. But when pressed for specific action items by the facilitator, she had none. It was clear the care coordinator was not going to follow up. She confessed she did not believe them. Some HCAs were new and, she thought, inexperienced and therefore slow. In response, the HCA clarified that this resident was younger and stronger than most residents and both newer and experienced HCAs were taking longer to get him up. The care coordinator then raised a seemingly tangential concern that many residents were "*half asleep around the lunch table.*" Why, she wondered, were they getting up so early to begin with? The manager advised that not everyone needed to get up at the same time. But, an HCA countered, they had to get them up for physiotherapy. This comment prompted a conversation about the scheduling of physiotherapy. The action item that resulted from this peeling back of layers required the care coordinator to collaborate with the physiotherapist to

create a schedule that allowed residents to sleep in if they wanted to, thereby creating more time for aides to dress residents.

This exemplifies how, through respectful, multidisciplinary dialogue, the process was able to trace the interconnected parts of a problem, identifying conflicting desires, responsibilities, and pressures to design a solution that took situational factors into account. It is worth noting the initial tone of the discussion was marked by resentment. By the end, a much warmer tenor had been achieved. The solutions resulting from such dialogues were often surprising. *Re*-scheduling physiotherapy was not a solution that could have been anticipated from a cursory understanding of the problem, which was initially presented as a struggle with an agitated resident and dismissed as a consequence of inexperienced staff.

Challenges of the reflection process

The process was not without difficulties. As noted, the initial meetings were hard. "*Where I hear the pain coming from is from the leaders, because they feel quite assaulted. That's the language they use – 'assaulted' by staff. It takes them about six meetings before they stop feeling assaulted*" (HA leadership, I4). The bitterness expressed by workers shocked some managers. Other managers felt misunderstood, with their efforts to listen missed and their consideration unappreciated. The volume of complaints could overwhelm managers, and yet they recognized that it was essential to ensure space for negative emotions. To manage this tension, several participants suggested better preparing managers by warning them of the difficulties of the reflection process and letting them know the process became easier and would enable them to make their commitments and care understood.

Participants identified other challenges. There was a tension between scheduling meetings at a consistent time and ensuring diverse participation. Staff agreed it was important to hold the meetings at a regular time and the facilitator believed this consistency was crucial to building trust in the process. Unfortunately, this meant that while the weekly meetings were open to all staff, in practice they were attended by those scheduled to work on meeting days. This compromised the process's ability to include different people and likely resulted in some problems being missed.

In some facilities, finding a room big enough for the gatherings was a challenge, indicating not only the uniqueness of staff reflection meetings but the need to design these relational practices into the buildings themselves. Finally, there were questions of workload, particularly for managers. Some managers admitted that addressing the action items took time. They suggested that while meetings needed to be scheduled weekly, more time was required to complete action items. Nevertheless, managers expressed that the effort was worth it. "*It is an hour and a half out of my week that can probably change my whole week*" (GI3).

Despite these challenges, staff observed that getting together to have these discussions was enjoyable and left them feeling hopeful. This was most clearly witnessed during an education day that brought over a 100 PPCA participants together to celebrate their accomplishments. The day concluded with what has become a tradition in the reflection process, with staff expressing their feelings in a single word. Their choices conveyed a sense of belonging, commitment and joy. As our fieldnotes document: PPCA participants said they felt "encouraged," "inspired," "educated," "refreshed," "informed," "lucky," and "not alone."

Discussion

Our study found that the facilitated reflection process improved the quality of care work. It grappled with a wide range of problems and resulted in new practices, some of which were extended beyond the facilities in which they were developed. It is tempting to focus on these solutions. However, to do so risks reproducing dominant discourses that privilege quantifiable or tangible outcomes. Rather, our analysis shows that among the significant accomplishments of the process was the creation of a respectful *space* for honest conversations. The safety staff experienced was not merely a side-effect. It was fundamental for staff to reveal problems and thereby make them possible to resolve. Similarly, the respectful dialogue fostered was not just a pleasantry. It was essential, not least for colleagues to engage with one another and trace out the complex ways problems were embedded in work routines and organizational practices. This respectful communication enabled staff to develop solutions that made sense for the organization and people involved. Thus, we would suggest that the key achievement of the process was the production of this safe space. The many impressive solutions were actually the side-effects: consequences of what happens when workers can come together and engage in respectful dialogue.

The importance of respectful, honest dialogue is supported by research on problem-solving in long-term care. In the facilitated reflection process Vikström and Johansson (2019) studied, the transformations the staff experienced were attributed to the authentic sharing and considerate listening fostered by the facilitator. Similarly, in their study of the use of reflection groups to address regulatory burdens, van de Bovenkamp, Stoopendaal, van Bochove, & Bal, 2020 observed that it was necessary to create "comfort zones" where workers felt safe to speak. In this communicative environment, staff were willing to be honest about how regulations were impacting their work. They were able to speak across occupational divides, "bringing their worlds together" (p276), and work to maintain, adapt, or eliminate regulations as they saw fit. While the authors give some technical suggestions for the creation of such comfort zones, they do not delve into the relational complexity of this accomplishment.

Our analysis revealed that considerable relational work was needed to create and maintain a comfort zone. This involved anticipating power struggles or conflicts by excluding managers and bringing in a facilitator. Time was allotted for the airing of grievances and addressing rumors and resentments. Work was done to transform emotional venting into concrete issues that could be addressed. Staff were encouraged to speak openly and without blame. Such speaking was modeled by the facilitator who also modeled active listening by asking questions for clarification and paraphrasing. When managers were incorporated, considerable work needed to be done to assuage resentments and ensure the forum continued to be oriented by staff's concerns. We suggest that this relational work was central to the process's effectiveness. In much the same way that Fletcher (1999) identified the relational practices required to create the conditions for workplace teams to emerge, our analysis reveals the relational work required to foster the conditions for innovation to occur: conditions in which staff felt comfortable expressing concerns, exploring the complexity of problems, and experimenting with potential solutions. This relational work transformed a gathering, fraught with misapprehensions and resentments, into a productive space for problem-solving.

The significance of relational labor revealed by our study is corroborated by recent research in LTC settings. Research on what is termed "adaptive leadership," for instance, indicates that successful management requires the capacity to distinguish between technical and adaptive problems (Corazzini et al., 2013). Technical problems are those that can be clearly defined and solved through the application of the correct expertise. Adaptive problems, by contrast, are complex and relational. Solving them requires leaders who can solicit multiple perspectives and encourage both brainstorming and experimentation, as we saw with the PPCA. Failure to recognize the relational nature of LTCF problems, as research by Corazzini et al. (2013) demonstrate, results in poor outcomes. The directors of nursing in their study who ignored these aspects "found themselves facing staff terminations or missed opportunities…to address resident-centered care comprehensively" (p6).

The relational dimensions of reflection groups may also attenuate some of the harms stemming from over-regulation. Regulation operates by finding problems, proposing rules, and monitoring compliance. However, research has shown that an over-reliance on regulation in the LTC sector can become burdensome (Braithwaite, Makkai, &

Braithwaite, 2007; van de Bovenkamp, Stoopendaal, van Bochove, & Bal, 2020). Not least, rules decided from afar can impede the personalization of care and the adapting of work to local conditions. Writing about the tension between regulations and care, Bourgault (2017) notes that good care requires rule bending and, at times, breaking. This should not be viewed as a failure, she argues. Rather organizations need to plan for this by training staff to make appropriate judgments and ensuring processes are in place to support such deliberation. Such processes, she argues, could make “caring bureaucracies” a possibility rather than a contradiction in terms.

An important contribution of the PPCA was the space it provided to deliberate the functionality of rules on an ongoing basis. For instance, we saw exceptions made to institutional policies to meet particular residents' needs and preferences. In these cases, concerns that such exceptions might prove unfair to other residents or set problematic precedents were raised and discussed. In other instances, we witnessed efforts to help staff to follow rules where they had been broken (e.g., one person doing a two-person lift). Each was considered on a case-by-case basis and deliberated collectively. In this way, the reflection process afforded a space where it was possible to negotiate conflicting preferences, needs, demands, ideas, and approaches between, for example, staff, residents, families, and regulatory bodies. What's more, unlike the moral case deliberation studied by van der Dam et al. (2011), wherein the solutions proposed to ethical dilemmas were not easily put into practice, the PPCA was able to implement new work routines. We believe this is partly because ethical dilemmas were not isolated from other norms but treated as one of the many tensions that emerge as a normal part of care work. Making sure reflection processes are in place to support this negotiation is one strategy to ensure that following rules results in good care rather than becoming a meaningless – or worse, harmful – ritual.

It is also worth noting that regulatory and reflection processes inhabit different worldviews. Regulations, as Banerjee, Armstrong, Daly, Armstrong, and Braedley (2015) observe, fit within a reductionist worldview wherein care can be fragmented into discrete tasks, scheduled in advanced, secured through rules, and even timed. By contrast, there is a growing body of feminist scholarship which recognizes good care inhabits a relational world. Mol (2008, p.9) suggests care has its own “logic.” Watson (2005, p.304) speaks of care as an entire “cosmology.” Regardless of terminology, what is being flagged is that supporting good care requires rethinking fundamental assumptions about the nature of the world. The world of care is relational, dynamic, and multi-perspectival. Within this worldview, interconnection precedes autonomy, as Watson notes. In fact, autonomy is a product of relational support. As our study indicates, the same may be said of innovation. It is not an individual accomplishment but a relational one: a product of respectful speaking and listening. Organizational practices in LTC continue to reflect a reductionist worldview and have not yet been adapted for the relational world of care. Given the dynamic nature of caring for persons who are aging and in ill-health, it is vital to have a space where problems may be addressed as they emerge and in ways that suit local contexts.

The PPCA process has its limitations of course. Notably, it could do better at incorporating residents' perspectives, perhaps by including residents or residents' council representatives in the PPCA meetings. Solutions were ultimately limited by the knowledge of participants. However, it is not difficult to imagine that reflection meetings could bring in experts to offer knowledge about relevant issues, as in the case of the meetings of medical directors described by Banerjee, James, McGregor, and Lexchin (2018). These meetings often began with a presentation by an expert on a topic deemed pressing and even local policymakers were invited to attend. Similarly, the reflection meetings studied by Braedley and Szebehely (2017) were led by a staff member who had completed a national certification program in dementia care. The reflection process thus served as a method of integrating this knowledge into staff problem-solving.

Our study is also limited by its focus on meetings and participants. Research tracing the implementation of solutions and their effects is warranted. Nonetheless, we wanted to focus on the relational work of speaking, hearing, and honoring the practical wisdom of staff because this is so often missed in calls to improve care through top-down forms of accountability. Indeed, respecting the wisdom of staff undoubtedly played a role in the enhanced sense of self-worth experienced by care workers. Their empowerment was particularly notable in a sector where many care workers feel dismissed and this connection warrants further investigation. How might increased self-worth be developed through these processes? Does the sharing of successes across PPCA meetings enhance a sense of accomplishment and expertise? And what implications might the increased sense of self-worth hold for the challenge of retaining staff and perhaps even for mobilizing for better LTC policies and funding?

Finally, we conclude by recalling the optimism and hope encountered in the PPCA process. One of the fundamental assumptions behind relational practice, according to Fletcher (1994), is that human connection is of value in and of itself. By starting from this presumption and fostering respectful communication, camaraderie, joy, and innovation resulted. The process left participants feeling cared for while they were striving to improve the care of others. We hope that this paper contributes to the growing recognition that the relational world of care needs new ways of “being/knowing/doing,” to quote Watson (2005, p. 305), and serves as a welcome reminder that when appropriately supported, LTC work can be deeply fulfilling. It also serves as an important caution, a reminder that bringing workers together – particularly given the challenges of current working conditions – might not result in either respectful dialogue or innovation without considerable relational awareness.

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