

THE HOUSEHOLD MODEL

The Household Model:  
Meeting the Social and Emotional Needs  
of Residents at Samaritan Place

A Field Practicum Report  
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### Abstract

This report reflects my practicum experience with Samaritan Place which took place between August 1, 2013 and December 13, 2013. My practicum explored the culture change movement within long-term care. This movement reflects a shift from an institutional model of older adult care towards a home like environment where residents are involved in planning for, and living their life to the fullest extent possible. Samaritan Place utilizes the Household Model out of the culture change movement that emphasizes improving the quality of life for residents and their families. The Household Model is a philosophical and practice framework that emphasizes building a strong community and exploring relationships that develop between long-term care residents and caregivers, organizational leaders, family and other community members. It is about participating in daily life activities within these relationships that ultimately leads to improved quality of life.

This report is a synthesis of my practicum at Samaritan Place that includes my observations, participation, and personal experiences as I worked with people with dementia within the Cottages. I explore the Household Model and several other models of long-term care. I look at how the Household Model within the culture change movement is being implemented at Samaritan Place and its impact on the quality of life within the Cottages. I reflect on my experiences within Samaritan Place and highlight my learning from the integration of theory and practice with specific focus on the Ecological Framework. I also explore how spirituality has been further developed within the Household Model as Samaritan Place is a faith based long-term care facility.

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I have had interactions with long-term care facilities since I was a child. Long-term care has also been an integral part of my professional background as a social worker in health care. Through these experiences I have developed an appreciation for the elderly and respect for their right to a high quality of life with the opportunity to voice their ideas and choices for how they want to be cared for.

In the *Patient First Review Commissioner's Report* by Tony Dagnone in 2009, residents of long-term care facilities shared their concerns about quality of life issues. These included the lack of attentiveness to residents' needs and scheduling practices that were more beneficial to staff than to residents. In completing my Master of Social Work degree, I wanted to continue to explore how care for the elderly could be changed to ensure a high quality of life where the elderly were allowed to live with dignity and direct the care that they received.

In long-term care, there is a movement away from the institutional model of care. I chose to complete my practicum at Samaritan Place, a long-term care community that has adopted the Household Model. This model focuses on the provision of care in a home-like environment; which is a distinct move away from an institutional model of care. Samaritan Place is a Catholic health facility whereby spirituality and faith are core values. These values are reflected in the mission statement "where care is compassionate, resident directed and respectful. We advance the healing care ministry of Jesus Christ by responding to the needs of spirit, mind, body and culture of those who enter our home" (Samaritan Place, n.d.,p. 4). This practice report explores the concepts of the Household Model as it has been developed at Samaritan Place, how this model is lived out through the mission, vision, and value statements and the facility's faith perspective, and how this impacts on the care residents receive and their perceptions of quality of

life. I also examine how the Household Model fits with core orienting perspectives in social work that include the Person-In-Environment and Ecological Frameworks.

As my focus was with the Dementia Cottages at Samaritan Place, I also review dementia care in relation to the concepts of person-centered care and eldertopia. Person-centered care is defined as an approach to care that respects the individual being cared for and those working with them. This approach to care involves continued listening, trying new approaches to care and routines, and treating each individual as unique (Shields & Norton, 2006). Dr. Bill Thomas, describes eldertopia as “a community that improves the quality of life for people of all ages by strengthening and improving the means by which (1) the community protects, sustains, and nurtures its elders, and (2) the elders contribute to the well-being and foresight of the community” (Thomas, 1995). Samaritan Place is a faith-based organization where spirituality is an important factor as they explore how the Household Model of care can be implemented while they live out their mission, vision, and values. The current care model at Samaritan Place does not include social work. Therefore, I consider how social work could be incorporated to assist the current leadership team at Samaritan Place as they walk the journey toward resident-directed care while assisting residents to be part of the home and community.

### **Institutions for the Elderly in Saskatchewan**

Many institutions for the elderly, commonly referred to as homes, in the Province of Saskatchewan had their roots within religious organizations (Kishchuk, 2010; Robertson, 1982). These homes provided a custodial model of care that provided food and lodging for elderly clients. When these religious organizations undertook initiatives to meet the needs of the elderly within their communities, they did so in an uncoordinated manner. In the 1960s, these organizations started to meet and later formed an association of membership known as The

Saskatchewan Association of Special Care Homes. The purpose of this association was to exchange experiences and knowledge amongst themselves. This group also advocated for services for the elderly with the provincial government (Kishchuk, 2010).

As the needs for skilled nursing services increased, these homes began to move towards a medical model of service similar to the care provided within an acute care setting. As such, the institutional model of care of the elderly within long-term care settings was born. Jurkowski (2013) states that long term care facilities provide services for individuals on a long-term basis that includes the following: professional nursing care, medication management, personal care, as well as social and recreational services. These facilities also include and offer meals, cleaning, sanitation, and laundry services in a safe and healthy environment.

Elderly people living in long-term care settings typically have a variety of chronic physical and mental health problems (Beaulieu, 2007; Cox, 2007; Sing 2011; Stephenson & Sawyer 2004). The institutions have long hallways, with a hospital-like atmosphere, medicine carts, and nurse's stations, with staff going from one resident to the other, performing tasks. The goal of the staff is to complete all of the assigned tasks before the start of the next shift. According to Jurkowski (2013) and Kane (2001), the task within a specific time frame determines the type of care that each resident receives on that particular shift. The primary tasks center on making sure that all medical needs are met and that each person receives their needed physical care. These tasks take precedence over the person, who is often left alone without positive human stimulation and contact. Staff are more concerned about making sure all of the daily tasks are completed and in keeping with government regulations (Jurkowski, 2013; Kane, 2001).

Long-term care facilities have been the subject of growing criticism from members of the public concerned about care and quality of life for the elderly (Cox, 2007; Jurkowski, 2013;

Kane, 2001). Concerns have been voiced about the standard of medical care within these settings and the focus on rigid daily regimes that give little attention to needs beyond the physical. The Saskatchewan government conducted a Patient First Review in October 2009 to hear stories of people's experiences with health care. Concerns about senior care and long-term care were evident, and stories were shared about less-than-ideal quality of care and a lack of attentiveness to the residents' needs. Residents and families reported feeling that institutional scheduling practices were designed to benefit the staff rather than the residents and revealed what happens when quality of life is not met for residents and their families. These statements are further supported within the literature on culture change within long-term care (Jurkowski, 2013; Singh, 2011; Stephenson & Sawyer, 2004).

### **Origins of Catholic Health Care in Saskatchewan**

Catholic Health Association of Saskatchewan services were started in 1907. Between 1907 and 1952, there were 23 Catholic hospitals established with the involvement of 11 different congregations (Robertson, 1982). Long-term care homes were also established in the early history of Saskatchewan, and by 1968 there were 12 Catholic long-term care homes in the province. The goal of these facilities was to serve humankind by responding to the unmet needs in our society through a ministry of compassion (Catholic Health Services of Saskatchewan, 2011).

**Focus of Catholic Health.** Under Catholic Health Services, the following values were developed for all Catholic health care facilities. They were to be holistic in care provision, treating the physical, psychological, and spiritual dimensions of their clients' lives that included pastoral care for clients, their families, and the facilities' staff. Catholic facilities were also expected to serve the poor, the uninsured, and underserved within the community, recognizing

the human dignity of the person and delivering services with full respect for human life, at all stages and in all its dimensions (Catholic Health Services of Saskatchewan, 2011; Robertson, 1982).

Currently, Catholic Health's goal within each of its facilities is to form a community of healing and compassion and create places that tend to the physical, psycho-social, and spiritual dimensions of the human person and provide hope to all who receive services. Catholic Health of Saskatchewan works in partnership with public and private health care sectors within the province (Catholic Health Services of Saskatchewan, 2011; Robertson, 1982).

**Samaritan Place.** In 2009, the Catholic Health Ministry of Saskatchewan (CHMS) discussed building a new long-term care home. As this discussion moved forward, Amicus Health Care was formed as a subsidiary of CHMS to build the new facility. In 2012, Amicus Health Care hired the first Executive Director to assist in the building and to develop programming for the new facility. In 2011, the mission, vision, and value statements were drafted with input from community representatives and the CHMS. The leadership team was hired and, by January 2012, staff was hired and orientation provided. The official opening took place in April 2012, and by May of that year, the building was at full occupancy. Within Samaritan Place, residents are affirmed and supported in their life's journey, focusing on specific needs of residents through the facility's commitment to its mission, vision, and values (Samaritan Place, n.d.; Samaritan Place, 2013b).

### **Practicum Experience at Samaritan Place**

As I reflect on why I chose to do a practicum at Samaritan Place, I will first provide a history of my experiences and interactions with long-term care facilities and their residents.

### **Personal Experiences with Long-Term Care Facilities**

My first experience with a long-term care facility occurred in my childhood. My mother started a position in the business office at the local long-term care facility. I was able to go see where Mom worked, and I remember thinking that Mom worked at a neat place. The Administrator had built a park next to the building for children to play in while visiting grandparents. As well, a trampoline was set up in the auditorium and balls and other toys were available for children. There were several other children from our hometown whose parents worked at the facility, and we often gathered at the park or the auditorium to play.

During my elementary school days, we made trips to the nursing home to participate in parties involving the residents. We would sing and have refreshments. It was during this time that I met a specific resident who was disabled, and I made sure to visit her each time that I came to the nursing home. She loved to ask questions and quiz us on our multiplication tables, and it was a joy to visit her. As a child, I remember speaking with other children who were apprehensive about going to the nursing home on class trips and would not say hi to the residents. I was very comfortable speaking with the residents.

During high school, I participated in a visitation program at the nursing home for my Ethics class. We were required to talk about history with the residents we visited and then report back to the class. I heard many stories about how Saskatchewan was settled and how difficult farming was at that time.

When I was a young child, my paternal grandmother was diagnosed with dementia. I remember visiting her and having to tell her my name each time we saw her. My parents made sure that we had a list of events from our lives to tell her about during each visit. As Grandma's dementia progressed, she became less communicative and did not interact with visitors who came to visit. I was still in school when she passed away.

My maternal grandmother also lived in a nursing home after her health deteriorated and she required emergency surgery. Grandma was very sick when she was first admitted to the nursing home and took several weeks to recuperate. During university, I would visit Grandma in the nursing home every week. Grandma made her room into her own “home”. As a child, I remember the wonderful baking and meals she would prepare when we came to visit her. Now, while in the nursing home, her love of entertaining continued. She always had a bowl of peppermint candies and a bowl of chocolate rosebuds, and she always made sure to offer us these candies several times during the visit. Part of the ritual of visiting Grandma included a walk to the kitchen where we made ourselves a cup of tea and then we would go back to her room to visit. She loved playing card games, and we would often play a game during our visit, or I would bring pictures from vacations. The final ritual from my visits would be Grandma walking me to the door when I left and she would always wait by the glass door and wave as I drove away.

I have also worked as a caregiver at a long-term care facility. This was an enjoyable job and I learned the valuable lessons that we can learn from our elders. The nursing home I worked at was institutional. We had regimented routines where each resident was woken up at 7:00 am and taken to the dining room for 8:00 am, followed by baths and medical treatments. The nursing home had very good recreation, leisure, and spiritual care programs. Residents were always taken to each of these events. As I reflect, I do not recall that I asked if the residents wanted to go to the events; it was assumed that they would want to go.

These personal experiences have shaped my personal values and practice in working with the elderly. I have discovered the wealth of knowledge all elderly people can provide to those who are younger, including me. I have developed a deep respect for the elderly and want to

provide care that meets their spiritual and psychosocial needs. This means developing a strong relationship so that I truly know who I am providing care to. I must make myself vulnerable to those who I am caring for by allowing the elderly person to have a relationship with me. While growing up with grandparents in long-term care, it was easy to develop a relationship through the bond of family. It is not always easy to form a relationship with someone who is not related to me; however, through intentional work I have discovered that this is possible. The relationships that I have developed with my elders play an important part in my life.

### **Practicum at Samaritan Place**

My first experiences visiting a long-term care facility were positive, and these interactions have shaped my personal, professional, and spiritual point of view of care for the elderly. As concerns regarding care of the elderly in long-term care have come forward, I have had to look at my past experiences and understand how these experiences might have been different under a resident-directed model of care. In addition to reflecting on care models, I am also interested in understanding the spiritual dimension of the care of the elderly within a faith-based organization: How do the mission, vision, and values get incorporated into the care that is provided to the residents? My personal faith and spiritual journey is part of what I bring to my work as a social worker and to my practicum setting.

Based on these experiences, I chose to complete a practicum at Samaritan Place, a Catholic long-term care facility that employs the Household Model in order to provide resident-centered care. The focus of my time at Samaritan Place was in the Cottages where residents with dementia-related illnesses reside. The leadership team at Samaritan Place identified the Cottages as an area for me to specifically focus upon during my placement. One of my initial questions was: How does Samaritan Place ensure the quality of life of these residents'? My report details

the work that I facilitated in the Cottages and how this fits into the Household Model and the mission, vision, and values of Samaritan Place.

**Site.** Samaritan Place is home to 100 residents. There are three households within the building: the Prairie Neighborhood (divided into streets named Sunset, Harvest, and Wheatland); the Park Neighborhood (divided into streets named Meewasin, Waskesiu, and Blackstrap); and the Cottages (divided into streets named Candle and Emma). There are 56 individuals living in suites within the Park and Prairie Neighborhoods with an additional 20 companion suites throughout that are designed for two people who have different care needs yet want to remain living together. There are 24 secured suites in the Cottages designed for individuals who have cognitive impairments. The household is each resident's home, where people direct their own lives, individually. Each of the households is part of a neighborhood, which has its own dining area, living room, and other small areas for gatherings.

**Staffing.** Each staff member or care partner is assigned 12-14 residents, providing each resident with daily nursing care in accordance with the residents' assessment, choices, and care plan. The care partners work within a multi-disciplinary team where the resident directs the daily schedule. The care partner promotes the residents' psychosocial well-being through meaningful relationship building.

Licensed Practical Nurses provide clinical leadership to the households. In addition, a Nurse Practitioner is an advanced practice nurse who is licensed to assess and treat most health conditions. The Nurse Practitioner is available to each resident to support the medical care they receive and works with their designated family physician.

The Leadership Team of Samaritan Place includes the Executive Director, Director of Care Services, Director of Life Enhancement, Director of Spiritual Care, and the Director of Support Services.

The programs offered through Care Services ensure that the care provided is compassionate and resident-directed, and that the residents live according to their needs, expectations, and choices. Physical, spiritual, and emotional care is provided to meet residents' daily needs to ensure that they function at the highest level possible.

The Director of Life Enhancement focuses on the residents' choice of activities to improve the quality of life of each resident at Samaritan Place. Activities provided at Samaritan Place assist the residents' social, cognitive, physical, and spiritual needs. Volunteers provide companionship, friendship, and help reduce loneliness in residents. They work directly with Life Enhancement and Spiritual Care.

The Spiritual Care Director ensures that the residents' spiritual needs are addressed, responding to the needs of spirit, mind, body, and culture. Mass, healing services, ecumenical services, celebrations of life, and one-to-one visits are part of the services provided by Spiritual Care. This position also helps to integrate the Household Model with the mission, vision, and values of Samaritan Place.

Samaritan Place has created a Resident and Family Council, which all residents and their family members are invited to participate in. Council meetings are held on a monthly basis and serve as a communication link between the residents, staff, and administration of the Home.

### **Ideology**

Samaritan Place uses the Household Model of Care that evolved from the culture change movement within long-term care. In this section, the influence of the Medical Model on long-

term care and different models of Culture Change will be explored. Also, the link to quality of life, person-centered care, eldertopia, servant-leadership and spirituality to the Household Model will be discussed.

Within the literature on Culture Change and long-term care, several models have been developed and utilized to promote resident-centered or resident-directed care as opposed to the traditional medical model. These models include: the Eden Alternative, Wellspring, the Green House Model, and the Household Model (Jurkowski, 2013). These models are explored and compared in the following literature review. Additional ideologies that are included are quality of life, person-centered care, eldertopia, servant-leadership, and spirituality.

### **Medical Model**

The traditional medical model is based on the delivery of health care that emphasizes the treatment of disease and relief of symptoms with intensive use of medical technology. The diagnosis is central to determining treatment strategies to eliminate symptoms or behavior (Jurkowski, 2013; Kane, 2001; Shura, Siders, & Dannefer, 2010).

Within long-term care, the medical model has influenced the care that elders receive. Under this model, the focus is on care regimes (toileting regimes, medication regimes, medical treatments, bathing regimes, etc.), all scheduled in a specific routine that cannot be changed. Staff rotates through and residents have multiple staff caring for them. Within this environment the facility makes decisions for the residents through a hierarchical system of departments that look at specific care needs.

Under this model of care, the greatest importance for care resides in departments for treating physical illnesses and biological and activity needs of daily living. Little emphasis is placed on the staff who care for residents' social and interpersonal well-being, such as social

workers, occupational therapists, and activity programmers. The separation between medical and non-medical staff and their individual goals for the residents can result in a person being treated as a collection of separate and disconnected needs (Shura, et al., 2010). Thus, creating a more homelike environment is less of a priority than caring for residents' medical needs.

### **Models of Culture Change**

Long-term care facilities have increasingly been moving away from a task-oriented, medical-driven model of care towards a more holistic model which emphasizes the residents' perspective and their defined experiences and needs (Jurkowski, 2013; Kane, 2001). Culture change includes a multitude of efforts aimed at transforming the psycho-social, organizational, operational, and physical environments in order to enhance quality of care, quality of experience, quality of life, and create a viable sustainable business. This is accomplished through developing a setting that is a supportive home that meets residents' identified physical, social, emotional, and spiritual needs while being an enjoyable workplace (Jurkowski, 2013; Kane, 2001). Culture change in long-term care requires the staff to ensure that the residents they are caring for are thriving and receiving the best quality of care. The emphasis is on seeing past the disease process to the person for whom they are providing care. Everyone is known by who they are, by their life roles and according to their special relationships. The care provided is grounded in the ability of each worker to ensure that the resident always comes first before the task. Relationships between the residents and workers and each other are encouraged and flourish as they engage with one another in meaningful activities.

Within the culture change movement, quality of life enhancement is the overarching goal (Jurkowski, 2013; Kane, 2001). This approach focuses on the residents' relationships within the long-term care setting and their ability to participate fully in their daily routines, care, and

activities. The emphasis is both on the quality of the care received and the quality of the life lived.

There are important differences between the Institutional and Social Models of care in the culture change movement (see Appendix D). Generally, long-term care services provide a unique combination of traditional medicine and social services. Health care professionals are still seeking to find the best combination of the two (Jurkowski, 2013; Kane 2001). Medical professionals are trained to cure illnesses and heal injuries. Consequently, they often fail to recognize and address emotional, spiritual, and psychological suffering during the provision of care. This can compromise the comfort and quality of life of the resident. However, four models of care exist that are examples of how the care of the elderly can move from the Institutional Model towards a Social Model of care, thereby leading to an improved quality of life for the elderly. The following section will look at the Eden Alternative, Green House, Wellspring, and Household Model.

**Eden Alternative.** The Eden Alternative model was developed in 1991 by Dr. William Thomas to address the three areas identified by Thomas as plaguing nursing homes: Boredom, helplessness, and loneliness (Jurkowski, 2013). To address these plagues, Thomas developed 10 principles which are the building blocks of the Eden Alternative model. These principles assist in building relationships between staff members and residents, developing opportunities to provide meaningful care and activities for both the residents and other living creatures within the home. Spontaneity is also incorporated as an opportunity to enrich the home. While the Eden Alternative has been extensively researched, the research has yielded mixed results indicating improvement in quality of life (Jurkowski, 2013; Singh, 2011; Stephenson & Sawyer, 2003).

**Green House.** The Green House model encourages a movement from a large institutional setting towards a smaller, home-like environment with 7 to 10 residents (Jurkowski, 2013). Each Green House has self-contained private rooms with their own bathroom and ceiling tract lift to accommodate frail elderly residents. Residents can bring in their own furniture and they can choose their own décor. The rooms are connected by short hallways to the living room, kitchen, and dining areas, laundry and storage space. There are no nursing stations or medication carts within these spaces. The nurse call system is wireless and uses silent pagers; and the staff is organized into self-managed teams. Cross-trained nursing assistants do the cooking, cleaning, and provide personal care for each house (Jurkowski, 2013; Singh, 2011; Stephenson & Sawyer, 2003).

An interdisciplinary team comprised of physicians, nurses, therapists, social workers, dietitians, and others provide practical guidelines for use by the caregivers, giving maximum control to the residents. The residents are encouraged to participate in meal preparation, cleaning, and laundry. The Green House model is designed to give primacy to quality of life outcomes without giving up responsibility for the clinical outcomes and associated clinical care.

**Wellspring.** This model aims to improve the well-being of residents through quality improvement initiatives (Jurkowski, 2013; Singh, 2011; Stephenson & Sawyer, 2003). Clinical modules are developed to train staff regarding incontinence care, nutrition, fall prevention, skin care, well-being, palliative care, and leadership. A geriatric nurse practitioner oversees clinical aspects of care, while managers and associates are trained in all of the clinical models. Managers and staff also learn coaching and mentoring. Staff is permanently assigned to teams and is responsible for providing care to the same residents, allowing the staff to get to know the residents better. Staff is trained in assessing problems and taking a proactive approach to

resident care. Underlying the intervention to improve the quality of care for residents is a work environment philosophy that enables employees to make decisions about their work and care for residents and to foster a team approach (Shura, et al., 2010).

**Household Model.** The Household Model, as developed through the work of the Pioneer Network, consists of a small group of residents living in a physically-defined environment that "feels like home" with a kitchen (with a wide variety of food accessible to residents around the clock, including breakfast-to-order and on demand), a dining room, and a living room. Staff is consistently assigned so they can develop meaningful relationships with the residents, work in self-led teams, and perform a variety of tasks. The sense of being at home is expressed in recognizing and honoring the rhythm of each individual's life. All residents in the household have opportunities to participate in the daily life of the household in a manner and to the extent they choose (Shields & Norton, 2006; Shura, et al., 2010).

Each household has decision-making autonomy and is consistently staffed. Residents get up when they want, bathe how and when they want, go to bed when they want, eat when and what they want, and decide how they will spend their day. Household life is "normal," spontaneous, and full of new experiences.

Five different types of circles within the Household Model promote the continued work of culture change (Shields & Norton, 2006). The learning circle is the most basic form and can be used by different groups of people for exchanging all sorts of information. The community circle is based on the learning circle but is used more with elders living with dementia. Team meeting models (including the stand-up) are focused and involve all in attendance. Finally, the competency circle is an ongoing process for training and education. Staff members are expected

to study important competencies so that they in turn can teach the rest of the organization (Shields & Norton, 2006).

According to Shields and Norton (2006), three components support culture change: 1) Renewal of the spirit: the staff, residents, and families work together to create purpose and meaning within the nursing home; 2) Reframing the organization: traditional departments are eliminated to integrate disciplines with the self-led household team structure; and 3) Leadership: leadership is spread throughout the organization. Frontline staff, residents, family members, managers, and executives share leadership responsibilities and are all empowered to make life-impacting decisions as a team.

### **Quality of Life**

The Eden Alternative, Wellspring, the Green House, and the Household Model emphasize quality of life, ensuring that residents live a rich and rewarding life where they receive quality care and experience a good quality of life. Each model provides a way to move from a medical institutional model towards a philosophy rooted in culture change where caring for residents is directed by residents and boredom, loneliness, and helplessness are addressed through the building of relationships. Through these relationships, each resident is seen as a unique individual with a life story full of potential, linking them to a variety of meaningful activities that lends to their quality of life

The definition of quality of life remains difficult to define. Kane (2001), has identified 11 domains common to quality of life: 1) sense of safety, security, and order; 2) physical comfort; 3) enjoyment; 4) meaningful activity; 5) relationships; 6) functional competence; 7) dignity; 8) privacy; 9) individuality; 10) autonomy; and 11) spiritual well-being. A person needs to be able to trust that they will be known as a unique individual with their own personality and traits that

are part of who they are as they interact with the world around them. This brings about a sense of security and safety. Physical comfort includes being free of pain and discomfort, and having their needs noted and addressed. Life must also include enjoyment, recognizing this will be different for each individual. This will include participation in meaningful activities where the individual may be an active or inactive participant. Within long-term care, relationships must be nurtured. These relationships are between residents, residents and staff, residents and their families, staff and the residents' families, and with the outside community. Each of these relationships must be nurtured and encouraged along the long-term care journey. Residents must be allowed to make choices and to participate in daily life based on their physical and cognitive abilities. Whatever choices that they are able to make should be encouraged.

Privacy should be promoted and protected. Kane (2001) identifies privacy as important for residents to: “1) exercise autonomy and maintain individuality; 2) achieve emotional release particularly important at times of loss, shock, or sorrow; 3) conduct self-evaluation, which requires private information processing and reflection; and 4) achieve limited and protected communication” (p. 298). Each person in long-term care deserves to be known as an individual person who is able to express their own identity and to have continuity with their past. As well, each person should be able to exercise their autonomy to make individual choices and to direct their own life. Finally, residents within long-term care should be able to experience spiritual well-being. Collectively, these domains of quality of life fulfill the needs of residents on an individual as well as a community level. The importance that individuals place on each domain will differ, making it important that staff interact with each resident on an individual basis.

### **Person-Centered Care**

In recognition of the psychosocial needs of the elderly, literature shows a shift towards person-centered care (Jurkowski, 2013; Singh, 2011; Stephenson & Sawyer, 2003). Person-centered care emphasizes involving elderly residents in their own care, supporting autonomy and encouraging those activities that enhance meaning for the individual. While there is no single definition of person-centered care, the literature identifies common elements: getting to know the person, physical comfort, enjoyment, meaningful activity, relationships, functional competence, dignity, privacy, individuality, autonomy and choice, and spiritual well-being (Epp, 2003).

Through my practicum I developed a better understanding of person-centered care. First, I saw the importance of working with the residents within the Cottages and making sure that they were at the heart of the decision-making process. Second, I learned that it is important to speak directly with the resident. While it may be challenging in the Cottages when there are barriers to communication related to dementia, it continues to be important to speak directly to the resident. Third, I discovered the importance of caring for the whole person. This means getting to know the person you are caring for. This happens through listening to the resident's story, either as told by the resident or their family. During my practicum a gentleman was standing at the window in the living room with his golf cap on, looking at the clock on the wall and saying he had to get going. At a recent Quality of Care Meeting, we learned from family that this man had been an avid golfer in his retirement. As I talked with him, I asked him about golfing and if he would like to sit down and talk with me about his favorite course. Life Enhancement had several books of golfing in the living room and we looked through them. This experience led to my fourth understanding. I discovered the importance of acknowledging the importance of relationships and engagement in the lives of residents. This example is one of many where I saw these four aspects of person-centered care as I worked in the dementia cottages.

**Eldertopia**

The pursuit of Eldertopia can provide a better understanding of how elderly people continue to participate in society (Thomas, 1995). Thomas (1995) states that, “an elder is a person who is still growing, still a learner, still with potential, and whose life continues to have within it promise for and connection to the future” (p. 3). He goes on to say that, “an elder is a person who deserves respect and honor. Whose work it is to synthesize wisdom from long life experience and formulate this into a legacy for future generations” (p. 3).

The culture change movement is dedicated to ending institutional care and replacing it within a range of person-centered cultures that are dedicated to growth and genuine human caring. Eldertopia recognizes elderly people as being of value, and this requires moving away from the medical model which sees elderly people in need of being cured through medical intervention, where care is limited to a set of prescribed needs (Thomas, 1991). Long-term care facilities are challenged to become places where the elderly are treated with love, respect, dignity, tenderness, and tolerance.

Throughout my practicum I have grown in my appreciation of the elderly and how they contribute to the community at Samaritan Place. As I reflect on my past experiences, I realize that I have always had a deep respect for my elders. This practicum has shown me how to include elders in developing a sense of community while providing care that improves quality of life. In my past experiences, my goal was to provide compassionate care, but it did not necessarily include the elder. This experience has shown me the importance of involving my elders.

**Servant-Leadership**

Servant-leadership is a model of leadership that Samaritan Place has incorporated into its mission, vision, and values (Samaritan Place, 2013a). Servant-leaders serve those they work with, such as clients, their families, and co-workers, through living out the mission, vision, and values of the organization. The skills of a servant-leader include: listening, motivating people, carrying the vision, and calling forth leaders (Young, 1999). Servant-leaders listen to people to hear what they are saying and watch for non- verbal messages. What is the person saying about their needs, and what are they able to offer? What are their strengths and weaknesses and how do these define or describe the situation?

Through listening to stories and sharing their own stories, the leader motivates others within the organization. While this is part of listening, it moves beyond in that it encourages colleagues, volunteers, and others to become motivated to live out the mission of the organization. The vision of an organization is how the mission is carried out, as exemplified through the Mission and Spiritual Care Strategic Plan for Samaritan Place. Servant-leaders recognize the importance of carrying the vision of the organization and encouraging others to do the same. They lead by example and through coaching, encouragement, and teaching (Samaritan Place, 2013b).

Finally the servant-leader calls out leaders within the organization, enlisting the help of others in the journey of living out the mission, vision, and values of the organization. Through each of the skill sets described the servant-leader helps the organization to continue the journey toward their mission and ensure work continues towards that end (Young, 1999).

Servant-leaders make a commitment to listen to others. The opinions and ideas of others are sought and valued. They strive to understand and empathize with others. Empathy implies acceptance of all members of the team. Servant-leaders must remember firsthand the difficult

demands placed on the staff. A servant-leader must be open to information from multiple sources. Within long-term care, they must be aware of the changing needs of the interdisciplinary team and of the residents they are serving. Consensus-building is a skill that builds a culture of cooperation and harmony. For example, staff schedules, resident activity calendars, and clinical assignments are all areas of possible negotiation and consensus. The servant-leader seeks possibilities and sees not only what is there but sees how things could be. Conceptualization forms the basis for thinking beyond traditional ways of delivering care. Within long-term care, leaders must strive to bring new approaches to enhance quality of care and quality of life for the residents and staff they serve. Servant-leaders believe in the intrinsic value of human beings and are committed to improving the lives of others. Finally, servant leadership is about community building. Each member is valued and encouraged to contribute to the whole. Within long-term care, where staff is privy to the most intimate details of the lives of those they serve, strong connections take place. Day-to-day interactions between residents and their families and staff build bonds as they turn to each other for support.

Young (1999) suggests that servant leaders develop quality relationships, building a sense of community and finding ways to help others and to give back to the community. During my practicum, the staff of the Cottages came up with the idea of collecting pop cans for recycling and using the funds to purchase items for the cottages to improve quality of life. Through the Residents' Council, ideas for use of these funds took place. As well, one of the residents spoke with staff about attending a specialized camp this summer. This individual had limited family involvement and funds, so staff worked with the resident and developed a fundraising plan. This included a fundraising supper and working with the Ministry of Social Services to plan for this resident. The resident participated in each of these events and showed

great excitement as plans came together for him to go to camp. He was sure to let everyone know that this was what he wanted. I observed that the staff were excited to see his dream of attending come to fruition. These examples show how servant-leadership is implemented within Samaritan Place, where staff are empowered to become leaders in terms of working with the residents and their families and fellow colleagues. Through this work, the staff and residents, through the Residents' Council came up with ideas to improve the quality of life of all of the residents. Further, on an individual basis, staff through servant-leadership discovered the dream of one resident to attend camp, learned how this would positively impact his quality of life, and worked with him to develop a plan to make this happen. These staff were recognized at the 2013 Christmas Staff party for their contribution to improving the quality of life of this resident and for building community within the Cottages.

### **Spirituality**

Spiritual care has been identified as part of holistic care within health care settings (Richards, 2005). It is only recently that a deeper understanding of caring for the whole person has recognized that this must include caring for the spirit. All staff must become integrally involved in spiritual care for residents and their families (Richards, 2005; Butot, 2007; Baskin, 2007).

Spirituality is an integrating factor in the care of the whole person, and there is no aspect of care provided in nursing homes that does not have some spiritual component (Wagler & Martin, 2007; Richards, 2005). This point remains true whether a person is struggling with cognitive deficits or is mentally alert. Social workers must consider all aspects of the residents' everyday life to ensure that their needs are being met and they have a quality life despite facing disabilities. Basic social work tasks in long-term care include: assessment, care planning,

discharge planning, counselling, finding resources, making referrals, and working with families (Cox, 2007). These aspects of the job may have spiritual implications and the social worker must be alert to them (Richards, 2005; Stephenson & Sawyer, 2004).

It is important for staff to integrate spiritual assessment and interventions into the plan of care of nursing home residents (Richards, 2005)). Varying spiritual beliefs and lack of education and experience with spiritual care are barriers to implementing spiritual interventions. It is important for long-term care facilities to provide spiritual education to increase nursing competence in this area (Richards, 2005; Cox, 2007). In addition, spiritual in-services may be appropriate for enhancing spiritual care in long-term care facilities. Faith-based long-term care facilities advance the healing and caring ministry of the church by responding to the needs of spirit, mind, body, and culture (Robertson, 1982). Every person has personal values and spiritual beliefs. For some, religion and faith is central to who they are. For others, spirituality may not be based upon religion but may be identified or expressed through an appreciation of nature (Samaritan Place, 2013b). The goal of care must be to help residents feel that they are at home and not part of an institution. To do this, a resident-centered approach must be incorporated where staff is called to constantly listen and respond to needs. This is what spiritual care is about in the broadest sense (Richards, 2005).

All staff within long-term care settings are part of providing spiritual care (Richards, 2005). It happens while talking to residents while providing care. It takes place by encouraging storytelling and by encouraging residents to participate in developing their care plans (Cox, 2007). It happens when staff see a resident having a difficult day and sit with them in order to try to understand what is happening. These are all relationship-building exercises, a part of

caring for the whole person. It is about accompanying the resident through their journey and helping them and their family to understand their resources (Cox, 2007; Richards, 2005).

The Household Model is about culture change in long-term care. It is about creating a home where living happens naturally and brings meaning and quality to the lives of elderly people. The household is where residents share what is sacred about the house and its people. It is where values are consciously created and preserved. This is accomplished through the sharing of rituals, spontaneity, friendship, spirituality, celebration, recreation, choice, independence, art, and humor. A Spiritual Care model is utilized by Samaritan Place and captures how the Household Model is incorporated into all aspects of care (see Appendix E). It shows how the leadership team promotes this model of care. At Samaritan Place, life is a journey which involves the passions of the resident (What is the life story of the resident? How does Samaritan Place help residents to reflect of the life's journey in a spiritual fashion? Tell us about your spiritual journey and how we as a community can support you.). The passions of residents are often disconnected from their lives through illness such as dementia or depression. It then becomes the responsibility of staff to help residents, regardless of their illnesses or abilities, rediscover their passion for life, thereby restoring a sense of dignity and self-worth, new meaning, and purpose. Linkages to the community inside Samaritan Place and the wider outside community, as well as connection to friends and family is important, as is exploring spiritual resources (Richards, 2005; Butut, 2007).

### **Culture Change at Samaritan Place**

At Samaritan Place, the Mission Statement is as follows: "We are a Catholic health care facility where care is compassionate, resident directed, safe and respectful. We advance the

healing and caring ministry of Jesus Christ by responding to the needs of the spirit, mind, body and culture of those who enter our home.” (Samaritan Place, n.d., p. 4).

The mission, vision, and values (see Appendix F) of Samaritan Place embody the culture change movement within long-term care. Samaritan Place has chosen the Household Model as its philosophy in providing care to its residents while moving away from the medical institutional model of care. This journey is where relationships are built and where learning takes place each day, always remembering the resident comes first, while remaining committed to providing the best care. This means that quality care must be achieved and Samaritan Place must adhere to Saskatchewan Health care guidelines.

During my time at the Cottages in Samaritan Place, I observed movement towards balancing the medical and social models of care. However, I found that it was easy to get pulled back into the institutional model of care. At Samaritan Place, staff receives training in the Household Model to ensure that the values of personal-centered care and resident-directed care are consciously created and preserved. Under this model rituals, spontaneity, friendship, spirituality, recreation, choice, and independence are encouraged; and art and humor are manifestations of a culture of grace.

All aspects of the residents’ care, including treatments, exist to support and serve the person within the context of his or her life pursuits. During the first weeks of my practicum I assisted in setting up a quality of life meeting for one of the residents. The day of the meeting a special Mass service was scheduled in response to the Syrian crisis, which would include a time of prayer for the people of Syria. One resident, whose quality of life meeting was to take place at the same time as the mass, felt that it was very important that she attend this service. She confided in me that she valued the different cultures of the staff and wanted to show all of the

staff the importance of praying for one another. I was able to facilitate a change in the time of the meeting to allow this resident to attend the Mass. This resident articulated her appreciation to the team for changing the time of the meeting. As staff left the quality of life meeting, I overheard several staff commenting that they had not realized the importance of the Mass to this resident.

I observed a number of challenges to implementing the Household Model during my practicum experience at Samaritan Place. First, Samaritan Place is a young organization, with a short history. However, Catholic Health has a strong established history within Saskatchewan and Saskatoon, and there have been growing pains for Samaritan Place as they have implemented a different model of care. Second, Samaritan Place operates within the Saskatoon Health Region and Saskatchewan Health (Government of Saskatchewan). Regulations mandate that certain services be provided and that detailed statistics be kept regarding quality of care. It can be a challenge to implement a social model of care within this environment of competing demands. Third, changes in leadership at Samaritan Place (new executive director, nurse manager, etc.) took place during the time of my practicum. It takes time for new leaders to learn and understand the Household Model of care and to look for ways to ensure its success. Fourth, it takes time to gain staff support for the Household Model (while staff schedules allow for familiar staff working each shift, there is a variety of acceptance of this model of care). Some staff work at multiple long-term care sites which all incorporate different models of care. This impacts the delivery of care at Samaritan Place. In addition, many of the staff are from different cultural backgrounds, which impacts understanding of the Household Model and its implementation. Fifth, there is an increasing complexity in the care of the elderly and their families. How is the Household Model implemented when there are differences between what

the resident wants and what the family wants? Finally, during my practicum at Samaritan Place, staff members voted in favor of a union. It is unclear how this will impact the Household Model of care. Will there be acceptance from the union for this model of care that ensures resident and family involvement? The union may push for Samaritan Place to move back to an institutional model of care.

Within this section I have explored the ideology of Samaritan Place. The Household Model is a philosophical and practical framework based on culture change that emphasizes building a strong community and moving from an institution model based on the medical model towards a home-like model. It is about exploring relationships from a servant-leadership model that incorporates person-centered care and values and about exploring the spirituality of each resident, of their families, and of the staff members. It is about participating in daily life activities within these relationships that ultimately lead to improved quality of life. My focus was on working with residents with dementia and exploring how the ideology of Samaritan Place facilitates working with this client group. I found it rewarding and challenging to work within this ideology. It takes time to explore with residents their story and to learn who they are. I found that it can be very easy to slip back into the institutional model of regimented schedules. I enjoyed working with residents to formulate care plans. It was wonderful to observe staff getting to know each resident and to ensure they were listening to the resident. As part of my learning objectives for my practicum, I will now explore social work theory and how this fits with the Household Model utilized at Samaritan Place.

### **Theory**

Prior to this practicum at Samaritan Place, my social work experience was within a medical setting that included developing skills in providing Person-Centered Care to ensure

clients had a voice in developing plans for the provision of their care, based on their individual needs. One of my practicum goals was to learn about culture change and how the Household Model was implemented at Samaritan Place, specifically within the Cottages where dementia residents live. The following section will briefly describe the underpinnings of the ecological framework and explore the ideas of loss that residents of long-term care and their families experience.

### **Ecological Framework**

The theoretical underpinnings of my studies and practicum can be found in the ecological framework. Within the ecological framework people in their communities are best understood in the context of their wider environment. Germain and Gitterman (1986) identify the following factors that help with understanding the way in which people interact within their wider environment: relatedness, competence, self-direction, and self-esteem. Relatedness refers to the human being's inborn capacity to form attachments to other people. The ability to connect to others through attachments and other social affiliations is seen as a central component of optimal functioning throughout the life span. Competence is the ability to feel effective within one's environment, to feel self-confident, trust one's judgment, achieve one's goals, and engage in positive relationships with others (Germain & Gitterman, 1986). Self-direction refers to the capacity to maintain a sense of control and purpose in the face of internal strivings and impulses as well as environmental pressures; it is the feeling of personal power that enables one to make choices and decisions and to take effective action on behalf of oneself and one's primary groups (Germain & Gitterman, 1986). Self-esteem refers to the person's positive feelings about him/herself (Germain & Gitterman, 1986). These develop as the individual experiences feelings

of relatedness, competence, and self-direction over time. Self-esteem incorporates the concept of self-efficacy or a belief in one's effectiveness (Germain, 1979).

An ecological perspective assumes that people are best understood in the context of their wider environment. It involves looking at the reciprocal relationships between people and their environments and how each acts to influence the other. Germain states that "the ecological perspective provides insights into the nature and consequences of such transactions both for human beings and for the physical and social environments in which they function" (1979, p.7).

Consequently, the ecological perspective emphasizes analysis within the physical and social environments. Adjustment, on the other hand, occurs when an individual passively accommodates the environment, despite any detrimental psychological, social, emotional, or physical effects on the individual. It is important to understand to what degree a person is in control of the decision-making process or whether internal or environmental forces are at play. This will lead to determining the next steps to take in assisting the resident with adjustment issues.

The ecological perspective emphasizes the interactions that clients have within their environment and is a useful tool for approaching culture change in long-term care where the building blocks of ethical and compassionate care are the relationships individuals have with one another—co-workers, residents, families, managers, and health teams. Understanding how each of these relationships relates and interacts is valuable in understanding where the barriers exist to fully carrying out person-centered care.

At a direct social work practice level, the ecological approach requires social workers to improve the level of fit for their clients not only at an individual level, but also at the larger system level. In this approach, the social worker looks at mobilizing community resources to

improve community life and to develop responsive policies and services and influencing regulations (Germain & Gitterman, 1986). I believe that this will lead to work at the agency level as well as at the local health authority and provincial levels of care.

As self-contained communities, residential care facilities are well suited for analysis based on environmental considerations. The institutional constructions of time and space, the interactions of staff, residents and families, the support or restriction of autonomy—all these things inform the experience of the elder living in residential care.

Meaningful reform to how care for our elderly is provided within long-term care, using an ecological lens, involves changes to both the physical and the social and emotional environment (Gilster, 2005). It involves interventions that recognize the influences of social location, culture, and gender of residents to mitigate passive adjustment to programs that do not quite meet their needs. Further, it requires monitoring of both the individual experience and the wider organizational culture (Stanzlik, 2011). Instead of approaching care in an individualized and disconnected way, ecologically inspired care views the individual in the dynamic context of the overall environment to see where meaningful interactions are blocked and where incongruent practices arise (Germain, 1979; Stanzlik, 2011).

### **Loss in Older Age**

During my time at Samaritan Place I was given the opportunity to explore loss. In this section I will explore the idea of loss and how it impacts the quality of life of elders living in long-term care.

As individuals age, it becomes more and more likely that they will experience a significant loss. This may be due to the regular process of aging or may be due to physical or mental health problems that are out of their control. Richards (2005) identified that the most significant losses

experienced by the elderly include the deaths of their loved ones, physical frailty, and relocation. They discovered that these significant losses had a negative impact on the older adult's sense of independence and satisfaction, and quality of life. Suggs and Suggs (2003) also discuss losses in relation to the many transitions that older adults have to make as they age. These include retirement, moving, death of family and friends, and loss of physical functioning.

Loss of physical health, loss of cognitive health, losing friends, losing family members, and many other issues often precipitate the decision made by an older adult to seek additional assistance, whether or not it is a move to a long-term care facility. It appears from the literature that the culmination of some or many of these losses can result in a sense of hopelessness (Beaulieu, 2012; Cox, 2007; Kane, 2001 references). Assisting older adults to work through these transitions and develop resilience and hope promotes the opportunity for them to find meaning and success as they continue to age.

Greene and Cohen (2005) also referenced the benefit of gaining awareness through review of an individual's life experiences and how one can benefit from this process. Personal understanding of how one has coped with difficult incidents over the course of many life experiences can offer insight into how one can continue to develop coping skills and hope for difficult situations in the future.

Connecting with one's strengths and how one has overcome past life obstacles are some of the key factors that assist in developing resiliency in individuals. Allowing older adults to tell their story and leave their legacy to someone who is willing to listen can be another extremely important part of developing a sense of hope (Richards, 2005).

Kitwood (1997) has written about personhood and the care of elders with dementia. Personhood, as he has defined it, is "a standing or status that is bestowed upon one human being,

by others, in the context of relationship and social being. It implies recognition, respect, and trust” (Kitwood, 1997, p. 8). Therefore, it has less to do with what the individual knows of him or herself than with whether the other chooses to recognize and share in that individual’s humanity. In the case of persons with dementia, this is a crucial factor, since late stages of the disease require that others actively maintain the personhood of that individual. Kitwood (1997) argues that staff caring for the elderly who are faced with behavioral challenges or other issues must use their knowledge of the person they are caring for to guide and contextualize the interventions they choose. To accomplish this they must integrate personal history and family knowledge in the care of the elderly.

As Kitwood (1997) points out, this kind of caregiving is more involved than the traditional physical nursing and bodily care. He advocates for moral education to ensure that the caregiver truly know how to care for the elders in their care. First he suggests that staff become involved in an exercise of reflection and discussion of cases to ensure that they are not oversimplifying situations or making assumptions about an elderly person. Secondly, he suggests taking a personal history of a resident and relating some aspect of it to practice. This allows staff to both get to know the unique and personal qualities of a resident, and to translate that knowledge into caregiving practices. Finally, he suggests role plays to simulate life as a person with dementia.

### **Dementia care.**

The Alzheimer Society of Canada defines dementia as a syndrome consisting of a series of symptoms, such as loss of memory, changes in judgment and reasoning, changes in mood and behavior, changes in communication abilities, and changes in the person’s ability to function on a day-to-day basis (Alzheimer Society of Canada, 2011). The different types of dementia

include Alzheimer's disease, Lewy Body Dementia, Vascular Dementia, Frontal-Temporal Dementia (Alzheimer's Society of Saskatchewan, 2011).

Within dementia care, person-centered care is focused on the whole person, not just on the disease process. The residents' remaining abilities are explored while planning for their care. Within person-centered care, the resident should be consulted about preferences choices and needs. With this knowledge, the caregiver should engage the resident in the tasks to be completed, taking their lead in what should be done. The caregiver should engage in spontaneous interactions using a variety of senses, family, significant relationships, and work to connect with the resident.

Kitwood (1997) says that residents with dementia need comfort, attachment, inclusion, occupation, and identity. To provide comfort to another person is to provide a kind of warmth and strength which might enable them to remain in one piece when they are in danger of falling apart due to a sense of loss.

We live life within face-to-face groups (Cox, 2007). To be part of the group is essential for survival. The social life of those with dementia tends to dwindle away (Cox, 2007). To prevent this from happening, care staff must have opportunities to get to know each resident. Interventions may include storytelling, touch, music, readings, prayers, pictures, rituals, conversations, or helping a resident write a letter to their family or friends.

The stories of survival, love, and sheer gumption that are the fabric of people's lives can give caregivers hope in their own roles. Residents then become mentors; by recounting their stories, they can often work out their own purpose in life, while at the same time reminding caregivers of theirs.

Often a long-term care resident may reach out to hold another resident's hand or to comfort a person who seems upset. Those with dementia may not know all the facts about a situation, but they retain a sense of feelings and intuition for the human response that is called for in that situation.

It is a great challenge to find ways for residents with dementia to sense that they still have an important place in the world. Social workers can help find ways for residents with dementia to safely meet those needs in order that they too might have a sense of meaning in life.

### **Role of Social Work in Long-Term Care**

One goal of my practicum was to explore the role of social work within long-term care. In this section I will explore my values as a social worker and how they impact my work with residents and their families. Further, I will explore the various relationships that exist within this setting and how they are influenced by Household Model.

#### **Values**

Social work values are rooted in the belief and worth of every human being. The Saskatchewan Association of Social Workers (SASW) lists the following values for social work practice: 1) Respect for Inherent Dignity and Worth of Persons, 2) Pursuit of Social Justice, 3) Service to Humanity, 4) Integrity of Professional Practice, 5) Confidentiality in Professional Practice, and 6) Competence in Professional Practice (Saskatchewan Association of Social Workers, Guidelines for Ethical Practice, 2005). Values lead to determining appropriate courses of action. Sachs and Newdom suggest that we must be "explicit about our values to make clear what we believe and how what we believe is related to the selection of theory base and practice goals and methods" (1999, p. 16).

The values of Samaritan Place (see Appendix F) include seeing each person as unique and as someone to be respected and cherished. Caregivers need to be compassionate and wholly present to each person while providing care that pays attention to the body, mind, spirit, and culture. The residents, their families, and staff all work together to provide a meaningful life for all. Communication and relationship-building are key in developing a strong and integral community for all who live and work together in the household.

### **Relationships**

Social work has sought to use the process of developing a relationship between the practitioner and the user of services as the basis for interventions. Social workers have not only a moral responsibility to engage with the users of services in a full and purposive way, but an accurate assessment must reflect the complexity and multi-faceted nature of peoples' lives in order to lead to effective interventions. These interventions embrace a holistic understanding of clients, hearing their stories, and understanding the context of their living life.

**Relationships with staff.** Staff are important to the quality of life of residents with dementia who reside in long-term care. Staff see the residents daily as they provide care for them and as they interact with them. This takes place through talking during the provision of care, spending time during activities, and seeing residents interacting with each other (Cox, 2007).

Families are an important resource to staff as they have knowledge of the resident's history. Family presence improves residents' psychological and psychosocial health. Family members are called on to make decisions regarding care for cognitively impaired residents and to provide continuity that may otherwise be lacking (Cox, 2007). The Alzheimer Society of Canada reports that families spend an average of 4.3 hours per week visiting their loved ones

within long-term care, emphasizing the importance of family involvement (Alzheimer Society of Canada, 2011).

**Strong social support system.** A strong social support system helps participants identify meaning even at the end of their lives. This goes beyond the support provided by paid staff who work with older adults. Special relationships with family, friends, faith communities, and other groups are important in maintaining the sense of meaning and hope individuals need as they age (Richards, 2005). Personal relationships include relationships built between older adults and their family members, older adults and social workers, as well as family members and social workers. Having strong, supportive, positive relationships when coordinating care for an older adult helps maintain a sense of hope that someone cares for them, views them as important, and will continue to invest in their lives (Cox, 2007; Beaulieu, 2012).

**Person-centered care.** Person-centered care means taking time to connect with the person as a unique individual. Even if a person cannot speak, as in late dementia, they often express their feelings and needs in other ways—through their eyes, their facial expression, and their body language. When talking to a resident at Samaritan Place, I found that if I paid close enough attention, I would almost always see a reaction—a raised eyebrow, a twinkle in the eye, a furrowed brow, or a laugh. To me, person-centered care means slowing down enough to just “be” with the person for a few minutes—to look beyond the endless to-do list of caregiving and enjoy the person. Unfortunately, with Alzheimer’s disease and other dementias, a stigma remains that people with dementia are not fully “here,” that they are no longer themselves. Caregivers often treat them accordingly—as a diagnosis, not a person.

During my time in the Cottages, I began to see the residents as vibrant people with a continued story to share. One of the residents had run a business with her husband and helped

with bookkeeping and paying the bills. She would often ask staff what they needed help with. We developed a list of activities for her to help with such as folding laundry, wiping tables, and sorting through magazines. She also participated in most activities being offered in the Cottages as she liked to be busy. She had been active in her home community and this active lifestyle needed to continue at Samaritan Place. These reflections show the importance of seeing the elderly as vibrant contributors to the community.

**Role of social workers.** Cultivating relationships is key for social workers who are working with older adults in long-term care facilities (Beaulieu, 2012; Cox, 2007; Richards, 2005). Once strong, supportive, positive relationships are built, there are good grounds to help foster a sense of hope among older adults. It is imperative for staff to focus on finding time to purposefully meet individual residents where they are at, listening to their stories, and helping them thrive (Beaulieu, 2012; Cox, 2007; Kane 2001).

In order to do this effectively, as the aging population continues to grow, staff will need support to invest in these relationships, both with individuals and their families (Beaulieu, 2012; Cox, 2007; Kane 2001). The staff and leadership team at Samaritan Place are committed to the Household Model and social workers could assist in helping developing these relationships.

**Social Work and Person-Centered Care.** Social work values and spiritual care are linked to providing person-centered care for residents with dementia within long-term care. I believe that they mirror the elements of the culture change movement designed to make long-term care facilities resident-directed.

By responding to the spiritual dimensions of residents and incorporating this into their practice, the social worker is in an ideal person to promote culture change with the long-term care setting. The social worker's strength-based and person-in-environment perspectives allow

them to see beyond the illness or disability and to advocate for a life full of meaningful activities where the resident has autonomy and choice. Through the ecological perspective, the social worker is able to explore the social and emotional environment and its impact on providing person-centered care. The social worker is able to work with the resident's entire family and staff to assist in making sure that the resident's story comes to life and that it becomes part of the care plan. Social workers are also able to be part of the education of staff and of the residents and their families.

### **Ethical Issues in Long-Term Care**

Long-term care for people with chronic illnesses such as dementia, can present ethical challenges. In this section I will examine some ethical challenges relating to care for residents with dementia and Person-Centered Care and self-determination. Finally, I will explore the ethical principles and practices used at Samaritan Place.

#### **Dementia**

As dementia progresses and cognition declines, the individual's comprehension, judgment, and ability to make appropriate decisions becomes impaired. Ethical issues arise with respect to protecting autonomy (Cox, 2007). Persons with dementia are often unable to make decisions regarding their assets or other financial matters but still are able to make decisions regarding their medical care and treatment. As a means of recognizing their capacity and protecting their independence, competency assessments need to evaluate many areas of functions. Practitioners must be knowledgeable about assessing capacity. As well, they must be able to identify if those handling the affairs of the resident are indeed serving the client's best interests. Finally, practitioners must be able to assess who the client is that is being served. Is it the person with

the illness or the family? This can be problematic if the family's desires conflict with those of the resident and meeting the needs of one means offending the other (Cox, 2007).

Kitwood (1997), in his work regarding dementia care, shows the importance of the social and emotional aspects of care of what has been typically defined as a medical condition. It becomes a challenge as to how care staff can provide autonomy and involvement in care planning when clients are no longer capable of independent decision-making or in situations where they exhibit behaviors such as aggression.

### **Self-Determination**

Residents must have the right to say yes to living in a specific facility (Stephenson & Sawyer, 2004). Today's climate of health care change and the shortage of long-term care beds, and limiting these beds to the frailest elderly, may impose challenges to the ideal where residents have choice in determining where they receive long-term care. Within the Saskatoon Health Region, residents must accept the bed of first offer which means they may not get to go to the facility of their choice. However, they can go onto a transfer list once they have been admitted to a long-term care facility (Saskatoon Health Region, n.d.).

Residents should have the right to choose to accept or refuse any care or service offered in the long term-care facility. This is related to self-determination and autonomy. Residents should have the right to exercise their right to make decisions as they deem correct for themselves. Special attention must be provided to ensure they are being consulted where possible. If the legal next of kin or a substitute decision-maker is making the decisions, care must be taken to ensure they are acting in the best interest of the resident (Stephenson & Sawyer 2002).

Confidentiality of resident's information must be safeguarded. It is important that only relevant and necessary information is recorded in the resident's record to ensure that the known

wishes of the resident as to their care needs and choices are recorded. Each professional must ensure that they follow their professional duties of recording and that they follow the Health Information Protection Act (HIPA).

The rights of a resident to choose the way they wish to pursue their spirituality should be preserved. The resident should autonomously be able to choose how they participate in spiritual care activities (McKernan, 2007). Spiritual care workers should be available to assist the resident if they so choose. Given that Samaritan Place is a Catholic facility, care needs to be taken to ensure that residents do not feel they are being proselytized. Staff must ensure that the residents' choices are protected.

End of life care and the choice of accepting or declining care have a spiritual component as the resident faces the end of their life. Care must be taken to support the resident in their choices.

### **Care Issues**

At Samaritan Place, Quality of Care conferences take place with residents and their families to discuss care needs and issues. As well, "huddles" take place where concerns within the facility and issues regarding care of residents can be discussed. Education is provided as to safe provision of care and to the Household Model of care. Samaritan Place uses the Gentle Persuasion Approach which recognizes that residents' behavior is often associated with unmet needs. Through Gentle Persuasion (Advanced Gerontological Education, 2010) staff are encouraged to build on the relationships that they have with the residents to de-escalate behavior. During my time in the Cottages, I observed the impact of the Gentle Persuasion approach. Through Life Enhancement and the nurse practitioner, life storyboards were developed to be placed on the door or wall outside the residents' rooms. One family put a video together of

special family events. One afternoon this specific resident was becoming quite aggressive as she wanted to leave as she had chores to do at her home. I was able to show this resident her memory board outside of her room which calmed her down. I was then able to talk with her about showing the video her family had made and I took time to sit with her to watch the video. During the video I asked her different questions about the events and this discussion continued after the video was completed. I was able to discover some new information on their family business and the resident's involvement. The resident made bank deposits for the business every morning and enjoyed talking with me and other staff about her responsibilities in the business.

### **Respect for Cultural Differences**

Care must be taken to ensure that all staff are supported to care for residents within the facility and the choices that they make for their life. Samaritan Place has a large number of staff from different countries such as the Philippines and India. Cultural differences around the care of the elderly and issues around end-of-life care or medical care of the elderly may be present. It is important for staff to understand these differences and to ensure that the residents' right of choice are respected and encouraged. Through learning circles various topics are explored with the staff involving residents and their families. In one of the cottages a resident with dementia was only able to communicate in her native language. The staff and the family identified that this resident was becoming more withdrawn and depressed. With the help of family, a series of cards with familiar sayings was developed. Staff were able to take these cards into this resident's room while providing care to improve communication. The family noticed a change in the resident's mood when this was introduced.

### **Ethical Principles and Practices at Samaritan Place**

As a Catholic health care facility, Samaritan Place follows the *Catholic Health Care Ethics: A Manual for Practitioners*. The following ethical principles are promoted in the health care guide: 1) the call to respect and dignity: Respect for the dignity of every human person, where the lives of all persons possess an inherent dignity and worth; 2) respect for all human life, that understands the interconnectedness of every human being. Human persons are in relationship not only with each other but with all of creation; 3) the call to promote justice for the common good of all people living in society refers to everyone and it cannot be merely relegated to the state (Catholic Health Alliance of Canada, 2012, p. 14-16).

Samaritan Place, through the Director of Spiritual Care and Missions, has an Ethics Committee to ensure that ethical issues are addressed in a manner that supports the residents and their families and staff. Samaritan Place also has access to the Ethicist hired by the Catholic Health Association of Saskatchewan who works from St. Paul's Hospital in Saskatoon.

An ethical issue arises when competing values or duties pull people in different directions. Health care professionals may be left with a feeling of discomfort with a specific decision or course of action. They may be confronted with more than one possible course of action and not sure which will be the best or find themselves in disagreement with colleagues or leadership as to the best options for the client (Catholic Health Alliance of Canada, 2012).

Good quality care requires dedication and commitment to meet a range of needs in a way that allows residents to have choices while maintaining a relationship with their caregiver. The Household Model and the values of Samaritan Place promote discussions with the residents and their families to ensure they are receiving the care that they want and that they require. Ethics is a journey similar to the journey of culture change. There must be a willingness to continue these

discussions as issues arise to ensure that the organization continues to grow and change as it serves vulnerable residents.

### **Strategies**

The focus of my time at Samaritan Place was in the Cottages where residents with dementia-related illnesses reside. The leadership team at Samaritan Place identified the Cottages as an area of focus for ensuring improved quality of life for the residents. This section details the work that I facilitated in the Cottages and how this fits into the Household Model and the mission, vision, and values of Samaritan Place.

### **Individual Assessments**

Focusing on the individual and their specific situation is an important intervention when working with older adults who have lost their sense of hope. Individual case management and counselling relationships can be useful interventions when working with older adults (Pentz, 2005). When feelings of hopelessness arise, it is important for individuals to feel they are being heard and cared for.

In order to enhance my direct practice skills with residents and their families while working as part of an interdisciplinary long-term care team, I completed an assessment of residents upon admission to Samaritan Place. This document, along with the Life Enhancement and the MyPlan Care Plan (Saskatoon Health Region, 2013) told the story of the resident for purposes of building relationships. This information is used by the care partners and Licensed Practical Nurses (LPN) in developing the individual care plans and care cards for each resident.

I attended Quality of Life Conferences for residents of Samaritan Place, advocating for the residents to share their story and to let the team know of their needs and how they would like their care provided. As well, I explored opportunities for the residents and their families to share

what areas of interest could be accommodated through structured and spontaneous activities. This included work with the dementia residents within the Cottages.

### **Activities**

Engaging older adults in activities that involve multiple individuals who are in a similar situation or who belong to the community is another way in which social workers can help promote hope in later life (Pentz, 2005; Richards, 2005). Staff play an important role in organizing and planning day-to-day activities. Arranging the physical living environment, encouraging clients to use their own belongings, and maintaining a regular schedule for clients to access community resources are some specific ways in which the environment can contribute to developing a sense of hope (Cox, 2007).

**Organized group activities.** Interactions among residents during organized group activities are one aspect of community life at Samaritan Place. Programming provides frequent opportunities for residents to relate to each other while engaging in activities such as singing, ball playing, physical and mental activity. During my practicum I participated in several sessions with the music therapist. At the beginning of the session a few residents would sit at the table and participate. As the session progressed and music was created by the residents I observed other residents from the Cottages arriving to join the sessions. Also one gentleman who remained sitting on the couch at the back of the room, when handed a tambourine joined in the activity. I observed residents smiling and laughing through-out the session then when the session was over and the music therapist had departed, the residents continued smiling and interacting with one another.

Religious services provided another opportunity for the development of community at Samaritan Place. Several staff from the Cottages and I would escort residents to services in the

Chapel. It was wonderful to see the interactions between the different residents of Samaritan Place. While the residents with dementia did not necessarily understand all aspects of the service they certainly participated with the support all the participants. I observed residents sharing music and prayer books and directing residents to the words being recited. I felt calmness in the residents from the Cottages when they attended the religious services.

**Resident-initiated activities.** Residents were also involved in spontaneous activities that built a sense of community. Residents would bring out games and books and join with each other in continuous and natural ways. Some residents engaged in conversations during organized activities, when they were eating together at the same table, or when they were just relaxing on their own in common sitting areas. Residents developed social interaction roles within the Cottages as well. A few residents took on the roles of listener and emotional supporter for others. Other residents, who had more assertive personalities, attempted to be the ones to direct the behavior of both individuals and of groups. Within the Cottages, many residents had the capacity to carry out conversations and other kinds of interactions. The most sustained interactions occurred between residents and family visitors. Declining capabilities, especially cognitive decline, generally resulted in reduced participation in these relationships.

**Reminiscence groups.** The Household Model seeks to hear the stories of residents and their families and to base care on this gathered information. This is part of person-centered and person/resident-directed care as well as a way of promoting quality of life.

As discussed previously, I spent my time in the Cottages where residents with dementia-related illnesses live. One of my activities of the practicum was that I had the opportunity to lead Reminiscence Groups. It was exciting to hear the residents tell their stories and observe how a statement from one resident led to further comments from other residents. Laughter could be

heard throughout the cottage during these groups, and it was wonderful to see smiles on the faces of the residents involved. Through my participation in these groups, I discovered how the residents in the Cottages can be part of planning for their care. I was able to implement Reminiscence Groups specific to the Cottages (Emma and Candle) around Grandparents Day, Thanksgiving, Halloween, Remembrance Day, and Christmas. These groups were well attended by residents and their families, and staff participated and assisted residents in telling their stories. As a result of this interaction, the staff incorporated many of these discussions into their work with the residents. For example, they are now talking about horses with one of the residents who shared a story of how she assisted one of her granddaughters riding her first horse during the Grandparents Day Reminiscence Group. Plans are being developed with a volunteer and care partners to keep this program running.

### **Rituals**

Another intervention technique that can be used by social workers in long-term care settings is the development of individual as well as community rituals. Suggs and Suggs (2003) recognized in their research that there are not many rituals used when helping older adults deal with the many transitions they face. They promote the use of rituals in a long-term care setting because of the importance a ritual can have in helping an older adult cope with the changes they are facing: The use of rituals can bring comfort and some feeling of stability to the residents' lives. They can become an important means by which the resident can maintain the connection with their lives before the nursing home and continue their connection with family and friends, and with areas of meaning in their lives (Suggs & Suggs, 2003). Richards (2005) says that developing rituals for celebrating important events in an individual's life, remembering an

individual who has passed away, or a special day can all be important ways in which social workers can help promote a sense of meaning and hope in the life of an older adult.

At Samaritan Place, Spiritual Care leads services of remembrance when a resident passes away and residents from each area of Samaritan Place come together to say their goodbyes and to remember the person. It was very moving to see a resident from the Cottages interacting with other residents during these services and to watch the staff supporting the residents.

### **Spiritual Care**

Spiritual care has been identified as part of holistic care within health care settings. We have only recently come to a deeper understanding that caring for the whole person must include caring for the spirit. Wagler-Martin defines spirituality as “the essence of our being, which permeates our living and infuses our unfolding awareness of who and what we are, our purpose in being, and our inner resources; and shapes our life journey” (2007, p.137).

Spirituality is an integrating factor in the care of the whole person, whether they are struggling with cognitive deficits or mentally alert (Richards, 2005). Social workers must consider all aspects of everyday life for a resident to ensure that their needs are being met and to ensure that they have a quality life despite facing disabilities (Richards, 2005; Cox, 2007). Basic tasks in long term care include assessment, care planning, possibly discharge planning, counselling, finding resources, making referrals to outside agencies, and working with families (Beaulieu, 2012). These tasks may have spiritual implications and the social worker must be alert to them. Spiritual distress may be noted when we see a resident or their family with feelings of anger, guilt, sadness, grief, discouragement, loss of independence, fear of dying, loss of hope, or low self-esteem, and special care must be taken to address these concerns (Richards, 2005; Butot, 2007; Wagler-Martin, 2007). The leadership team at Samaritan Place and care

partners work well together to identify when concerns like these arise and the Director of Spiritual Care is able to address these concerns. My involvement as a practicum student afforded me opportunities to address these concerns as well with the leadership team at Samaritan Place.

It is important for staff to integrate spiritual assessment and interventions into the care plan for nursing home residents. Varying spiritual beliefs and lack of education and experience with spiritual care are barriers to implementing spiritual interventions. Therefore it is important for long-term care facilities to provide education to increase competence in this area. At Samaritan Place this education is offered during orientation to the Household Model and to the mission, vision, and values.

The goal must be to help residents feel that they are at home and not part of an institution. A resident-centered approach should be incorporated that allows staff to constantly listen and respond to the needs of each resident. This is what spiritual care is about in the broadest sense. This happens through talking to the resident while providing care. It takes place when storytelling is encouraged and when residents are encouraged to participate in developing their care plans. These are all relationship-building exercises and part of caring for the whole person. It is about accompanying the resident through their life journey and helping them and their family to understand their resources for living a full life.

### **Meetings and Circles**

Throughout my time at Samaritan Place I participated in learning circles (daily huddles) morning and afternoon with Care Partners and LPNs. These circles included discussions around issues of care and quality of life for the residents. In addition, I participated in learning circles with the leadership team around programming, planning, and problem-solving. I also attended Cottage planning meetings. These planning meetings were interdisciplinary with an emphasis on

programs and services for residents and their families from a person-centered care perspective. Their objective was to ensure that the individual needs of each resident were met and that each resident was seen as a unique individual. Each member of the team was able to discuss ideas that could be incorporated into specific care plans with a goal of improving quality of life with the full involvement of the residents. We explored the needs of residents with dementia and how to ensure they are able to participate in planning for their care and in making autonomous decisions. As part of an interdisciplinary team, we worked at program development (person-centered and directed care plans) to ensure improved quality of life, and a sense of community. We explored how to incorporate the residents' stories into the care routines and activities.

The information that was gathered through interdisciplinary assessments, quality of life conferences, and learning circles (huddles) was incorporated into planning for resident care (medical, physical, psychosocial, and spiritual) that worked towards quality of life for residents. Staff at Samaritan Place, through this participation, continued to discover how the Household Model of care is incorporated into the mission, vision, and values of Samaritan Place.

I worked with Life Enhancement and Spiritual Care to set up an evening session for family caregivers on dementia with the Alzheimer Society of Saskatchewan. This learning session took place on October 23, 2013, and approximately 20 people attended. Information on dementia and treatment of dementia and self-care was presented.

An evening session for residents, families, and staff on grief with the Saskatoon Funeral Home took place on November 20, 2013, and was attended by approximately 40 people (residents, families, and staff). Information on grief associated with moving into long-term care, loss of health status, and end of life care was presented.

### **Conclusion**

My learning objectives were met during my practicum placement. I wanted to challenge myself as a social worker and to see the Household Model at work. The leadership team and staff of Samaritan Place were very supportive of my learning. This section outlines my learnings of the Household Model. How it was implemented at Samaritan Place and the ongoing challenges. I explore how social work can be further involved in implementing the Household Model and linking it to the mission, vision and values of Samaritan Place. Throughout my practicum I also explore spirituality and how this fits into my practice as a social worker. Finally, I explore my own personal reflections of my time at Samaritan Place.

### **Holistic Care**

The work that I completed through this Practicum has assisted me in understanding the importance of the holistic care of residents in long-term care. Through the information gathered during the admission processes and through ongoing interactions with the residents and their families I developed a clearer understanding of what brings quality of life.

I became part of the interdisciplinary team at Samaritan Place and could advocate for residents according to their expressed needs and wishes. I witnessed how care plans and the care provided take place with the resident as the lead. At a recent quality of life meeting, a resident had specific questions about medical care and this led to a good discussion. The resident took a lead in describing what she would be willing to agree with in terms of assessments for services. The care partners were able to share with her how they could support her in the process, and the resident was able to state confidently that she would feel supported. This leads to quality of life for the resident and is how the mission, vision, and values are lived out daily and how I, as a social worker with the leadership team of Samaritan Place, could ensure this takes place. I also found that it can be easy to fall back into the institutional model of care when a resident makes a

choice that may not be the best choice. I found myself stating that the resident was not compliant with care suggestions. I heard similar statements from other staff. During these times I reminded myself of the mission, vision, and values of Samaritan Place to be resident-directed.

### **Role of Spiritual Care**

An important piece of my learning at Samaritan Place has been around the role of the Director of Spiritual Care. It is about bringing the mission, vision, and value statements of Samaritan Place into daily practice. It is about supporting staff to understand their role within these statements, and how to incorporate them into daily practice. This is about servant leadership, serving the residents and their families. This involves all staff and leaders within Samaritan Place.

As a social worker, I realized the importance of my role in bringing the mission, vision, and values of Samaritan Place to the forefront of every interaction. These interactions are with residents, family members, and the staff. This is one of the aspects that makes Samaritan Place different from other long-term care facilities. The dedicated Mission position (Director of Spiritual Care and Missions) is important to the development of the overall mission, vision, and values of Samaritan Place. This position ensures that staff will be supported and challenged to understand these statements and how they are lived out each day by all the staff. Spirituality is an integrating factor in care of the whole person, whether they are struggling with cognitive deficits or they are mentally alert. Within social work we must consider all aspects of everyday life for a resident to assure that their needs are being met and to assure that they have a quality life despite facing disabilities.

### **Implications for Research**

There are a number of implications for further research arising out of implementing the Household Model. It is important to note how having a sense of purpose can instill a sense of hope in older adults. Volunteer programs and other programs that allow residents to participate in daily life are extremely helpful to the residents. It is important that research be completed as to the quality of life these programs offer.

More information on how staff and family relationships can better be developed would provide assistance in fostering hope among older adults facing losses.

Research could also be conducted on the role pets play in an older adult's level of hope. In one of the Cottages at Samaritan Place a rabbit is cared for by several residents. They take time to feed, walk with, and hold the rabbit.

Finally, it would be interesting to consider the idea of hope in relationship to the workers at Samaritan Place. How do their individual and corporate roles foster hope in the residents? How do these relationships assist them in completing their work and in developing a community?

### **Role of Social Workers**

Throughout my practicum I worked to inform Samaritan Place of the role of social work in this setting and specifically in the use of the Household Model and care practices in meeting the psychosocial and spiritual needs of residents. I explored the role of social work in providing spiritual care that leads to improved quality of life for the residents of Samaritan Place. Social work is able to assist the Leadership Team and staff in promoting and developing the community in each household. This is accomplished through ensuring that each resident is able to participate in meaningful activities that meet their spiritual and psychosocial care while meeting their physical needs. The social worker would be able to work with the caregivers in each of the

households to assist them in developing learning objectives that would encourage getting to know the residents and allowing them to express their choices. These learning objectives would be addressed through education sessions, huddles and learning circles.

Social work would be able to assist the leadership team and households to develop linkages with outside services, such as Mental Health and Addictions, Alzheimer Society of Saskatchewan, Saskatchewan Association for Community Living, and the Saskatoon Council on Aging to name a few. These agencies would be able to provide additional support and quality of life to the residents of Samaritan Place.

### **Personal reflections**

As I reflect on my time at Samaritan Place, I realize that person-centered care means slowing down to be with the person for a few minutes, to look beyond the to-do list of caregiving or the actions of a social worker and to enjoy the person, to build on the person's strengths and to find out what they enjoy. As I entered into this practicum experience I was encouraged to read the book, *30 Lessons for Living: Tried and True Advice from the Wisest Americans* by Karl Pillemer (2011). This book provides personal anecdotes from elder Americans about successful aging and how to learn from these experiences. Similarly, during my time at Samaritan Place I have learned from the residents of the Cottages about the importance that all of life has brought together.

As a social worker I believe in the importance of assisting those in need, and in ensuring they have a voice in accessing services. I discovered that family and staff become the voice of the residents' with dementia who no longer tell us what they want. This takes place when time is taken to know each individual and their life story. It is also important to be part of the change process as witnessed through the culture change movement within long-term care. Through my

practicum at Samaritan Place I have had the opportunity to support residents and their families and staff as well. I have had the opportunity to see the culture change movement at play and to see how the Household Model leads to improved quality of life.

When I was deciding on my practicum I was drawn to Samaritan Place's Household Model philosophy. As my practicum started I realized the unique community that was being formed within Samaritan Place. I experienced the emotions of joy, laughter, anger, and crying that happens every day. Each day as I walked into Samaritan Place I was greeted with the warm smiles of residents and staff, and sometimes I was greeted with stories of complaints, anger, and sadness. I worked with residents and their families and the staff to address these concerns. I was awed by the halls beautifully decorated with pictures, paintings by residents and some by professional painters. The chapel is placed in easy access to the entire building, a place that is brightly lit with stained glass windows; this is a place that is welcoming to all people of every faith.

As I walked through each neighborhood within the facility, I could smell the different meals being prepared. I saw residents, staff, and families gathering around tables where coffee and snacks were readily available. Card games were being played, puzzles were being put together, and newspapers were being read. A television was often on and the news was being listened to. Music is often played and there is usually the background sound of conversations (some in agreement, some in disagreement). I loved spending time in the neighborhoods and with the residents and staff.

Being new to Samaritan Place, I often found myself overwhelmed by the information I needed to absorb each day: Who is scheduled for a quality of life meeting? Are there planning meetings? What is on the schedule for activities and learning opportunities? Walking down the

halls I got to respond to residents, families, and staff who wanted to talk. This communication took place through communication aids, or through the use of their native language, or through non-verbal expressions.

During my time at Samaritan Place staff members knocked on my door and often came in to talk about a resident's concern. Sometimes it was family members coming in to ask questions about their loved ones or sometimes people had staffing concerns. Within the philosophy of Samaritan Place it is important for staff and volunteers to remember that everyone is working in the resident's home. This means that everyone has the responsibility to connect with the residents and their families and with other staff in order to make Samaritan Place a wonderful place to spend time.

### **Final Remarks**

During my practicum at Samaritan Place, I explored the use of the Household Model in providing for the psychosocial care needs and quality of life of residents, exploring how this model was developed to transform the culture of long-term care from an institutional model (based on the medical model) towards a home where residents and their families work together with the caregivers to provide person-centered care and resident-directed care. To accomplish this goal I went through the Household Model orientation provided by Samaritan Place and worked closely with the Spiritual Care Director and the Director of Life Enhancement and Clinical Care to understand how this model is incorporated. I actively participated in daily huddles, learning circles, and quality of life conferences, which link the Household Model to the mission, vision, and values of Samaritan Place. This was a great way to promote quality of life as emphasized by the Household Model and to ensure that the residents always remain the focus of the care being provided (medical, physical, psychosocial, and spiritual).

As Samaritan Place is a Catholic health facility, spirituality and faith are core values. Throughout my practicum I developed a good understanding of the Household Model and how the mission, vision, and values of Samaritan Place are lived out daily. I was challenged to broaden my view of social work with the elderly in terms of person/resident-centered care and to move towards a resident-directed perspective. I was reminded to always listen to the resident and take their lead. As I think about my past practice, I realize that I have not always acted from a resident-directed perspective. I now stop and reflect before making a decision or developing a plan. I ask myself if I am being resident-directed and I ask myself if I am ready to listen to what the resident is saying. Throughout my career as a social worker I have felt that I had good listening skills and good advocacy skills. The resident-directed perspective utilized within Samaritan Place is helping me fine-tune these skills and to continue to improve and adapt my social work practices.

Throughout my practicum I have discovered that psychosocial and spiritual care around dementia has to do with giving back to people their sense of identity so that they can participate fully in life and the larger community. Caregivers, family, and friends are called to help elders with dementia with their memories that tell the story of their life. In order to accomplish this, the caregiver must look into their own spirituality and how this assists them in working with elders with dementia. My past experiences have shaped my belief that the elderly of our communities have much to offer us and to teach us. The Household Model at Samaritan Place is about promoting relationships that allow for decision making about care activities and living life to the fullest.

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## Appendix A

### Household Model

1. The household is each resident's home and sanctuary.
2. The people who live here direct their own lives, individually and collectively.
3. The boundaries of the person and his/her home are clear and respectful as a matter of course.
4. Grace, a shared sense of what is sacred about the house and its people, is deeply valued, consciously created and preserved. Rituals, spontaneity, friendship, spirituality, celebration, recreation, choice, independence, art and humor are all manifestations of a culture of grace.
5. The people who live here are loved and served by a responsive, highly valued, decentralized, self-led team that has responsibility and authority.
6. Leadership is a characteristic, not a position. Leaders support and are supported by values-driven, resource bearing principles and practices as a way for each person to actualize his or her full potential.
7. All systems, including treatments, exist to support and serve the person within the context of his or her life pursuits.
8. We build strong community with one another, our family, our neighbors, and our town. Each household is part of a neighborhood of houses, dedicated to continuous learning.
9. The physical building and all its amenities are designed to be a true home. Institutional creep in design and culture is treated as wolf at the door (Shields & Norton, 2006 P 37-38).

## **Appendix B**

### **Social Work in Long-Term Care**

1. Through psychosocial assessments. Spiritual and religious concerns are tied to emotional and physical issues
2. Encourage those who live in LTC to make sure that staff understand their personal view on the importance of spirituality by carefully assessing and listening to what a resident and those who care say what is meaningful to their lives
3. Social workers are important advocates for resident's spiritual concerns.
4. Social workers can educate other staff about the importance of the spiritual care in long term care work in conjunction with other staff such as chaplain or recreation therapists. It is useful to ask staff what is important in their own spiritual life.
5. Modeling for other staff the sense of being present with residents. Really hearing what residents are saying. What they share is a gift.
6. Social workers need to keep their own spirits alive in the work that they do and to encourage other staff as well.
7. Social work practice in long-term care requires us to maintain our sense of hope. Calls us to remember the basic social work principles of starting where the person is, knowing the individuals and building on people's strengths. (Richards, 2005)

## **Appendix C**

### **Key Roles of Social Workers in Long-Term Care**

- Enhancing quality of life of residents and counteracting the impact of helplessness, hopelessness, loneliness and boredom
- Establish therapeutic relationships with residents where appropriate
- Dealing with interpersonal issues experienced by residents and their families
- Ensuring residents' self-determination is safeguarded
- Locating and arranging resources (macro and micro levels)
- Fulfilling a leadership role, along with others, in contributing to effective operation of facility utilizing specialized knowledge and skills that include: communication, problems solving, system knowledge, knowledge of community resources, ability to assist persons in different roles to work more effectively together
- Promoting a positive atmosphere and attitude and playing leadership roles in counteracting stereotyping, stigmatization, and discrimination
- Sharing responsibility for educating residents, families, and staff colleagues

(Adapted from CASW Website on Long-term Care)

## Appendix D

### Comparison of Institutional and Social Models of Care

<b><u>Institutional Model of Care (adapted from</u></b>	<b><u>Social Model of Care (adapted from</u></b>
<p><b><u>Shields &amp; Norton, 2006):</u></b></p> <ul style="list-style-type: none"> <li>• Focus on care</li> <li>• Scheduled routines</li> <li>• Decisions made for the resident</li> <li>• Staff rotate</li> <li>• Environment = workplace</li> <li>• Structured activities</li> <li>• Staff care for residents</li> </ul>	<p><b><u>Shields &amp; Norton, 2006):</u></b></p> <ul style="list-style-type: none"> <li>• Focus on living (care)</li> <li>• Flexible routines</li> <li>• Decisions made with the resident</li> <li>• Staff assist with the same residents</li> <li>• Environment = home</li> <li>• Planned, flexible and spontaneous activities</li> <li>• Mutual relationships</li> </ul>

## Appendix E

### Mission and Spiritual Care at Samaritan Place

There are many definitions of spirituality. At Samaritan Place the Director of Mission and Spiritual Care has settled for an analogical definition penned by St. Irenaeus who lived in the 2nd century: “The Glory of God is when men and women are fully human and fully alive.”

Subsumed in this definition are the following approaches to Spiritual Care:

1. Responding to the articulated religious and spiritual tradition of the resident.
2. Recognizing that life is a journey which involves the passions of the resident.

What is the life story of the resident? How does the office of Spiritual Care help residents to reflect of the life’s journey in a spiritual fashion? Tell us about your spiritual journey and how we as a community can support you. **According to this context Mission and Spiritual Care at Samaritan Place views the discipline of Life Enhancement as working toward the same goal (#2), while at the same time respecting the integrity and uniqueness of Life Enhancement’s professional identity.**

3. Realizing that the passions of residents are often disconnected from their lives through accident, illness, depression, etc. Some questions and concerns around these are: How can Spiritual Care help the resident rediscover their passion for life thereby restoring a sense of dignity and self-worth? Around this set of concerns are: Finding new meaning and purpose; dealing with Anger, Guilt, Sadness, Discouragement, Loss of Independence, Fear of Dying, Loss of Hope, and Low Self-esteem.

4. End of Life includes such realities as: Forgiving and receiving forgiveness, Saying goodbye, Coming to terms with whatever I perceive may occur after I die, as well as practical concerns such as Care Carts, clergy support, grief ministry and education.
5. Other concerns of Spiritual Care are: Support from the community; Family connection; Friends; How do I connect with the transcendent/holy? What are my spiritual resources? Can you help me express my vaguely felt needs?  
Other\_\_\_\_\_ (Samaritan Place, 2012)

**Appendix F**  
**Samaritan Place**  
**Mission, Vision and Values**

**MISSION**

We are a Catholic health care facility where care is compassionate, resident directed, safe and respectful. We advance the healing and caring ministry of Jesus Christ by responding to needs of the spirit, mind, body and culture of those who enter our home.

**VISION**

A home where everyone who enters can experience harmony in relationships and joys in everyday life.

**VALUES**

Our actions are guided by our belief in:

- **Human Dignity:** Focusing on each person as a unique individual to be respected and cherished.
- **Compassion:** A quality of presence and caring that accepts each person as they are, to foster healing and wholeness.
- **Holistic Care:** Focus on healing the whole person through the unity of body, mind, spirit and culture that is sensitive, open, and respectful to each person.
- **Spirituality:** A living spirituality is grounded in the experience that God dwells among and with us, and through our interactions with one another we reveal God's presence.
- **Collaboration:** Residents, families and staff work together to create a fulfilling and meaningful life for all.

- **Integrity:** Trust and mutual accountability are rooted in dialogue among all who live and work in this home