Relational Practice in Long Term Care

by

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Abstract

This critical ethnography explores the concept of relationality from the perspective of nurses working in long term care. The existing literature on this concept, in this context, has mostly focussed on allied health professionals. Data was collected through field observations, solicited diaries, and semi-structured interviews conducted with seven nurses working in long term care. A theory of relational work was used to inform a reading of, and thinking through the research process, data collection and analysis. The findings from this study indicate that nurses privilege the relational in their work, seek out opportunities to cultivate family-like relationships with residents, and see hands-on care as an opportunity to strengthen feelings of connection with the people they care for and with. These findings have potential implications when considering appropriate skill-mix in long term care and for re-evaluating the meaning of nursing work to nurses who work in these settings.

Keywords: Relationality; Nursing Care; Long Term Care; Nursing Home.

Dedication

to my parents, and my grandparents before them: across oceans bearing stories

and to Aijaz Said Karim whose stories are yet to be told but whose music and tactical nous filled the many, seemingly endless, solitary hours.

this thesis was written in the shade of an ever-blooming, sweetly fragrant, plum blossom.

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the nurses who shared their vision of relational care

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Chapter 1

Introduction

In 2017, the Office of the Seniors Advocate of British Columbia published the results of a province-wide survey that catalogued the experiences of people living in long term care. The report offered a sober appraisal of a life lived in care. In the news release that accompanied the publication, the Seniors Advocate noted

> [w]e have heard from 20,000 British Columbians - 10,000 residents and 10,000 family members - and together their voices send three strong messages…more staff, more freedom and more conversation...Residents need more help in some areas reflecting the fact there are not enough staff; many are lonely and want to be talked to and engaged (Office of Seniors Advocate [OSA] 2017a, para. 7)

That the need for more staff was one of the central issues identified in the report comes as no surprise to those who have looked critically at this sector (McGilton et al., 2016a; McGilton et al., 2016b; McGilton et al., 2013; Montayre & Montayre, 2017). That the report chose to illustrate this fact through plaintively noting the unaddressed emotional needs of people living in long term care foregrounds the concept of relationality in a way that is often "devalued and disappeared within the biomedical model" (Defrino 2009, p. 300). Indeed, as the Seniors Advocate noted, "[w]e are very good at using clinical measurements to gauge how we're doing in this area" (OSA, 2017a, para 4), but seemingly less so at recognizing the contours and concerns of a selfhood in the midst of frailty and decline (OSA, 2017a; OSA, 2017b; Tanner, 2006). That staff are seen as a means by which loneliness can be alleviated, conversations generated and engagement facilitated, speaks to their essential role within this interdependent network of care and support for the people living in long term care (OSA, 2017b). Defrino (2009) argues that this attentiveness to the social and affective needs of the individual in the context of care is central to nursing work—as both the site of caring labour and the instantiation and embodiment of relational practice. It is this practice of relationality by nurses in a long term care setting that will be the focus of this current study. In her closing comments the Seniors Advocate (2017a) reminded the public "that for people who are living in

residential care, this is their home, and very likely their last home" (para. 9)—which makes attentiveness to their physical, psychological, social, spiritual and emotional needs that much more important.

The idea of home, or home-like spaces, has come to occupy a central place in the discourse on the provision of care for older adults (Fleming et al., 2017; Chaudhury et al., 2018). This philosophical and aesthetic re-orientation from the large-scale and impersonal institution, towards an intimation of the domestic and the familiar (Braedley & Martel, 2015) has been driven, in part, by a cultural shift that has re-centred the personal (Brownie & Nancarrow, 2013), privileged the relational (DeFrino, 2009; Doane & Varcoe, 2007; Kontos 2011), and recognized that frail and vulnerable older adults require nurturing spaces in which to live and flourish (Sherwin & Winsby, 2010).

This is of some significance in the contemporary moment, marked as it is by population aging "where the number of people aged 85 and older [grew at] nearly four times the rate for the overall Canadian population" (Statscan, 2017, para 1), and where one-third of this population were reported to be living in "collective dwellings such as nursing homes and residences for senior-citizens" (Statscan, 2017, para 1). Even within spaces that replicate the architectural and ideological morphology of the 'total institution' (after Goffman, 1961), the rhetoric of care is often informed by a discourse of domesticity. Care facilities are invariably, though not unproblematically, described as 'home-like' (Braedley & Martel, 2015; Fitzgerald & Robertson, 2006; Fleming et al., 2017)—the relationships fostered within them 'family-like' (Dodson & Zincavage, 2007; Rodriguez, 2011). These relationships, in turn, sustain certain "habitual schemas and dispositions" (Wainwright & Turner 2003, p. 4). Such patterns unfold in the social and caring dynamic that obtains between residents and staff, but also family and kin, administrators, volunteers, and informal caregivers (Banerjee & Armstrong, 2015)—and in spaces that are increasingly marked by diversity and heterogeneity (Bourgeault et al., 2010; Small et al., 2015). Banerjee and Armstrong (2015) suggest that residents "live in a nexus of relationships with sometimes competing interests" (p.12). How such 'competing interests' unfold in these recalibrated spaces is of relevance to the quality of care and quality of life that is rendered possible. An inhabitable space that is evocative of home, a grammar of intimacy structuring the speech and gestural acts of caregivers, a sense of connectedness and considerate caring practices—such interventions matter

and can shape the relationships between staff and residents, in particular, in substantive and profound ways (Bradshaw et al., 2012, OAS, 2017b).

A consideration of the 'nexus of relationships', in Banerjee and Armstrong's (2015) evocative phrasing, draws attention to what Woodward (2012) refers to as the "scene of care" (p. 23): a narrative turn that makes visible the social actors and sociopolitical forces that frame, foreground and contextualize the encounters between care recipient and caregiver(s)—highlighting a condition of embodied interdependence and vulnerability.

Woodward (2012) draws attention to the scene of care as a way of retrieving relational complexity. It is an ethical and aesthetic strategy that re-centres the care recipient and caregiver, while simultaneously considering the "many moving parts in a neoliberal economy" (p. 35). Furthermore, the scene of care functions as a fruitful and necessary counterpoint to a normative discourse that renders older adults a "public secret…habitually imagined as non-citizens, if not embodiments of bare life" (Woodward 2012, p. 19). Woodward (2012) proposes that what is at stake here—in this nexus of relationships—"is the fundamental human need to belong to meaningful social spheres, to experience the feeling of security that is, hopefully, the feeling of family" (p.45).

1.1. Purpose of Research

The purpose of this research is to deconstruct and examine the scene of care and to think critically with and about the relational encounter between nurses and the people living in long term care—from the perspective of the nurse. To do, in fact, what the OSA (2017b) suggests we have not been so good at doing—to reflect on the interactions that take place between the nurse and resident not merely as a set of instrumental tasks, but as relational practice. My interest in undertaking this research is shaped, in part, by my own reflections on the scene of care while practicing nursing in a long term care setting. I had, at that time, been struck by the way nursing colleagues would often employ familial terms—"mum", "papa", "grandma"—and the language of intimacy, "love", "dear", when addressing or referring to residents. It was a practice that was frowned upon and, on occasion, explicitly proscribed by management, despite the

fact that they themselves frequently deployed the (hetero)normative tropes of family to encourage, in the staff, a familial disposition towards the people living in care: ‘our residents’. It had seemed to me to be a straightforward instance of the use of unprofessional language, a subgenre of “elderspeak” (Thornton & Light 2006, p. 276): language that an employer or a college of nursing would upbraid an individual for using. Later, I began to think in a more critical and generous way about how these words (and the caring actions that bracketed them) might be read and understood differently—not as problematic discourse but as a language that was situational, the discursive building blocks of new forms of kinship, perhaps—informed by the demands of the moment; a transnational reflexivity, that carried with it an awareness of the circumstance of care in all of its unknowable complexity (Doane & Varcoe, 2007).

In the scene of care, relationality matters. It is salient to the way the people who live in care experience place: the ‘home’ (like) spaces of care that can be read as sites of repose and (re)productive domesticity. It is of significance to their experience of embodied vulnerability—to how the acts and gestures of care are seen and felt (DeForge et al., 2009). The relational encounter also matters to the way that care workers experience their labour—the worth of their often invisible work, and how the recipients of care might be seen as reflections of their own equally vulnerable, precarious selves (Defrino, 2009: Rodriguez, 2011; Stenbock-Hult & Sarvimäki, 2011). Furthermore, relationships with residents function as a “source of personal fulfillment and an impetus for regulated nurses [for example] to stay in their current employment situation” (McGilton et al., 2013, p. 774).

Chapter 2

Literature Review

In the main, the literature review for this study consists of a critical examination of the major themes that emerge from the existing research on relationality and nursing care. The literature was initially sourced through the following databases—Medline, CINAHL, Ageline, PSYCinfo, eBook Nursing Collection, Humanities Source and the academic search engine, Google Scholar—using the keywords relationality, nursing, care. An additional focus was on the state of long term care in British Columbia with literature sourced through Medline, CINAHL, Ageline, PSYCinfo, and the academic search engine Google Scholar—using the keywords long term care, nursing home, residential care, British Columbia.

Beginning with a brief overview of the state of long term care in British Columbia, this review will then examine in detail some of the major themes present in the extant literature on relationality and care.

2.1 Home-Like

The shifting and problematic context of long term care is due, in part, to what Banerjee (2007), suggests is a conceptual ambiguity at its core. Banerjee (2007) advances this thesis through a consideration of how long term care, though ostensibly concerned with the health (and wellbeing) of older adults, has not been brought under the legislative and organizational purview of the Canada Health Act and indeed has been "practically invisible at the federal level" (Banerjee, 2007, The Federal Policy Context section, para 1)—excluded, for example, from the 2002 *Romanow Commission on the Future of Health Care in Canada* (Armstrong et al., 2012) and the 2004 *Kirby Commission on Mental Health Report* (Campbell, 2016). By contrast, the Canadian Medical Association (CMA) made the issue of care for older adults a central feature of its 1984 *Task Force on the Allocation of Health Care Resources*—drawing explicit attention to the vulnerability of seniors in a loosely regulated system (Twomey, 2013). As the CMA presciently noted, the provision of long term care outside the Canada Health Act has

resulted in a fragmented, provincialized structure that in its sometimes *byzantine* enactments, is frequently at odds with the principles of public administration, comprehensiveness, accessibility, universality and portability, enshrined in the act itself (Banerjee & Armstrong, 2015; Daly et al., 2016). This is of no small significance for the older adult who requires timely access to affordable, quality, comprehensive care (Banerjee & Armstrong, 2015; Canadian Healthcare Association, 2009) and underpins the CMA's call for "a national seniors strategy to address needs along the full continuum of care" (Canadian Medical Association, 2016, p. 5).

The literature under review advances a set of arguments that situates long term care in a globalized environment—one subject to a local/transnational political order, strategically liberalizing the flow of capital and labour (Banerjee & Armstrong, 2015; Baines, 2015; Campbell, 2016). This ideological orientation can be traced back to the 1980s when Canada and other countries of the global North began to rationalize and reconfigure the delivery of social services (Baines, 2015; Lowndes & Struthers, 2016; Skinner & Rosenberg, 2005). Health care was not immune from this market-oriented process, with its accompanying discourse of efficiency and efficacy, metrics, documentation and standardized care (Armstrong et al. 2016; Baines, 2015; Daly et al., 2016; Estes 2014). Estes (2014) suggests that the policies pursued by the state and its institutions have resulted in an "'aging enterprise', which assures that the needs of older adults will be processed and treated as a commodity (e.g., medical services) and sold for a profit" (p. 94). Indeed, in the absence of national standards and with each province fashioning its own regulatory regime, long term care is vulnerable to privatization and for-profit initiatives (Armstrong et al., 2012; Berta et al., 2006; Daly et al. 2016;). As a 2009 report by the Ombudsperson of British Columbia noted "residential care in British Columbia…can be provided in a variety of ways, and by a variety of agencies, organizations and entities…[while the] applicable legislative and regulatory framework in British Columbia is complicated" (p. 2).

The stark consequence of the commodification of elder care can be read in the process through which British Columbia restructured long term care in the early 2000s (Cohen et al., 2005; Cohen et al., 2009). Indeed, what transpired during this period is illustrative of how the provision of long term care can be undermined through the application of a "public sector management model based on private sector performance

management" (Baines 2015, p. 195). While the provincial government articulated its undertaking in terms of *Continuing Care Renewal* (Cohen et al., 2005), the reality was less sanguine. Instead, long-promised long term care beds were substituted for assisted living units, while a number of long term care facilities were closed resulting in a net reduction in long term care beds. Furthermore, the closures were unevenly distributed across regional health authorities, with little regard for the needs of local populations (Cohen et al., 2005; Cohen 2012).

Cohen et al. (2005) note that for the government of British Columbia, *Continuing Care Renewal* was premised on reducing the number of older adults in long term care while increasing the number living at home or in assisted living—thus shifting the caregiving and financial responsibility from the state to the individual (Cohen et al., 2005). In so doing the government's actions echoed recommendations put forward by the British Columbia Department of Health in a 1989 report entitled *Toward a Better Age* that called for an emphasis on home and home-like spaces as more appropriate sites of care and caregiving (Brody et al.,1997). In the early 2000's, assisted living units appeared to offer the promise of 'home' while addressing a vital social need.

The proliferation of assisted living facilities across Canada, highlights their significance in the continuum of care (Maxwell et al., 2013) and simultaneously draws attention to the multiple instantiations of caregiving an older adult may encounter along any given health trajectory (Penning et al., 2018). While assisted living facilities are intended to provide "supportive care, emphasizing autonomy and privacy in a home-like setting" (Stock et al., 2017, p. 40), the "absence of federal (and at times provincial) standards or regulations for the AL sector…has resulted in significant variation across and within provinces in the definition, size, admission/discharge criteria, staffing, [and] services" (Maxwell et al., 2013, p. 334) it offers its residents. Though assisted living may have been conceptualized as a compelling and cost-effective alternative to long term care, the limited repertoire of care and services and skill mix afforded residents have surely attenuated its capacity to provide the kind of comprehensive support an older adult might reasonably require to age in place (Cohen et al., 2005; Maxwell et al., 2013; Stock et al., 2017).

In British Columbia, the consequence of closing long term care facilities and beds and substituting these for assisted living units has resulted in the instituting of a more restrictive set of criteria for admission into long term care (Cohen et al., 2009; Cohen, 2012). This economy of scarcity has meant that only those who are in need of 'complex care' are deemed eligible for admission into long term care (Cohen 2012; Zhang et al., 2012). Cohen (2012) notes that this more restrictive admission criteria has meant that priority placement in care is based not on the length of time spent on any given waitlist but on need. Thus, an older adult in an acute care setting designated as alternate level of care (ALC) might be selected in advance of someone in the community (Canadian Institute for Health Information, 2017; Cohen et al., 2005; Cohen, 2012). Conversely, older adults waiting to return to the community (as opposed to being admitted to long term care) face longer ALC days (Canadian Institute for Health Information, 2017), placing them at increased risk of declining health status, a recurring need for acute care treatment and premature admission to long term care (Sutherland & Crump, 2013).

While the restructuring of the continuing care sector remains a work in progress, what has become apparent is an increasing privatization of care for older adults in both assisted living (Cohen et al., 2005) and long term care (Armstrong et al., 2012; Banerjee & Armstrong, 2015; Braedley & Martel, 2015, Cohen et al., 2005; Longhurst & Strauss, 2020, OSA, 2017b, OSA, 2020). Moreover, it is a form of privatization with a transnational dimension, as large for-profit care chains look to diversify their investments (Harrington et al., 2017, Longhurst & Strauss, 2020). This has a bearing on staffing and skill mix, which is salient because residents in long term care settings have increasingly complex needs requiring increasingly complex care. Thus, as Kontos et al. (2017) argue, they are vulnerable to being cared for as opposed to being cared with. Cammer et al. (2013) note that this requirement for care is situated in a context that is itself complex—one marked by a constant state of flux and ambiguity. This is, in part, driven by what Cammer et al. (2013) suggest is the pressure to tailor principles of best practice to fit the working reality of inadequate resources and contradictory policies. This "hidden complexity" (Cammer et al., 2013, p. 1016) takes place in the scene of care marked by increasing resident acuity (McGilton et al. 2012a), diminished lengths of stay (Zhang et al., 2012), and often under-resourced end-of-life care (Munn et al., 2008).

Several studies have noted that the staffing complement in not-for-profit facilities is superior to that which obtains in for-profit environments (Armstrong et al., 2012; Caspar et al., 2012; Longhurst & Strauss, 2020; Lowndes & Struthers; McGregor et al., 2005; McGrail et al., 2007; OSA, 2020)—including higher levels of nursing staff (Harrington et al., 2017). In these settings, nurses often play a decisive role in shaping staff morale and the provision of quality care (McGilton et al., 2016b) In addition, not-for-profit facilities offer more hours of care per resident, resulting in better health outcomes, such as lower rates of hospitalization, than for-profit facilities (McGregor et al., 2005).

The issue of care hours has entered the public realm as a marker of how long term care facilities have fallen short of addressing the needs and wellbeing of older adults (OSA, 2017b). That the majority of long term care facilities failed to meet a minimum number of care hours per resident per day has been one of the central discussion points emerging out of a recent survey of long term care conducted by the Office of the Seniors Advocate of British Columbia (2017b). Entitled *Every Voice Counts*, the survey draws attention to gaps in the care of the older adult. For instance, over half of those surveyed wanted more frequent baths/showers and fully one quarter of residents did not receive adequate help to the toilet (OSA, 2017b). The report also highlights issues of social isolation noting that nearly half those surveyed reported a lack of friendship (OSA, 2017b). In addition, almost half of those surveyed poignantly noted that staff was not able to make time for friendly conversation on a regular basis (OSA, 2017b). And nearly two thirds of those surveyed reported that, in the main, they did not "have [a] special relationship with staff"(p.29), though conversely over half the respondents report having a staff member they "consider a friend" (OSA, 2017b, p. 32).

The prefatory remarks to this section of the survey suggests that explicit expressions of relationality serve as an essential register of the caring dynamic in long term care (OSA, 2017b). Indeed, the survey notes that "it is important for residents to *believe* [emphasis added] that staff actually *care* [emphasis added] about their health, well-being and happiness" (OSA, 2017b, p. 29). The capacity of staff to demonstrate caring behaviours is often dialectically shaped through the affect and behaviour of the residents receiving care (McGilton et al. 2012b). In addition, McGilton et al. (2012a) note that the expression of caring behaviours is informed by adequate staffing levels, workload, and the relational skill of managers.

2.2 Personhood & Relationality

The lack of adequate staffing in long term care means a certain sameness of approach (Armstrong et al., 2012; Armstrong et al., 2016; Banerjee & Armstrong, 2015; Lowndes & Struthers, 2016; OSA, 2017b)—scripted and routine and often hurried. The scripting of care is further informed by standardized categories enshrined in the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) (Armstrong et al., 2016)—a type of universalist grammar that passes for evidence-informed practice. While the RAI-MDS is generative of data, it is often decontextualized and disembodied (Armstrong et al., 2016). Nurses may attempt to 'contextualize' and 'embody' this data through personalized care plans and resident-specific documentation, but these processes can create "a large time burden" (Daly et al., 2016, p. 68), and this, coupled with concerns about regulatory regimes, can result in the erasure of specificity.

The counterpoint to this process of commodification is person-centred care—a philosophical orientation coalescing around ideas of personhood, relationality and meaning in the work, for example, of Carl Rogers (Brownie & Nancarrow, 2013) and Tom Kitwood (Agnelli, 2015; Kontos et al., 2017). In a systematic review of the literature on person-centred care, Brownie and Nancarrow (2013) note the benefit to staff and residents, alike. Staff derive a sense of satisfaction coupled with the "capacity to provide individualized care" (Brownie & Nancarrow, 2013, p. 9); residents experience "lower rates of boredom and helplessness…and reduced levels of agitation in [the case of] residents with dementia" (Brownie & Nancarrow, 2013, p. 9). In addition, Caspar et al. (2013) posit that, for staff, person-centred care is facilitated through empowerment, access to resources and time, and a positive inter-professional dynamic. McGilton et al. (2012a) further suggest that the repertoire of skills possessed by nurses makes them ideal facilitators of this mode of care. Kontos et al. (2017) re-calibrate the contours of person-centred care through a model of relational citizenship that valorizes notions of interdependence, reciprocity, and embodied selfhood, reminding us of the dialectic nature of the relational dynamic.

It is possible that certain institutional spaces are more conducive to centering the person than others. Brownie and Nancarrow (2013) draw attention to the *Eden Alternative* and the *Green House* model as forms of care that privilege personhood and

quality of life. But even in long term care spaces that replicate Goffman's (1961) notion of the 'total institution', the relational encounter is a central feature of life (see also Swain, 1979). Gubrium (1975) poignantly notes that, for residents, "much of daily life revolves around ties of various kinds…indeed, a good portion of the 'work' that residents and patients do at the manor involves the effort to maintain or avoid social ties" (pp.83-84). In part, this work represents the reconfiguration of relationality as home is abandoned for the facsimile of home-like in the institution. Ties are forged with other residents, maintained with family and kin, fashioned with staff in the intimate and discursive encounter of caregiving (Gubrium, 1975).

In thinking about the broader implications of how relational ties shape the contours of care, Gubrium and Buckholdt (1982) observe how, in these settings, they

> repeatedly encountered questions of real and fictive kinship…the everyday issue of how, among a variety of direct or indirect, common or uncommon claimants, family status is assigned in the care, treatment, and informal relations of institutionalized persons, together with its ensuing rights, obligations, and sentiments. (p.1878)

In the scene of care, Gubrium and Buckholdt (1982) observe that the meaning of family is not merely rhetorical but emerges from the concrete caring and relational actions and sentiments of individuals in response to the needs and circumstances of residents. Thus, as Karner (1998) suggests, "it is the intimate nature of caring more so than the home environment [per se] that engenders a family-like relationship" (p.71). This is not to say that the idea of family, or family-like, or kin-like is not part of the rhetoric utilized by care facilities to convey the idea of home and its attendant comforts. Indeed, in the studies of Berdes and Eckert (2007), Dodson and Zincavage (2007) and Rodriguez (2011), the ideology of family and family-like functions as a crucial animating principle designed to convey a certain set of caring obligations within a resonantly homelike setting.

Braithwaite et al. (2010) suggest that "families are created via discourse" (p.392), and that those families "that depart from cultural norms are even more dependent on discourse to define themselves internally and to those outside the family" (p.392) Bourdieu (1996) reminds us that "[t]he [d]ominant, legitimate definition of the normal family...is based on a constellation of words, house, home, household, *maison,*

maisoneé—which while seeming to describe social reality, in fact construct it" (p.19). A social constructionist approach to the conception of family draws attention to the processes "by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live" (Gergen, cited in Braithwaite et al., 2010, p.392), and thus how families "are formed, maintained, changed and repaired through language use" (Braithwaite et al., 2010, p.392).

Relationships that are situated "somewhere 'between' family and friendship" (Nelson, 2013, p. 263) are often referenced as fictive kin: "something 'more' than 'mere' friendship or acquaintanceship…treated as if they were family" (Nelson, 2013, p. 263). Here the specific nomenclature is of less significance than the sentiment or emotional valence ascribed to the relational dynamic. Taxonomies of fictive kin describe these relational phenomena as

> re-creating [though not unproblematically] such aspects of family as socioemotional attachment (including love, intimacy, and psychological support), ongoing belongingness (including the sharing of material resources to provide material support and protection), and entitlement (involving both the rights and the responsibilities that are perceived as being components of family membership) (Nelson 2013, p. 262)

Nelson (2013) reminds us that the affective and gestural contours of fictive kinship are shaped by circumstance and situation. In the case of caregivers and care recipients, for instance, such interdependencies exist "along a spectrum from 'friendly' through 'friendship' to being 'like one of the family'" (Nelson 2013, p. 263). In addition, the terrain of fictive kinship can be marked by "ambivalence, obligation, exasperation, trouble, [in addition to] joy, and pleasure" (Barker, cited in Nelson, 2013, p. 262); and by coercion and exploitation in instances where the ideology of family institutionalizes obligatory forms of relationality (Dodson & Zincavage, 2007).

Redrafting the borders of kinship to engender new forms of relationality in residential care (and elsewhere) allows us to view these relationships "less as a comparison to blood and legal family (and friendships) than phenomena in their own right" (Nelson, 2013, p. 277). Thus, the scene of care is also the site of a reconfigured domestic tableau—one in which nurses and residents may be discursively fashioned into kin.

The 2017 report by the Office of the Seniors Advocate of British Columbia draws attention to the centrality of the staff-resident dynamic as a means through which a more explicit and demonstrative relationality might be vouchsafed. As previously noted, the report suggests that "[i]n addition to the skills and responsiveness of staff it is important for residents to believe that staff actually care about their health, well-being and happiness" (OSA, 2017b, p. 29)—as if relationality was merely performative and unidirectional. The literature on the relational dynamic in long term care is under-theorized and under-explored. It lacks intersectional nuance, an appreciation of the vulnerabilities of formal caregivers (Stenbock-Hult & Sarvimäki, 2011), and presumes that emotional proximity and affective expression are a necessary dimension of the work and not merely one more (possibly) unreasonable expectation from an employer, a family member, or indeed, the Senior's Advocate. While the literature does touch on the relational and affective experiences of care aides, the relational encounter between nurse and resident has been relatively under-explored. This deficit warrants attention because of the important role that nurses play in ensuring healthy outcomes for residents (McGilton et al. 2012a; McGilton et al., 2013) and also because "relational practice is a valuable process for the patient's [and resident's] well-being, the organization meeting its goals, as well as for the nurse professionally" (DeFrino, 2009, p. 304). In addition, DeFrino (2009) argues that a "[n]urses' power results from the relational work they do" (p. 294), and forms of empowerment, as Caspar et al. (2013) and McGilton et al. (2012a) remind us, are key to the facilitation of individualized, relational care. The literature tells us little about the quotidian labour of nurses in long term care: the use of touch, and gesture, forms of corporeality to convey affect (Lanoix, 2013), or what it might mean for nurses to spend half of their clinical day engaged in indirect care—documenting and collecting data (Dellefield et al., 2012), and experiencing moral distress (Edwards et al., 2013). DeFrino (2009) reminds us that "the relational work of nurses, where nurses connect, negotiate, and renegotiate within their socially located work between patients [residents], families and physicians, is work carried out with skilled and nuanced interaction (p.307). Furthermore, relational work can be said to exist within a "network of relationships necessary…to the attainment of multiple agendas in complex environments" (Liaschenko & Peter, cited in Defrino, 2009, p. 307)

This 'network of relationships' within which the nurse is located echoes the 'nexus of relationships' within which the resident is located. It is the richness of this

dialectic that this study will address and in so doing begin to address some of the gaps in the literature identified above.

2.3 Boundary and Vulnerability

What becomes clear from the literature under review is that a condition of vulnerability demarcates the state of relationality (Tanner, 2006). One might say, as de la Bellacasa (2012) does, that this is due in no small measure to an "essential heterogeneity" (p. 204) founded on an ontology of relationality and interdependency—where "ontology is continuously in the making" (p. 200). de la Bellacasa (2012) goes on to say that "this does not mean that there are no boundaries or stabilities" (p. 200) but, as Haraway states, "beings do not preexist their relatings" (cited in de la Bellacasa, 2012, p. 200). This may illustrate why nurses who are unable to engage in relational practice—who are positioned at some existential remove from the recipient of care—experience moral distress, suffer a sense of drift and "emotional detachment" (DeFrino, 2009, p. 307); or why the care staff in the DeForge et al. (2011) study experience distress at being unable to tailor their care to the needs of the individual; or why having to overcome personal and structural barriers to care (Rodriguez, 2011) "may *perversely* [emphasis added] be more satisfying than caring without barriers" (Berdes & Eckert, 2007, p. 342). Doane and Varcoe (2007) shed further light on this conditional state when they observe that

> [b]ecause each nursing moment is shaped by our own actions, by the actions and responses of others, and by the contexts within which we work, relational practice involves the nursing obligation to act at all levels including the intrapersonal, interpersonal, and contextual levels (p. 202).

The idea that 'beings do not pre-exist their relatings', speaks to a shared vulnerability that frames the caregiver and care recipient. Doane and Varcoe (2007) reference a proximity to difficulty, uncertainty and suffering as markers of this dynamic—encouraging the caregiver to enter the "abyss of difficultly and suffering" (p. 201); to be "instructed by the abyss, to let the abyss be, to let it play itself out" (Caputo, cited in Doane & Varcoe, 2007, p. 201). The abyss is, after all, the existential space that defines the human condition. It is, as Woodward (2012) argues—drawing on the work of Kittay—"a place of corporeal dependency…an elemental condition of all of our lives" Woodward,

2012, p. 21). Butler (cited in Tong, 2014) suggests that “there is no way to argue away this condition of primary vulnerability” (p. 289), though how this state of vulnerability shapes a life will differ based on a constellation of circumstances and factors: gender, health status, race/racialization, disability, socio-economic status, for instance. Dodds (2013), draws an important set of distinctions between vulnerability and dependency—arguing first, that “human vulnerability arises from our embodiment” (p. 182)—and that dependence is a “form of vulnerability” (p. 182)—but notes that while the state of vulnerability is essential to who we are at any given moment we may not necessarily be (explicitly) dependent on another to address or mediate it. The central issue for Dodd (2013), is how situational vulnerability might be addressed via a relational approach to autonomy – through which

> neither vulnerability nor dependence is inconsistent with autonomy…[o]ur powers or capacities are not developed in the absence of dependency, and they may be consistent with dependence…[while] vulnerability is not to be contrasted with invulnerability but with resilience” (p.198).

This conception of vulnerability and dependency offers a crucial counterpoint to the secular liberal notion of the autonomous individual, with, for instance, its emphasis on the singular relationship between caregiver and care recipient (Doane & Varcoe, 2007; Woodward, 2012; Dodd 2013) coupled with a ceaseless and devolving set of personal responsibilities and obligations.

In the scene of care the vulnerable bodies of care workers and nurses encounter the vulnerable bodies of care recipients in a powerful matrix of relationality. Vaittinen (2015) skillfully argues that an explicitly declared state of vulnerability is “a political necessity” (p.104) through which the body, in its abject state, “influences, challenges and shapes the structures of political economy…exert[ing] pressure on the sovereign power” (p. 112)—the state, the body politic, and civil society. “What needs to be asked”, Vaittinen (2015) suggests, “is *why* particular bodies in particular encounters can trigger political relations of care, whereas others elsewhere elicit only relations of neglect” (pp. 113-114).

In the context of this study the condition of vulnerability is consequential, in part, because as it engenders an existential and embodied proximity between nurse and resident—how “[c]are and its need constantly draw bodies towards each other”

(Vaittinen, 2015, p. 112). In the proximal circumstance that obtains within the scene of care—vulnerability becomes a medium through which the caring, relational encounter is articulated. “I see it as a strength that one can show, that one dares to show [how one feels]. We are all human beings…The more you show that you are vulnerable, that you are a human being, the closer you get to what is serious in life and the better care you will provide, I think” (Stenbock-Hult & Sarvimäki 2011, p. 37). Here we encounter the insightful comments of a nurse in Stenbock-Hult & Sarvimäki’s (2011) study, reminding us, counterintuitively perhaps, that vulnerability is a strength, a resource that nourishes self-awareness and is then summoned, by the practitioner, to deepen the relational encounter. Stenbock-Hult & Sarvimäki (2011) suggest that “one of the meanings of vulnerability for the nurse participants was having feelings which involved being sensitive, being open, and feeling (i.e. having mutual sympathy)” (p. 35) for the older adults they were caring for. What might be said, is that this ‘mutual sympathy’ can lead to new forms of relationality and increasingly elasticized and re-imagined notions of belonging and togetherness (Stenbock-Hult & Sarvimäki 2011). Indeed,-“[o]nly if nurses are able to deal with their own vulnerability will they be able to develop an existential and ethical attitude and encounter older persons’ vulnerability” (Stenbock-Hult & Sarvimäki, p. 40). Thus, the authentic relational self is to be found in and through vulnerability—at and beyond the boundary of what is possible in the caring encounter.

2.4 Research Questions

This study will consider the following research questions:

1. What is the meaning of relationality to nurses in Long Term Care?
2. How is relationality practiced by nurses in Long Term Care?
    a. Do they believe this has an impact on the residents they care for or with and if so, how?
3. What contextual factors shape the relational practice of nurses in Long Term Care?
4. Does the practice of relationality lead to an experience of kinship?

Chapter 3

Methods

The study adopted a critical ethnography approach to address these questions—an approach informed by the concept of relationality. While there are a number of studies that reference relationality in the context of care, it is in the work of DeFrino (2009) that the concept is fashioned into a set of theoretical propositions. What follows therefore, is an examination of DeFrino's (2009) four-fold theory of relationality.

3.1 Framework

DeFrino states that "power and knowledge lie in relational work" (2009, p. 294). It is through relational work that patient outcomes are improved and that nurses thrive and are professionally sustained. DeFrino (2009) advances a derived theory of relationality—that reads and functions like a framework—premised on four categories of relational practice: *Preserving Work*, *Mutual Empowering*, *Self Achievement*, and *Creating Team*. Preserving Work involves a holistic approach to the care of any given individual in a care setting. The nurse attends to detail—to the details of care—acting on and anticipating issues that may impact the health and wellbeing of the individual in care. In so doing "the nurse extends [their] responsibility beyond tasks or technical definitions of the job" (DeFrino, 2009, p. 299). Mutual Empowering reconceptualizes relationship, and "enacts an expanded definition of 'outcome'" (DeFrino, 2009, p. 299), inclusive of both patient and colleagues—building on and enhancing existing strengths and capacities while fostering knowledge and competence. Here, the nurse is a relational facilitator, "eliminat[ing] barriers to achievement for the patient as well as other health care team members" (2009, p. 300*).* Self Achievement characterizes the nurse who is an intrinsically motivated and self-aware professional—mindful of their conduct in the context of care and in the achievement of goals. DeFrino (2009) notes that "the nurse uses *feelings* [emphasis added] as a source of data to understand and anticipate reactions and consequences to care and helps the patient and other health care team members strategize an appropriate course" (p. 300). Creating Team is facilitated through the agency of the nurse resulting in a set of conditions in which "unit work and outcomes

can flourish and feelings of relational competence and teamwork can be experienced" (2009, p. 300). DeFrino perceptively notes that nurses draw upon a repertoire of relational skills and practices "that encourage interdependence" (2009, p. 300). In addition to this four-fold framework DeFrino (2009) advances five self-explanatory theory statements that taken together offer a productive summation of relationality in the context of care. The statements read as follows:

1. A significant amount of the nurse's knowledge of the patient comes from relational work with the patient.

2. Relational work creates positive professional rewards for the nurse.

3. Relational work is invisible knowledge work.

4. Relational work is devalued and disappeared in a biomedical model.

5. A disempowered nurse focuses more on tasks, experiences moral distress, and burns out. (DeFrino 2009, p. 301)

For DeFrino (2009) relational work is a means by which power and knowledge are recuperated and redeployed in ways that are of benefit to nurses, patients and the sites and spaces of care that bring them into relational proximity.

3.2 Critical ethnography

This study used a critical ethnography to explore the concept of relationality. Baumbusch (2011) notes that long-term residential care settings constitute a "rich ethnographic field" (p.184). This is due to the socially diverse populations who live, work, and intersect in these narrative-rich spaces, fashioned through the bio-political order (Baumbusch, 2011). Critical ethnography is of particular utility in deconstructing the scene of care—in making sense of the existentially exquisite and complex tableaus that frame the vulnerable and interdependent bodies of nurses and residents. In addition, this method initiates an intellectual and relational process that goes "beneath surface appearances, [and] disrupts the *status quo*…unsettles both neutrality and taken-for-granted assumptions by bringing to light underlying and obscure operations of power and control" (Madison, 2012, p. 5). The taken-for-granted assumption that, in part, gave

rise to the current study was that the use of a particular set of familial terms, kin-like references and terms of endearment were signifiers of a parochial domesticity. I had thought them problematic, unprofessional. Alternatively, it can be argued that a familial expression or a term of endearment can become a way of restoring dignity to the performance of task, a way of fashioning the relational out of (in)difference. Woodward's (2012) insistence on the need to narrativize the scene of care—to tell the story of care worker and care recipient in all of its complexity—is an invitation to a method of critical ethnography, one that resists epistemologies of domestication (Madison, 2012).

These acts of resistance are facilitated through the "immersion of the researcher in the field of study" (Baumbusch, 2011, p.186). The immersive state fashions a certain attentiveness to the subtleties and nuances that shape the relational encounter: a grammar of gestures; the use of metaphor; touch; the empathic gaze; the language of kinship. Tracing these lines of inquiry give structural purpose to the study. What do these words mean? Are they expressions of love or modes of coercion? Do they invoke a familial narrative of the past or one fashioned to give meaning to the present? Madison (2012) encourages, in the critical ethnographer, a state of intellectual and political openness to new ways of thinking with and about a subject area, a consideration of "other possibilities that will challenge institutions, regimes of knowledge, and social practices that limit choices, constrain meaning, and denigrate identities and communities" (p. 6). Critical ethnography invites the situated, embodied researcher to consider how other possibilities might lie fallow in the field of the relational encounter—yet to be theorized—that tell us something important about relational care.

A researcher who wishes to think with and about the meaning of relationality in the scene of care must, of necessity, shape the contours of its undertaking with an idea of the 'dialogical other' firmly in mind (Madison, 2012). Madison (2012) reminds us that one of the defining characteristics of critical ethnography is that it productively lends itself to "a deep and abiding dialogue with others as never before" (p. 10), as a way of making sense of our interdependence. Thus "[w]e are not simply subjects, but we are subjects in [perpetual] dialogue with others" (Madison, 2012, p. 10).

3.3 Site Selection

The study was conducted at a multi-storey 100+ bed long term care facility in the greater Vancouver area. The building itself has an unremarkable, unadorned exterior, complemented by an equally unremarkable configuration of interior space, characterized by long room-lined east/west corridors bisected by a compressed and invariably congested nursing station. Each floor has its own colour scheme: chintz, paneling, charts, the detailing on the doors of the single-occupant rooms. A multidisciplinary team of caregivers move about the floor with a practiced fluidity—their movements carefully choreographed with and against the clumps of care-aide and nursing students and the occasional student from the School of Dental Hygiene. The facility is noteworthy for its continuing utilization of both licensed practical nurses and registered nurses affording an opportunity to recruit from both disciplines.

Correspondence was initiated with the Executive Director of the facility in April of 2019 (Appendix 4). An initial telephone conversation with the Executive Director outlined the scope of the research. This was followed up by email exchanges with the director of nursing and other members of the administrative staff. Permission was subsequently granted to meet with the resident council—a necessary first step for ensuring that the resident's decision-making body had an opportunity to hear about the details of the study (Appendix 6) and to ask questions of the researcher. One of the many interesting questions that punctuated a mostly receptive response to the study came from a retired scholar who pointedly asked why I was using the term 'relationality' and not 'relationships'? It was a lovely, playful, and meaningful moment—a salient reminder that beyond the realms of academia are populations with a deep and abiding interest in the products of intellectual labour.

3.4 Participant Selection

Study participants were nurses working at the chosen site. A review of the literature indicates that the role of the nurse as a practitioner of relational care in long-term residential care settings is under-theorized and under-explored. This is, in part, attributable to the continuously shifting role of nurses in long-term care, and the changes

in skill mix as new models of care are advanced. The extant literature on nurses in long-term care notes that these practitioners bring expert knowledge to their clinical role. and that in care homes, where registered nurses (RNs) and licensed practical nurses (LPNs)

> have clearly differentiated roles, effective collaborative relationships, and greater RN presence on the units, resulted in fewer deficiencies and lower prevalence rates for undesirable resident quality measures, such as pressure ulcers, falls with injury, incontinence, and physical restraint use (McGilton et al., 2016a, p.7).

I visited the facility on multiple occasions in August and September of 2019, to speak with the nursing staff about the study, its scope and my intention to recruit participants. A recruitment poster (Appendix 3) was placed in the staff dining area. The intention was to recruit across a spectrum of age, ethnicity, sex, and professional discipline. In the end, a total of seven nurses agreed to participate in the study and consequently signed the consent form (Appendix 1) agreeing to do so: six women and one man; four LPNs and three RNs. Five of the participants first practiced nursing in countries other than Canada, and all seven were born outside of Canada (in countries categorized as the 'global south') and are now Canadian citizens. All seven nurses are full-time employees, each with more than five-years of nursing experience at this facility and had work schedules that included a combination of eight-hour day and evening shifts. This latter factor was of particular significance for this study because it is during day shift (0700h-1500h) and evening shift (1500h-2300h) that the nursing staff have the greatest number of interactions with the residents. Twenty-dollar gift cards were given to each of the participants as a mark of appreciation for participating in the study.

3.5 Data Collection

The process of collecting data for this study took place in a number of distinct phases. The first phase involved a series of site visits aimed at familiarizing myself with the configuration of space on each of the floors where the observations would take place. During this time, I had an opportunity to meet with various staff members and to see how the floor functioned and how it assimilated the presence of students. I was also able to determine where I might best position myself during the field observations and to consider the utility of sitting on a chair/stool with wheels to ensure that my presence

would not be an obstacle in what is already a congested space. Subsequent to these visits, I met with each of the study participants to look at their work schedule and determine dates and times to conduct field observations. I wanted to have an opportunity to observe the participants during their day shifts and their evening shifts. This was also an opportunity to let the participants know that I would not, for the most part, be engaging with them but would be observing their actions and interactions. I informed them that I would be locating myself on one of the mobile stools opposite the nursing station and that I may, on occasion, unobtrusively trace their steps as they made their way along the corridors towards a room or a person for whom they were providing care. What follows is a description of the specific processes through which the data for this study was collected with a parenthetic set of reflections on the situatedness of the researcher.

3.6 Field Observations

I observed each of the seven participants, in-situ, for sixteen hours divided equally between day shift and evening shifts—for a total of 148 hours of field observations. On the days and evenings when I was scheduled to conduct field observations, I would arrive on the floor where the study participant was scheduled to work and situate myself opposite the nursing station. This was an optimal location with sightlines along the elongated hallways, a partial view of the lounge and adjacent to the area where the nurses would position their medication carts. I had with me my pale blue graph-paper notebook in which I began to write about the space, the movement of people, staff, the people living in care, the rustle of fabric as a woman wheeled her way towards the elevator, the murmur of conversation, the repetitive sorrowful calling out of a word that has yet to be catalogued or found meaning for. I enjoy the act of writing; I write for work and pleasure. But the apt question for the novice researcher is “how to…look in order to write” (Emerson et al., 2011, p. 24). Emerson et al. (2011) suggest a number of productive approaches to the consideration and crafting of observations. First, take note of “initial impressions” (p.24), attending to the aesthetics and sensations of space and place. Following this initial approach, begin to pay attention to “what is significant or unexpected” (Emerson et al., 2011, p. 24), what draws the eye or ear—what surfaces amidst the low hum of the everyday. Next, consider what “those in the setting experience

and react to as ‘significant’ or ‘important’” (Emerson et al., 2011, p. 25), while also reflecting on “how routine actions in the setting are organized and take place” (Emerson et al., 2011, p.27). Lastly, Emerson et al. (2011), note that the “ethnographers' orientations to writable events change with time in the field” (p. 28), and that this transformative dialectic adds nuance to, and deepens and enriches, what is seen and heard.

I sat across from the nursing station on a wheeled stool. I often found myself having to shift my position as the people living in care navigated their way past me towards the elevators or the lounge. Sometimes they would sit next to me and a brief exchange of words might happen. Occasionally it would be necessary to alert the care staff to a request from one of the people living in the facility.

At the outset of the observation portion of the study I had thought I would be present on the floor for the full eight- hour shift but after sitting for four hours on that first day I was exhausted and decided that shorter shifts over a longer period of time would be more analytically productive. And, so, I rescheduled my visits to the site accordingly. I would arrive on the floor and take up my perch across from the nursing station. While the study subjects do move about the floor, a significant period of their time (particularly on day shift) takes place within close proximity to the nursing station. If they did walk along one of the hallways to attend to someone, I would follow them to observe their movements, their interactions along the way. On occasion they would explain an action to me. For instance, Naima (pseudonyms have been assigned to all participants to preserve confidentiality) talked me through the process of receiving a new admission to the facility—a process that required an extended period of time in front of the work-computer, and leafing through and completing sections of the chart of the person who had just arrived. Sometimes the nurse who I was observing would make a comment my way about workload or what they hoped to do during a shift but were not able to because time was inevitably short. But most of the time I came and observed them as they gave medication or retrieved ice-cream from the freezer in response to a request or completed a dressing or took someone’s blood pressure or entered a room with portable oxygen for someone in respiratory distress. And I wrote about these moments and what I heard and what I saw.

These jottings and others like them were made throughout my time at the facility. Leaving these observation sessions, I would often walk to a local cafe and there begin weaving these seemingly cryptic fragments of text into a more comprehensive set of field notes: a double espresso and pen on paper and a conscious realization that like all forms of writing what was being fashioned was a construction of what had been enacted and witnessed at the site (Emerson et al. 2011). That I did not visit the facility on consecutive days gave me time to reflect on the layers of meaning in the text that would circulate, sediment and surface through the subsequent days.

3.7 Situatedness

Emerson et al. (2011) note that “a primary goal of ethnography is immersion in the life-worlds and everyday experiences of others, [and that] the ethnographer inevitably remains in significant ways an outsider to these worlds” (p. 43). This dialectic of insider/outsider can be complicated when one has worked for over a decade as a nurse in long term care and is now professionally engaged in issues of health policy. I would, on occasion, find myself sitting across from the nursing station and thinking about how I would have dealt with a particular set of professional challenges: for instance the woman in the scarlet-coloured cardigan refusing her blood pressure medication or the South-Asian man in a black, moth-eaten anorak pleading to go home. I had managed countless analogous circumstances in the past but here I was an observer suppressing muscle-memory while paying nuanced attention to the details of the moment. Baumbusch (2011) notes that negotiating these multiple registers of identity can be complicated. As a way of dealing with the complications of insider/outsider identity I made a conscious decision to maintain a journal for the duration of the study. The reflexive space made possible through the white space of the page helped me to make sense of who and what I was as a novice researcher.

3.8 Personal Interviews

In-depth interviews are centred on a specific, focussed issue or topic, the goal of which is “to gain rich qualitative data” (Hesse-Biber & Leavy, 2006, p. 120). These forms

of dialogue are a “meaning-making endeavor embarked on as a partnership between the interviewer and his or her respondent” (Hesse-Biber & Leavy , 2006, p.119). It is a partnership founded on “*active asking* and *listening*” (Hesse-Biber & Leavy, 2006, p. 119).

3.8.1 Semi-Structured Interview

I conducted a semi-structured, sedentary interview with each of the participants. The interviews were scheduled following the completion of the field observations. I wanted to be able to have some understanding of who they were in the workplace and how they negotiated the many challenges of working in care. This information helped inform the phrasing of certain questions in the interview guide. A participant’s use of a particular expression or engagement in a caring act could then be referenced in specific and productive ways during the interview itself. Six of these interviews were in-person conversations. One interview was conducted by phone. The six in-person interviews were conducted in a small meeting room on the main floor of the facility. Being able to meet with the study participants in a space that was both familiar and accessible, facilitated the interview process. Prior to initiating the interview I read an ongoing consent script to ensure that the participant was cognizant of their right not to participate and of the continued confidential nature of our conversation if they permitted the interview to take place (Appendix 2). Following this, a hand-held recording device was activated and the interview recorded. One participant did not wish to have our conversation recorded and for this interview I took a set of detailed, contemporaneous, notes. During each of the recorded interviews I took occasional notes to highlight, for instance, a noteworthy facial gesture or an expressive use of hands. The interview was semi-structured. The interview guide provided a road-map for the interview itself—what questions to ask and in what sequence but I was also alert to pursuing particular lines of inquiry as the interviewees surfaced or reframed certain issues or thoughts (Appendix 5). At the end of each interview I explained that I would be transcribing the interviews and would schedule a follow-up conversation/interview thereafter. The transcription of the interviews was initially done through the partial use of voice typing available through the tools tab on the Google Docs program. This entailed using headphones to listen to and subsequently recite successive segments of the interview. Following this, I listened to

the interview while simultaneously reading through the transcription—making changes as necessary. I repeated this process, once again, to ensure that the final version of the transcription was a faithful rendering of the recorded interview.

3.8.2 Member Checking Interview

The member checking interview serves to “validate, verify, or assess the trustworthiness of qualitative results” (Birt et al., 2016, p. 1802). I initiated member checking interviews with each of the study participants following the transcription, analysis and synthesis of the first set of interviews. The member checking interviews were an invitation to revisit a cluster of key concepts that had been articulated in the first interview but that were also reflective of the synthesized data as a whole. This process involved reading (back) sections of the transcribed interview to the interviewee and discussing the themes in light of my own set of initial interpretations. Birt el al. (2016), suggest that such an approach to member checking can “validate results by seeking disconfirming voices (objectivism), yet...also provides opportunity for reflection on personal experiences and creates opportunities to add data (constructivism)” (p.1805). In addition to collating the data from these conversations, I took the occasional note as certain resonant statements were articulated.

3.9 The Solicited Diary

A solicited diary is a way of capturing qualitative data that is otherwise inaccessible to the researcher (Kenten, 2010). At the end of the first set of in-person interviews I provided each of the participants with a blank journal. I invited them to use the journal to make a note of any additional thoughts or impressions that may have surfaced as a result of the interview. In addition I asked them to make some brief notes, if they had the time and/or inclination, following their shifts—to write about anything that was noteworthy or of interest during their work day and in particular to note any experience that was illustrative of the issues and topics we had discussed in the interview. I informed the participants that I would collect the journals after a four-week period. Of the seven journals given to participants, two were returned with written entries.

3.10 Data Analysis

"What is happening here?" (Glazer, cited in Charmaz, 2006, p. 678) is the foundational question underpinning this study. It was a question that I had first asked when I was working as a nurse and heard my colleagues use familial expressions and terms of endearment to refer to the people they were caring for. At that time, it was not the generative question that it is now—but it was, I think, a rudimentary act of data analysis. I say this now—mindful of reflection as central to qualitative research—a researcher continuously reflecting on, and foregrounding, his own ineluctable beliefs and values (Long & Johnson, 2000). After all, "[i]t is the researcher's creativity, sensitivity, flexibility and skill in using...verification strategies that determines the reliability and validity of the evolving study" (Morse et al. 2002, p. 17).

I carried this reflexive disposition through the iterative process of data gathering and analysis. Morse et al. (2002) suggest that the concurrent collection and analysis of data "forms a mutual interaction between what is known and what one needs to know...[and] is the essence of attaining reliability and validity" (p. 18). For instance, a field observation would be accompanied with a corresponding jotting both descriptive and interrogative. Later the written-up field note would be accompanied by a reflexive journal entry to give form to this dialectic of data and analysis and reflexivity. Likewise, the walk home following a sedentary interview, would be accompanied by a reflection on certain resonant words or phrases that had been articulated by the interviewee: "family", "family-like", "they are like my family", "my work-family". That is to say, the process of analysis was not a discrete set of actions but an ongoing undertaking.

The data that was gathered through field observations, interviews and diary entries was organized, further analyzed and coded using the qualitative data analysis software NVivo 12®. The first formal step of the analysis was to read through the transcribed field notes, interviews, and diary entries. My intention, during this first set of readings, was to develop a provisional understanding of what is happening here and then to identify a few key words and expressions that might speak to the concept of relationality. I then used the Text Search and Word Frequency functions in NVivo 12® to create, respectively, a word tree and word cloud as a way of contextually visualizing the data. I then began to code the data. Charmaz (2002) notes that "[c]oding is the pivotal

first analytic step that moves the researcher from description towards conceptualization of the description" (p. 683). Through line-by-line coding I began to formulate a cluster of analytic ideas about the data (Charmaz, 2002). Following this immersive and contemplative process, I began to selectively code—drawing on a close reading of the initial codes—to sort and synthesize the data (Charmaz, 2002). Charmaz (2002) notes "that these codes cut across multiple interviews and thus represent recurrent themes" (p. 686). I used memo writing to explore the analytic landscape of these themes taking to heart Charmaz's (2002) conception of this practice as one that can help "spark fresh ideas, create concepts, and find novel relationships…[while spurring] the development of a writer's voice and a writing rhythm" (p. 687). The coding and memo-writing process together might be said to be a form of narrativizing—a set of interpretive acts through which "we define what we see as significant data and describe what we think is happening" (Charmaz 2006, p. 47).

After approaching the data inductively, I re-examined it through DeFrino's (2009) theoretical framework. This deductive process entailed reading through the transcribed data and then coding it on the basis of DeFrino's (2009) four categories of relational practice. Having done this, I used the matrix coding function in NVivo 12® to explore how the same piece of data could be intelligibly coded in different ways. The story that emerges about relationality in the context of care is one based on a synthesis of an inductive and deductive approach to the data—attentive to the voices of the study participants while alert to extant theories and "socially cultivated ways of seeing" (Tavory & Timmermans, cited in Jerolmack & Khan, 2017, p. 3).

Throughout the analysis the identities of the participants were kept confidential through the replacement of names and those of people they refer to with unique identification codes on all textual data from interviews (e.g., transcripts and analyses of the data, reflexive logs, coding sheets). A unique code was assigned to all study participants while all other potential identifiers were removed from the manuscript and either replaced with unique identification codes or general descriptors.

3.11 Rigour

Cypress (2017) defines rigour in research as “the quality or state of being very exact, careful, or with strict precision or the quality of being thorough and accurate” (p. 254). Morse et al. (2002) note that in the absence of rigour “research is worthless, becomes fiction, and loses its utility” (p.14). Therefore, Morse et al. (2002) emphasize the value of consciously building-in and cultivating rigour throughout a study as opposed to proclaiming it after the fact. Notwithstanding the lively discussions about nomenclature (rigour vs. trustworthiness) and how rigour might be achieved in qualitative research (Cypress, 2017, Morse, 2015), it has been argued that the concepts of reliability and validity have broad utility and value across various scientific paradigms (Cypress, 2017, Morse, 2015, Morse et al. 2002). Long and Johnson (2000) suggest that reliability can, for example, be evaluated through triangulation and auditability, while validity can, among other processes, be evaluated through reflective journal-keeping, prolonged involvement, and triangulation.

3.11.1 Triangulation

Long and Johnson (2000) note that triangulation refers to “the employment of multiple data sources, data collection methods, or investigators (p. 34). For this study, data was collected from three sources: field observations, participant interviews, and solicited diaries. Collecting data from multiple sources, while employing multiple data collecting methods helps contribute to a more nuanced portrait of the object of study—in this case relationality in the scene of care—while reducing what Long and Johnson (2000) suggest may be the “disadvantages inherent in the use of any single source, method or investigator” (p. 34). For instance, I observed Amanda in the scene of care on multiple occasions. It gave me an opportunity to witness how she responded to her colleagues and to residents—her use of certain expressions and words of endearment, her attention to detail when addressing a health concern. A picture began to emerge of who Amanda might be and how she embodied her identity as a nurse. In the personal interview(s), it was possible to reference what I had seen during the field observations—to ask her about the meaning of a word or why she attended to a resident in the way she had—to inform our conversation through this accumulation of detail, gleaned from the

scene of care. When I asked her to reflect on her use of the word ‘love’ and when I read her reflections through the framework of DeFrino (2009)—her use of feeling to navigate the difficult contours of a relationship with a particular resident *and* her use of feeling to navigate the landscape of her own emotions—I was struck by how resonant her words were with what I had witnessed of her—how reflective of who she seemed to be in the scene of care. Her diary entries were a confirmation of this: detailed, thoughtful, attentive to feeling, to self, to an inner life. Indeed, she wrote after every shift, reflecting on her practice and the relational encounters that shaped her days and evenings.

3.11.2 Auditability

An audit of the decision trail “involves the presentation of details of all the sources of data, collection techniques and experiences, assumptions made, decisions taken, meanings interpreted and influences on the researcher” (Long & Johnson, 2000, p. 35). The use of journal entries, jottings, field notes, and memos invite prospective researchers to trace the thought processes that led to a specific set of readings of the data.

3.11.3 Journal

Cypress (2017) notes that “researcher bias tends to result from selective observation and selective recording of information and from allowing one’s personal views and perspectives to affect how data are interpreted and how the research is conducted” (p. 259). Through reflexivity and reflective journal-writing these biases are made more explicit and intelligible to the researcher (Long & Johnson, 2000). Throughout the study period I kept a journal. This was a particularly useful practice in light of my background as a nurse who had been employed in long term care and who brought with him a particular set of perspectives about care, the caring environment and the professional identity of nurses.

3.11.4 Prolonged Involvement

Long and Johnson (2000) note the value of immersion in the research site over an extended period of time, suggesting that this allows for “emerging concepts to develop and for potential implications to be recognized…[and] for more opportunities to test out tentative explanations” (p.34). The structure and design of the study necessitated a number of site visits prior to the formal commencement of the research but it was the field observations conducted intermittently over a three-month period that afforded me the opportunity to gain a deeper set of insights into the labour of care and the concept of relationality.

Chapter 4

Findings

This chapter will begin with some reflective and foregrounding remarks on space and visibility at the research site. This will be followed by a look at some emergent, intersectional themes at the centre of which is the concept of family functioning as a master signifier and which inform the related concepts of home and care while contrasting with and clarifying the concept of the boundary. Thereafter, there will be an examination of some of the key findings based on DeFrino's (2009) theoretical framework.

4.1 Space and Visibility

> *There is something to be said about proximity and the number of staff, students, residents - and the space how narrow it is and what this suggests about the refashioning of relationships (field note, October 2, 2019).*

On that first day of field observations, I was struck by the ever-shifting constellation of bodies—the redrafting of public and private space. The people who lived in the care facility would propel their walkers and wheelchairs along corridors, often brushing past and against the uniformed bodies of staff and students. And in-turn, nurses and care-aides would situate themselves proximal to bodies in need—checking a pulse, changing a dressing, re-directing, repositioning—an orchestration of hands and gestures and movement. The congestion of bodies was particularly pronounced when medications were being administered and then the nurse and the nursing station would exert an almost gravitational pull on residents and care staff alike. I hadn't thought about the workplace and spaces in this way when I was nursing, but now, as an observer, I began to think of how it served to reconfigure bodies, to draw some closer, in a way that resembled a strange, possibly estranged domesticity—the spatial politics of home. I couldn't imagine another work environment where bodies were brought together in such a manner, where casual touch was the tactile grammar that pieced together the narrative of any given day. You didn't need to know that scholars were constantly invoking the

idea and metaphors of home to describe long term care, only to witness what occurred at the beginning of a day shift. But not everyone is drawn thus. Certain people living in care were less obviously visible than others: the frail woman in the mauve house-coat sitting in the lounge who rarely draws the attention of the care staff, for instance, or the woman prone to repeated, seemingly inchoate, vocalizations who is invariably ushered—that is to say wheeled—into her room between meals. Day after day the same. The quiet resident at the end of the corridor or in the lounge, and the one who was no longer able to control what she uttered—hidden from view.

The compression of space draws certain bodies together. At any given moment, some bodies are visible, and others obscured. A space can do that to bodies—by and through its design. But it is also true that bodies can do this to a space—certain bodies, the bodies that are available and able to reconfigure a space through their presence or their gestures or their voice—the bodies that have the capacity to enter that space. Like the one evening shift when I sat adjacent to the nursing station and watched an interaction which I noted down as follows:

Naima hears a resident calling out “hey hey”. The voice is emanating from a room near the nursing station, so she does not have far to walk. I can tell from her expression that she’s familiar with this moment—the slight smile, the almost imperceptible nod of the head. As she enters the room the resident asks “Am I pretty? Naima says: “Yes you are, you are beautiful”. Naima wheels the woman out into the hallway and positions the wheelchair against the wall with the notice board advertising upcoming events. The woman has rouged her cheeks and her lipstick is gorgeously unsubtle—some crimson colour, though it’s hard to tell under these lights. She moves her arms to draw attention to her, then asks those who are looking: “Am I beautiful? Yes, I am”. The emergent and intersectional themes are given form and made animate through the dialectic of bodies and space.

4.2 Family & Family-like

Early in my first interview with Rheanne, a registered nurse with a ready smile and over ten years of experience, I asked a question about the type of interaction she

has with her colleagues and whether these were purely professional or if there were opportunities for more personal exchanges.

> ...there's not much turnover, you build that relationship with them you see them more than your family [chuckles] even because of your work, your work hours and I would say that the relationship is more like - it's your family [with emphasis]. It's your work family so it becomes more intimate. It's professional and at the same time there's interpersonal, personal relationships with staff and also with family members and of course the residents too, coz you see them every day for 5 days for 8 hours and you get to know them you get to know...their story. Even for your coworkers like the relationship….you have...the co-workers are really like I would say it's very strong and I think that's one of the reasons why I'm still here, it's the relationship that's built within the workplace, it feels like family.

It is a nuanced and layered response that in the accumulation of detail reveals how a set of ideas about family and relationships are constructed, conceptualized, and differentiated. These ideas about family are encountered throughout the data, illustrating how this "most pervasive and central of human institutions" (Brathwaite et al. 2010, p. 389) serves as a reservoir of embodied meaning through which the relational is articulated and made intelligible.

Several subjects spoke movingly about how their past relationships with family members had informed their nursing practice. When I asked Naima what she feels when she is giving care or interacting with the people living at the facility, she offered the following:

> ...I really enjoy what I am doing. I had other options before....to change my career to do something else...but I decided to choose this career because I was influenced by my grandparents. I was very inspired by them as well because back home like my grandparents like my grandfather he was a doctor like, right? So yeah so I always wanted to come into this profession so I could look after people like him...He had his own clinic he used to see patients, give them medications...I was very inspired by this, and I always [wanted] to do something like that.

In Naima's case this recollection of the familial past shapes the present. This was most apparent during a day of observation, when Naima was the primary nurse for a woman who was receiving palliative care. An excerpted field note captures this intermingling of past and present in the following way:

> [Naima] tells me that the care she gives to the people who live here is the kind of care she would have given to her grandparents, if she had been able to, if she wasn't a child when her grandfather died. So, this is her opportunity to give the care to others that she couldn't give to him. And this must be why there is an air of sorrow about her, or is it merely the gravity of the moment, having to walk in and out of a space where someone is actively dying. I think that there must have been moments when I was nursing that the care I gave to others was in some way a facsimile for care I was not able to give to friends or family (field note, October 25th, 2019)

For Minerva, this act of substitution functions as a balm against the on-going sorrow of not having been present when her dad was gravely ill. This was a relationship that was central to her identity as a nurse. Earlier in our conversation she told me that when she was first nursing she had made a series of dismissive comments about patients from the rural parts of the province in which she was practicing, and he had gently admonished her about the way she had spoken and reminded her that all her actions and speech should be guided by an ethic of kindness and generosity. She never had an opportunity to show him how much she had taken that advice to heart—and the wound was still there:

> my dad passed away some years ago and it was a sudden accident, so I was not able to [tearful] sorry, I was not able to provide care...to him. It was my mum and sister who did the care for almost three years. Yeah I was thinking to myself I am doing this to people almost for my life but I was not able to do this for my own dad when he needs me—it was—that was really sad...and I was thinking oh it doesn't matter you know, as long as you provide care to people who needs it, I think my dad would happy about this so yeah that's my personal story.

Minerva's 'doesn't matter', does matter. She makes it matter by caring for the people who live in the facility in the way she might have done so for her dad. Like Naima and Minerva, Rheanne also draws from a well of regret at not being able to care for a beloved family member

> ...when I started here, I had a very [with emphasis] good relationship with my grandpa so I see everybody as my grandpa coz when he passed away I wasn't there. That's kind of one of my regrets coz I wasn't there when he passed away...I was new here. To me I think that's what started the feeling towards the people who are here, but I see them as part of my grandpa...

In this way the past inhabits and animates the present—shapes the work and the relationship. Rheanne goes on to say, "...I need to know their story so I can relate and I

can understand more about them and I can kinda mmhm interact with them in a way they would respond because you know their story and you understand them and they would feel comfortable towards you". Here we see how Rheanne draws on narrative knowledge to forge new forms of belonging—how an intimate understanding of biographical detail enables a resident to be reconceptualized—even if momentarily—as a loved one.

This act of reimagining a resident as the embodiment of a loved one is not merely a shift in affect but has material consequences. We see this in Amanda's reflection on the labour of care: "because...we consider this place...their home so for me I noticed that if I treat them [the residents] as my family I know I work harder I know I give more but at the same time I like to do that because I want them to trust me...so that I could be able to help them more". This eliciting of trust through regarding the resident as my family is central to her practice. Amanda has worked at the facility for a number of years and brings a certain studied reflexivity to her work. In the following statement, she elaborates on the idea of seeing the resident as family. I have chosen to quote her at length, in part to illustrate the discursive quality of her thought process and how it serves to inform her nursing practice.

> in nursing...there so many things you can be, you can be, you know, an innovator, you can be you know, be good in clinicals you can be good in research, good in administration, but I believe my role here as a nurse is I think out of the box. I have to think out-of-the-box not just to be any ordinary nurse, because the work is kind of really, it's really hard physically and mentally because, yeah, but it's just different. Because I think, as a nurse, I think of this, as them, as my family so from what I've read in nursing literature about nursing you know being good in skills and knowledge—this one is different because I treat them as my family and I think that makes it easier for me and for the staff. If I tell them [the staff] like you know we have to treat [the residents] as family members, you know, how would we feel if, you know, they are your grandparents, how would you feel, or your parents, would you treat them that way? Would you allow them, you know, the person is becoming, is being, violent when you touch him...and then you force him to, you hold him, and force him so that he will be changed, I mean you know those things? You just have to leave him first and then come back because you know, we don't know what's going on with him, we don't know if he has a UTI, what's his condition. So as much as possible, by I mean, as a nurse I treat my work here as a nurse and treat them also as family members probably that's one thing that I have not read in nursing literature that's how I see it and for me it's very helpful.

What is striking about this statement is Amanda's reference to herself as someone who thinks "out of the box", and whose definition of thinking thus is to regard the residents she cares for as family. As she pointedly notes, this is not an idea she has found in the nursing literature—with its emphasis on "skills and knowledge". In thinking out of the box Amanda sets the groundwork for fashioning a new kind of nursing epistemology—a more capacious box, one might say—one premised on reconceptualizing the relationship between practitioner and the recipient of care. More prosaically, but with immediate and practical implications, Amanda illustrates how the idea of family can be deployed to invite staff to think critically about their practice—about how they approach the residents they provide care for and with.

As the interview progresses, Amanda begins to advance a distinction between the resident as family, and her own family, the one she returns to at the end of the workday.

> I consider this [the people living at the facility] as my family. I feel at home here, but my personal life is different, personal life is personal life...family life is different from work wherein you give yourself also sharing your care to them [the residents]. It's a lot different, of course, my family life is much deeper and more uh, it's more satisfying, fulfilling, it's like I wouldn't exchange them for anything but it's just probably proving that I love my work so much that I love the residents.

Amanda's declaration that "[i]t's a lot different, of course" suggests the self-evident nature of the distinction between family as a set of consanguineous and/or chosen relationships and that which is fashioned in the context of care—one's 'work family' as Rheanne put it; that Amanda closes this specific response with a declaration of her love for the residents suggests that the idea of family, in this instance, functions as a conceptual placeholder or metaphor, shaping the often shifting relational boundaries that circumscribe the caring encounter.

4.3 Family / Home

That Amanda and her colleagues draw so readily on the concept of family to describe the relational dynamic is due, in part, to the fact that, as Amanda puts it, "we consider this place...their home". This idea of the facility as home is one which

foregrounds the multivalent dimensions of the concept—its drift along a continuum between place and non-place (Fitzgerald and Robertson, 2006) and illuminates what these authors refer to as the "solid cultural labour of residents and staff to re-inscribe the [h]ome...with social meaning" (p. 59).

In the following statement, Amanda illustrates how acts of cultural and cognitive labour shape the scene of care into a place of belonging.

> Before, when I was working here, they're saying 'oh this is their home and everything'. I didn't care, I mean you know I just did what I needed to do as a nurse...that was when I was an LPN. But then, as an RN, because I was kind of like being the leader on the floor, I had to think like, be more like, resourceful on how I can help the floor and how I can help the residents and I realized that if I treat them gently, treat them with respect treat them like my family member actually I always actually say "I love you"...like before, after I do anything to them—it makes a difference. I don't know and I'm pretty sure quite a few of them would respond "I love you too", they would say that, you know, during the night or after I do something. I know it makes a lot of difference because they know they belong here.

Here we see how the oft-repeated rhetoric of the care facility as home is at first dismissed, then re-considered in the light of a change in professional identity. As a leader on the floor, Amanda recognizes that the scene of care is not merely a space in which a set of tasks are performed—then repeated—but a place in which the labour of care has a profound effect on residents and workers, alike. And where the concept of home and family are furnished with a renewed depth of meaning: to be cared for as if family, to be spoken to with words of affection—to know the meaning of belonging—as if home, at home. In the following, Naima makes explicit the home-family dialectic

> I consider them like family 'cause they are uhmm like, it's like their home. And they are living in...long term care which means they are living in their home when we...look after them we consider the relationship with them like family because you know them, for how many years you are working with them, you know them so you consider them like family.

You know them so you consider them like family. Here the act of knowing is linked to proximity and duration—the many years—during which a familial bond is fashioned. What is noteworthy, in her statement, is the shift in tone and meaning from "we look after them" to "you are working with them", as if to suggest that the labour of care made

possible by reconceptualizing the facility as home and the resident as family, can be inclusive of both the caregiver and the imagined recipient of care.

Kelly, a registered nurse with ten-plus years of experience in long term care, also regards the workplace as home-like. As she puts it “this is my second home, this is my second family, as from my home this is my second one, for me they are also part of my family, but it's the work-related, you know, I consider them family but work related”. When asked why she regards her place of work as something akin to her own home and family, she pauses for a moment, and then offers the following: “I guess because I do, it's like personal care with them emotionally and physically. It's like sometimes you even talk to them, if they need somebody to talk to, you know, maybe it's different when you're working in the office you talk about papers”. I didn't ask Kelly if she’d ever worked in an office before she became a nurse, but what she makes clear in her statement is that the act of care and more specifically personal care—emotional and physical—is what engenders feelings of home and the sense of family.

Like Kelly, Zara, a soft-spoken nurse who has worked in a number of different long term care settings, also refers to the workplace as home. “It's like my second home here”, Zara says, “I do it [care for residents] as if I was taking care of family, that is to say I do it with all my heart and with compassion, like they are my family. Some people do this work for money but for me these people are human beings and so to me they are like family”. Zara offers us a revealing taxonomy of the labour of care, distinguishing acts that are heart-felt and marked by compassion from those which are merely transactional. Zara’s devotion to the former is, for her, what gives rise to feelings of home and the familial. Later in the interview Zara further clarifies this perspective, noting that “I spend a lot of time here so it is like family—I respect them [the residents] and the Bible tells me to ‘love one another’, this is what I am the person that I am”.

In echoing his colleagues, James who has worked in various nursing disciplines, offers an additional set of insights into how a certain conception of home and family informs the labour of care.

> You know like when I do the care I feel like that I have a relatio... I feel like I have some kind of connection with them. It's not like I'm saying have any blood connection or something like—as a human being I have a connection with them and uh I try my best to be, make them

> comfortable, to make sure their needs are met…I mean like when we are here it's not I'm saying family, he's my uncle or my aunt but I feel like like as I am looking after my kids or my family at home i'm looking after somebody here...that's the kind of feeling. Like, if suppose my wife, she's sick or something, she needs something, I'm looking after her there, so the same I'm looking after, here.

Here, James documents the kind of familial intimacy and caregiving that informs the care he provides to the residents. He is careful to state that what is at issue here is not the type of relationship involved, uncle or aunt—the nomenclature associated with specific kin—but the feeling that attends the act of caregiving. As Minerva says:

> I mean family usually you define as blood related or you marry somebody that's a family uhmm but for them I see them every day and the nursing home is really a home to them it's like my half home too because I go there almost every day it's half my life there (chuckles) so I feel like I'm home there too and we're both in home so it's a, and you have this interactions with them every day it's like a family spending time together.

4.4 Family / Care

In each of these statements we see how the words family and home work to convey certain affective states and relationships—work as a set of accessible, intelligible metaphors and motifs that the research subjects draw upon to catalogue their experiences of work in the scene of care. But the experience itself, as Minerva observes, takes place in the daily interactions and rituals that define the caring encounter. Each of these can be read as a kind of domestic tableau, a scene, a simulacrum of what, if the circumstances were shifted slightly, might have taken place in that other home, the first home, the one left behind. It's here, in these moments of social reproduction, where the professional encounters the intimate, the corporeal, that the concept of family/home is struck, chiseled, rendered as archetype, then transmuted into something consequential for the resident and caregiver alike. In this scene, Minerva offers us a glimpse into such a moment.

> There was one morning I was helping him to put socks on, he said "oh I cannot put my socks on my back hurts". I said "I'll help you". So we really, we have fun every morning. I wash him and I tell him "go to brush your teeth", the way it's not as a nurse, It's like somebody, I can order him (laughs). He said "okay okay", I helped him to put his socks

> on, I said, I just jokingly said "you're my papa" he said "yeah I have no daughter you're my daughter" (laughs), so that moment we are like a papa and daughter. But I'm not using this to get his attention or use his feeling, feel like close to me so I can do my job easier. It's not, it's just have that moment really feel like close together. It's like like your papa cannot put his socks on, I'm helping you put your socks on and make sure your belt is tight enough so your pants are not loose (laughs) when you walk, right, your pad is changed, wash properly, not itchy there, yeah yeah he's so good he lets me wash. You know I said I'll wash your front he doesn't feel embarrassed he just lets me wash, I wash every inch of the skin and then dry...he lets me, it just feels like, yeah, it's like a papa and daughter in that moment. I'm not using this though.

First the accumulation of fine detail—a description of a set of quotidian and necessary tasks—all the reproductive labour that is so often written-out of the scene of care. Then re-reading it, the tell-tale line: 'It's like somebody, I can order him'—but gently, lovingly stated. And now we are in the realm of the home—the multi-generational household where the masquerade of formality can be momentarily set outside. It's like somebody, I can order him, is founded on a profound, yet entirely ordinary, familiarity between the care provider and the recipient of care, one that in this instance is also based on a shared cultural background. "We have fun every morning", Minerva says, that is to say the labour of care is both reproductive and fun. "I'm not using this though", Minerva adds, not using this moment of intimacy to gain the resident's compliance—just a moment in time, that in its contours and accumulation of detail resembles an archetype—resembles family.

Consider a contrasting moment that took place during one of my afternoons of observation. Zara had come on shift and she was going from room to room to check-in with and assess the residents that were part of her assignment. In one room the exchange was as follows:

> Zara: "Hello mum, how are you feeling today?"
>
> Resident: "I'm feeling a little tired now, I think I'll rest some more".
>
> Zara: "ok mum, I'll come and get you up in a little while".

When I asked Zara about this exchange, during the first interview, she responded with the following: "a certain resident refers to me as her daughter so I call her mum—it's an approach because she resists care—a change in approach from what I have tried in

the past—it's not an expression I use for anyone else". This abbreviated scene tells us something about the repertoire of caring strategies a nurse might employ on any given day. Here we see the resident making the initial reference to a familial relationship and Zara responding in kind—as kin, or perhaps fictive kin. That Zara describes this as an 'approach' (one of a number), illustrates how the concept of family can be understood as situational—emerging from a particular set of conditions—a word for, instance, uttered by a resident, recalling the past or an alternate present.

In the following, we see how Amanda selectively employs the word love and care to describe her interactions with residents. Her rationale for doing so precedes a description of a seemingly ordinary caring intervention but one that foregrounds Amanda's attentiveness—an attentiveness which she herself attributes to viewing the resident as if they were family. I have quoted the exchange at length to capture the breadth of what I think is being articulated here.

> Interviewer: I want to just go back to the question, and then ask you a couple of other things, I want to ask you how you think the resident understands this I mean do they….
>
> Amanda: Love you?
>
> Interviewer: Yeah
>
> Amanda: How? I think you can see it in their face.
>
> Interviewer: But how do you think they're interpreting it coz you're saying to me that you like, you don't say it to everyone.
>
> Amanda: Yeah
>
> Interviewer: You didn't say it to the cognitively intact person
>
> Amanda: Yeah.
>
> Interviewer: Because they may think that you really love them.
>
> Amanda: Yeah.
>
> Interviewer: So, first of all, what is the meaning of the word love? Like when you're saying that I can't say it to someone who is cognitively intact because they might really think I love them so.

Amanda: Actually for me it's like saying "I care for you" but I say it as "I love you, love you"—but I meant I care for you, that's what I meant.

Interviewer: So it's different then, it's not love, its care.

Amanda: Love is really a powerful word, but I personally, I feel like 'I care for you', I find it too shallow, so I like, I better, I prefer saying love because it's more powerful, but sincerity is there. I I do love them. I do love them to a point that I really want them to be comfortable.

Interviewer: What kind of a love is it then?

Amanda: Uhh doing more than what's expected. Like for example, I have, with this resident we always tilt her chair because you know she has a catheter on and she always plays with her catheter, so the best way for her not to touch a catheter was, aside from putting a treadle muff on her or lap belt, we tilt her chair. And if I'm not there I come in the shift and I see her head tilted she was tilted and with no pillow on. I really feel bad because how would you feel, she's tilted and her head is hanging like that. So I come in get her a pillow all the time, "ok you can rest your head now - you can rest your head" something like that. It's something more, it's like just think of your family, how would you like them to be treated, I want her to be comfortable that's why.

To do more than what's expected. To see the resident as family in the playfulness of a moment of care or in the discomfort that precedes the act of care—Amanda's discomfort ("I really feel bad") at seeing the resident in discomfort. To do more than what's expected. To see the resident as kin in the last hours of care—as Rheanne recounts.

It's like you, like you get into a trance. For me the most critical part of their life here in this facility is when they are palliative, because of, because of the relationship that you've built with them and you see them in the almost the end of their life. That's what I kind of, sometimes you, I forget, I'm a nurse, sometimes I feel like I am the grandchild, their grandchild, because it's their last stages when, when somebody is palliative. I make, we make sure, I think, it's just not me but all the staff here, make sure that if that person doesn't have a family beside them we make sure that we go into the room and make that person like just acknowledge I'm here, you just let them know that they're not alone. Things like that so in that stage, it's then, it's when I kind of feel that I'm not a nurse, that I am the family of this person. Coz especially, like I said, if they don't have a family who visits them and sometimes even when they have family, like even when they have families when

> they are at that end-stage already you go in there and be with the family when they're there. Coz you share the same stories with them, however long they've been here you can share the same stories and the family will say "oh yeah when she was young…". That's the, like you feel more part of, you feel like you're a family at that time, with the family, as well, even if they have a family.

Here, Rheanne illustrates how the scene of care and what occurs within it can confirm one identity while simultaneously loosening the borders of another. Even in the presence of kin—Rheanne is gathered into the familial narrative, because she too is in possession of a chapter of this story—what happened after admission and how the provision of care shaped what they meant to each other. That Rheanne describes this experience as akin to being in 'a trance' suggests the transformative power of these liminal moments—when a body lies on the edge of being and a nurse is invited into the folds of a family—as family.

The care that is possible on any given shift is of course contingent on workload and time and the assembled team. Here, in her diary, Amanda describes the start of an evening shift. "So busy due to 2 sick people that needed monitoring and 1palliative resident…I had to replace 2 staff who called in sick. When I went to ____'s room I saw her HOB [head of bed] higher than 45° angle, an O2 mask that was….@ 5 LPM and her face was bluish tinged." She goes on to mention how she stabilized the resident and then documents the frank discussion she had with a colleague about best practices when dealing with a cluster of signs and symptoms such as the ones this resident had been exhibiting and experiencing. Amanda intimates that this conversation did not go as well as she would have hoped; instead, her colleague was "argumentative". Every shift has the potential to look like this. Relational work is work that is relational.

Early in my interview with James, he mentioned that the person he is at home is the same as the person he is in the workplace: supportive, caring, always willing to go out of his way to do things for his family.

> James: The same yeah yeah. I feel because they [the residents] depend on us so if we don't listen to them, if we don't do, who's going to do that? so I feel them just like my family they are part of my family (laughs).
>
> Interviewer: Okay and why do you feel like they're part of your family

James: Because that's the profession I adopt to look after people so I want to give as much as possible.

Later in the interview I ask James about whether there are residents with whom he feels a particular connection. He responds with a certain degree of diffidence, making reference to a few individuals who have been at the facility for as long as he has, but careful to note that this does not influence the quality of care he provides to everyone.

Interviewer: And what does that feel like? Does it make you feel differently about your work when you have that connection with someone?

James: It's only like it happened, if you are going in a room or you [them] see in the hallway or, or at [the] nursing station you feel good actually….

He then offers the following anecdote

> we have one resident...she's almost 96 years old she has dementia and she don't remember our name [but she'll say] 'I know that guy'…she'll leave everybody and she'll come to me and she has been only here not even two years. Yet, but because of [the] face, not so much the name, they don't know that, it's hard for them to remember; if its Canadian English name it's easy to remember so, but if they see the face "I know that guy...he's a good man". So you know it's not like appreciating me, because that's my job—what I am doing—but it's their feeling too if she's choosing from other staff "I know that guy" and you know if I say come with me and she will come with you, and she will listen to you, so that means it's a little relationship and its' a relation with me but not other staff.

Though James makes no explicit reference to the concept of family—his description of what transpires in the scene of care draws attention to what it means to be recognized, to be remembered by someone whose memory is fading, to be trusted and related to and with, in preference to others, to feel the satisfying pull of the relational.

It's possible to think of the relational moment as something inherent in the scene of care that surfaces as a consequence of what transpires between the nurse and the resident: a specific act, shared laughter, mutual recognition. Here, Rheanne considers the scene of care through the lens of affect—offering us a discursive appraisal of how she inhabits this place

It's something that for me it's very emotion, like I'm an emotional person so the relationship that I build with the residents, it stays with me and uh but I also make sure that when the time comes, when I need to be a nurse, I am not, I, not that I don't have, I don't touch the emotional, the emotions I have developed with them, but uhmm it's how do I say, it, it's it's you have to, have to really set the professional side and the emotional side, especially in an acute acute situation, when they are in an acute situation. But in the daily, daily relationship with them it's more, uhmm, me wanting to make them feel that they are cared for, uhm the, the relationship—the personal relationship, the interaction, you know, the, the, it's like you're at home when I come to work it's like home. But I have to make sure, like I have professional responsibilities, so I have to focus on what I need to do for them as well. But I also engage with them, like as if I'm home, that they are family—I generally care for them—so does that make sense…?

The concept of family and home recursively foreground the specificity of caring acts and behaviour demanded by the circumstance. A moment of acuity calls for certain policies and procedures to be followed, then the relational can once more be attended to. One imagines a whole shift unfolding in such a manner—the attempt to balance the demands of the profession with that of the relational, "as if I'm home, that they are family". Rheanne's reference to the times "when I need to be a nurse" speaks to the fluidity of this identity—how an identity can be assumed or set aside—contextualized then re-contextualized. Later, the following exchange emphasizes this point.

Interviewer: So Just coming back to what, this piece that we were talking about earlier, you, you are, you do feel that you have the capacity, or that you are, on any given shift, that you're stepping in and out of the role of the nurse?

Rheanne: Mmmhm

Interviewer: In some sense

Rheanne: Mmmmhm

Interviewer: That you are - so what are you when you are not the nurse? Are you a family member?

Rheanne: I'm a family member (somewhat defiant / definitive)

Interviewer: Ok

Rheanne: Yeah, I'm a family member in the big house (laughs) coz yeah, that's how I feel and I, again, that's one thing that's keeping me here coz the relationships that's been built with coworkers and with the residents as well. It's nice to see them give a smile

> and you know that they are okay and that they are still hanging on and you know they are happy they are content. It's nice to see that, yeah, so I step *in and out* [emphasis added] and I'm a family member but I'm wearing scrubs (laughs), yeah.

4.5 Boundary

One can read Rheanne's words as a way to define a boundary. We might say that this boundary differentiates ways of being in the scene of care: professional, relational, familial. Rheanne speaks of this boundary as something that she traverses as the situation warrants. For Rheanne, the boundary is something like a Venn diagram. For others, the boundary is sometimes more fluid and sometimes more solid. Here, Minerva talks about the difference between day shift and evening shift and how a boundary is navigated in the exchange of stories.

> I think, so days is more busy. Days is more like you try and finish things on time mmm, make sure they go for meals on time. But evenings, it's like more homey. The days, and they are busy going [to] activities you know, families are coming they are busy and we are busy, but evening is more slow and the evening time is time you can sit down with them, you know, put them into bed they can tell you stories—I can tell them a story about me. I know there's a professional boundary there, you should not say too much about your personal life, but that's really I find is a channel to connect with a person and it's really enjoyable to listen to them to tell you, you know the story, when they were young what happened, and that's really a time feel like they're home and I'm there for you, for them, at home too—so it's different.

"I know there is a professional boundary there", Minerva affirms, but in the rituals of care that attend the evening shift, a place opens up for certain revelations. To acknowledge that "you should not say too much about your personal life" while simultaneously recognizing that in doing so a connection is being forged—is to privilege presence over policy. Later in the interview the idea of boundary and its delimitations resurface.

> to be honest there's no clear boundary uhmm (pauses) uhmm as a nurse or, or as a friend to them I can feel both ways. But when I carry out care uhmm, I make sure [I] do my duties, my job descriptions, correctly. That's number one—that's first as a nurse, not because I feel so comfortable with the person [that] I [am] gonna skip this or that. I need to do a dressing, you know, properly so I do it, I chart it, these professional duties I'll do as number one. And then time with them

> together, personal connection, that's the time you feel they are my friend or my extended family—sometimes it's mixed.

Though the boundary that differentiates Minerva the nurse from Minerva the friend lacks formal definition, Minerva makes clear that in certain instances, nursing tasks are to be prioritized: first the dressing change, then the charting of the dressing change, then the personal connection, the relational moment. Thus the boundary assumes a distinct, palpable form when the provision of care involves a set of tasks that are exclusive to a nurses' scope of practice but is, alternately blurred and porous when the care hews more closely to the quotidian—the basic rituals of bodily maintenance—the buckling of a belt, the adjustment of a pillow—care that is equally at home in the home and the care home.

But sometimes a boundary has a specific utility. For Zara, the establishment of a well-defined boundary is a necessary feature of working in long term care, where proximity to certain vulnerable bodies can lead to ambiguities.

> For me there is a similarity between the care I provide for the residents and the care I provide for my family, it's similar but there is a boundary—a professional boundary. You have to maintain that, especially with certain residents who might misinterpret what your meaning is if you say something or do something and you don't maintain a boundary. The care I provide is according to the needs of the person.

Here, Zara is thinking specifically about certain male residents who might read an ordinary, everyday act of personal care, or the words that accompany that act, as indicative of a kind of sexual intimacy. We see a similar set of considerations in how Amanda distinguishes between who she might direct certain affectionate phrases towards and who are 'undeserving' of this because of how they might respond.

> ...I have one resident who can be uhmm who can, who can be a flirt, like he's been, he would tend to tell the staff about being a lover—I will kiss you and everything blah blah blah—so I won't say that [I love you] to him like before I give him his meds, because I know instantly his face will light up and he will say something so I don't say that to people whom I think do not deserve it, but for people who need it, I will say it and would really embrace that statement. It can be a girl or a boy

In both of these instances we see how the scene of care demands a particular positionality on the part of the nurse. How and where a boundary is drawn and managed

is dependent on who is present in the scene of care. The actions of the nurse are informed by past practice and expected behaviour. A boundary is not a wall—but it does confer a degree of safety. Sometimes it is necessary to step in without stepping out.

Sometimes it's an issue of respect. Here, Kelly describes an instance in the scene of care that necessitated a more strict delineation of a boundary. I have included the preceding exchange because it is germane to the discussion as a whole.

> Interviewer: Ok So on the one hand you feel like the people here are like your family but there is a boundary, right? Is that accurate? There's always a boundary between you and the resident, right?
>
> Kelly: A boundary yeah
>
> Interviewer: And are you drawing the boundary or are they drawing the boundary?
>
> Kelly: I draw the boundary if I'm not comfortable with it
>
> Interviewer: And if you are comfortable is there still a boundary?
>
> Kelly: It depends, what kind yeah, so it depends and then sometimes I need to clarify it just clarify with them.
>
> Interviewer: And how do you clarify—what do you say to clarify?
>
> Kelly: Yeah let's say, how will I say it, I think one time a resident of mine made a joke I can't re...there was one time. At first, I just ignored it and then the second time he did it again and I had to tell him that is that a joke or you mean what you said? Then I said if you mean what you said and then you said something, and I said if you mean what you said, and I'm not comfortable with it please don't say it again next time. And then I remind them as well. Like one of the residents of mine, he likes to hold my hand, then I tell him "the relationship is that I am your nurse", you're still, he is the client, and then and we should respect that. "I respect you" I need respect from him as well.

In order for a boundary to exist it needs to be clarified—made visible: sometimes the nurse here, the resident there. Sometimes the resident needs to be told that there is a boundary. Sometimes Kelly needs to make this clear to the resident. And yet Kelly regards the residents here as a second family, as she says:

> I don't know what other words I can use because as I said it's already part of my, it's my life, part of my life that this is my routine. Like if I'm not at home, you are at work right, you give your best at home, so you give your best at work. It's because they're human beings, maybe because they're human beings, that's why I also have to call them family, my family at work. I call them family when I'm at work, my families at work right? So, when I'm at home, this is my family, my family that there's no boundaries, but over here I have a family with boundaries.

What kind of a family is a family with boundaries? A family that is contingent and situational—and one that is being constantly defined by the requirements of the profession and the pull of emotion. Kelly's "I don't know what other words I can use" reminds us that we are in the realm of the provisional—the contours of which are barely definable. Here Naima offers us a hint of the complexity at play.

> Uhm well like this is our profession, we are working there as a nurse, and we go there, and we give our best. We give them quality care we do our best with staying within our scope of practice and so at the same time yes, we do, we are like more cautious we are keeping a professional boundary between patient and nurse right. At the same time we are thinking oh like family, what I exactly meant by family, because we are, it is their home, they are going to stay there for a long term and also one of the most important reason for me to consider them a family is I always see my own grandparents—my own grandfather in them. So, because if grandfather was alive I would be looking after him and I would definitely look after him as a family that was always a dream—my wish to look after him so that's why I do consider them a family at the same time developing a professional boundary with my patients.

Naima reminds us that the boundary between the nurse and the resident is something that is contextualized and shaped by the shifting concepts of family and home and through the moments of caregiving and receiving that define a shift. A boundary is not fashioned in advance, then, but surfaces as a contingent response to what transpires in the scene of care.

Sometimes a boundary dissolves because the circumstance demands proximity. Here, Kelly tells us something about how bodies can be drawn together in certain critical moments

> About that? Actually, especially, when I use that a lot with my family members when there is, it's like when their family is dying, right? I know that they are dying and the family, it's like some of them, I don't know if it's guilt or whatever, but they don't know what to do. They don't

> know if they want to send [the resident] to the hospital or stay here or they don't want to change the degree of intervention and everything. So sometimes they cannot decide there, or there's lots of reasons. So, I'll sit, I'll tell them, I'll sit down with them and sometimes I'll use an example, like if she's my mom this is what I know. You cannot decide, but just sit down with me and let's talk about it and then if I'm the one, sometimes I'll just use it as an example, if she is my mom this is what I'm going to do. But at the same time you, you will have the last decision, I said, but I'm just telling you, it's like if she is my own mother, I'll tell them this is what I want to do and then at the end of the conversation I'll tell them she is your mom so you'll still be the one to decide.

The nurse helps the family navigate the liminal landscape of death and life. In doing so, the nurse, herself, ventures back and forth across the boundary between the personal and the professional: “it’s like if she is my own mother”—her own mother who has already passed.

We might say, then, that a boundary possesses a spatial dimension and a temporal dimension. For instance,

> From time to time my goal is different. When I first started this job my goal is if I can finish my medication, my dressing changing, whatever’s on the calendar, I’m finish on time I leave that's my goal. And now it's so different I look into personal, resident’s personal needs, something not on the calendar. It's really, really what they need from from a nurse, even a small comfort, if I can provide. Uhmm so, and I learned from my coworkers also, some good, good caring coworkers. I learned a lot through these years they taught me a lot, that's what I have learned from them yeah.

Here we see how a job description can change over time—how Minerva reconceptualizes the idea of work. At the beginning, what is necessary on any given shift can be contained within the bounds of linear time—for instance what the calendar on the desk at the nursing station makes legible—a list of tasks, appointments, follow-ups, for the nurse to attend to. Later, it’s what’s not on the calendar that matters. The tasks are still performed, of course, appointments made, companions booked, transport facilitated, but something else becomes possible as well—the provision of ‘a small comfort’—in response to a need: a pedagogy borne of observation and the caring gestures of colleagues. Thus, Minerva can say

> I think I feel satisfied when I do something uhmm not just on the agenda something extra for the person and the person, you know, really

> appreciates—even a smile, you know, even a small connection, it makes me happy. I think, my job nowadays, when I think about my job, it's not only a job. I go there every day, I'm thinking I do something for somebody, you know, they are—to make them happy, it's not just, you know, uhmm, go there, do my job make somebody happy. I get paid also, and it's like you go to somewhere to do volunteer job to help people, but at the same time I understand it's a nursing it's a nursing job for me, but the happy part about this is I can help them and it might be a big way or small way it doesn't matter, there's a moment they've been helped and they are happy and I'm happy.

A dialectic of happiness, then, and a boundary whose contours expand to contain what cannot be noted in a chart or a progress note, nor told to a colleague during the hurried coffee break you slip in and out of the staffroom for—just, 'they are happy and I'm happy', that singular precious moment, in the scene of care.

A boundary requires a certain tension to give it form. Sometimes an elasticized boundary can recoil, foreshorten, and the consequence is despair. In her diary, Minerva writes:

> Staff vacation calendar posted today...my vacation requests all got denied. I have a plan to visit____ now this plan looks like an illusion. I feel very depressed about this job, suddenly now. When I give care to residents today I feel disconnected with residents. Passion escaped from my chest. I was quiet during the shift. For whatever reason I was denied for the vacation there should have had an explanation before the posting just like the way we care about residents for this work.

Here, Minerva highlights how the material conditions of the workplace can shape the relational environment. The misapplication of collective agreement language results in a perceived injustice and leads to a kind of moral distress. It's powerfully invoked. You feel the bodily impact of it—the passion that escapes, the quiet that descends. The equation that Minerva formulates is explicit and instructive: the nurse explains the procedures of care to the resident as a way of performing relationality—the employer should do the same for their employees. When this doesn't happen a loss of certainty ensues. A vacation is a means of replenishing the reservoir of affect. When a vacation is denied, how will the replenishment transpire?

The elasticity of the boundary, and its spatial and temporal attributes, remind us that a care facility can contain a set of possibilities that are often foreclosed in a hospital setting. Here we observe how Amanda articulates this distinction.

> I think compared to working in a hospital, wherein everything is just professionally done, here, I can still be professional, but I still, I can, I will still treat them like my family member. Like if I were their nurse how would I want them to be treated? And that would mean treating them in a more optimal way, then I would like, treat them not only with regards to the physical, but also the other aspects of their lives; and that includes their emotions, their intellect, you know, like social life, their intake, nutrition, their family.

To be professional, to act in accordance with a set of professional standards, to comport oneself with an awareness of what the profession demands and still regard the recipient of care as family—to take precise note of a resident's intake, while attending to their intellect—to consider what is eaten and what is felt—is to advance an ethic of care informed by the specificity of place. What unfolds in the scene of care, here, in the rooms and along the hallways and in the lounges, and at and around the nursing stations, is a narrative founded on relationality. After all, as Amanda tells us, a care facility is not akin to a hospital. Amanda formulates this ethic of care through a recitation of the repetitive, quotidian processes that mark the encounter between caregiver and resident. It's a recitation that in its detail and exactitude, distills the emergent and intersecting themes in the study: family, home, care, boundary constitutive of and constituted by the scene of care.

4.6 DeFrino's Cartography

Reading and re-reading the interview transcripts, one is cognizant of how each of these concepts is being discursively fashioned. A question is posed, and the nurse invited to consider the labour of care, their caring labour with its many valences and meanings. What is it that these nurses are doing on any given shift? They are making and remaking their world—or perhaps more accurately, mapping their world and the scene of care, in all of its complexity—a cartography of caregiving, then. We might say that DeFrino (2009) inaugurates this act of map-making—through a framework that plots the coordinates of relational practice. This section will look at the data through the four

relational practices that constitute the cornerstones of this framework: preserving work, mutual empowering, self achievement, and creating team.

4.6.1 Preserving Work

We can see how the subjects in the study engage in preserving work through their attention to the details of care—beyond tasks or technical definitions of the job—beyond the boundary of expectation, as in Amanda's description of a set of health issues disrupting the daily wellbeing of one of the residents.

> one thing that really makes me love to take care of them is if there is, if there is something going on with them like some medical condition. And it's kind of like hard to, to like solve or something. I really try to be as resourceful as I can to think out-of-the-box and see how I can help them. And then I come up with these solutions and I talk to management about it and then when it is implemented. I really feel so good because I know that I've made a difference in those, with those residents. So many and I'm just thankful...For the longest time [we had this resident] like going to the toilet, from bed to toilet, like 12 to 20 times in a shift sometimes nights too. And then we've done so many things, so many medications to help with the bloating, so many medications to help with the gas, so many for even the UTI, everything, check everything. I said what's going on? How come she keeps going to the toilet? Then I realized, okay, you know the diagnosis, okay, okay let's see why does she want to go to the toilet? I checked, she's lactose intolerant, what does she have for coffee oh they give her the creamer so that's it! I said from this time on, give the Lactaid and it has lessened from 12 to 20 now it's a little bit less, maybe eight times or 6 times. But that's okay she goes to the toilet and after that washes her hands, then after 30 or 40 minutes sometimes even five minutes she would go again, it's like I cannot change her mentally she's already 90+. I can't just erase her mind from not going to the toilet. Let her be, that's her joy, that's her exercise but at least we have resolved the situation, she's not going there as often.

The approach is holistic. It necessitates thinking out-of-the-box, beyond tasks or technical definitions of the job. Resourcefulness is what is required. And a commitment to, and love for, what you do. But also, a love for the person and a desire to lessen their discomfort.

For James, the act of preserving work was most explicitly illustrated in the following scenario. He referenced it as an afterthought. I had already posed my final

question and he had responded to it. And now he was extemporizing, and this moment surfaced. It was clear that what he was recalling was suffused with a depth of meaning even though what he was describing was something ordinary—the daily work of maintaining a body—the banality of it. But this is what made it exceptional.

> The other day I came in the morning time [sic]. There was another nurse that was working. She said "oh [this resident] was vomiting, nauseated at lunchtime". Ok then, I ask, "oh ok" and she said, "I check vitals, fine, this and that". Then I said, "did you check the abdomen" she said "no". So I checked and the abdomen was distended. So it was like 4 o'clock. I gave [a laxative], I gave and 8 o'clock I put [her] on the toilet, even there was care aide too, but I said ok that's ok I'll took in the toilet. And she had a watery BM with a lot of gas, three or four times lot, even she was sitting on the toilet she said "oh I feel comfortable, I feel fine now, I'm fine". And too, it goes just normal. So if, I mean, I know that they going to not remember, but I feel comfortable, I feel happy that I did something. Even at 8 o'clock when said, if she do not do anything or something, I will call on-call doctor after hours. So we have after-hours, now we call and if she ask, if the doctor say that, I will send to hospital but anyhow, I solved the problem.

What stands out in this description is the fact that James initiates the intervention aimed at alleviating the symptoms of abdominal discomfort and follows it through to the moment of alleviation. That is to say that rather than call the care-aide to assist the resident to the toilet, "[t]he nurse shoulders responsibility for the whole" (DeFrino 2009, p.299). DeFrino (2009), identifies this concern for the whole as the hallmark of this first category of relational practice. These two examples of preserving work, in the phrasing of DeFrino (2009), can also be read as moments when a boundary is encountered and redrawn in order to facilitate the relational moment because it is "the professional duty of the nurse to know the patient...to understand him or her as a subject...with a social history" (DeFrino 2009, p. 302).

4.6.2 Mutual Empowering

To know and understand a person through their social history facilitates the mutual empowering DeFrino (2009) identifies as the second of four relational behaviours. At the heart of mutual empowering is the idea of redefining outcome. DeFrino (2009) offers us a rather prosaic list of how an outcome might be redefined: for example, the nurse "teaches with an awareness of the patient's needs and

barriers..supplies relational skills when working with the patient and health care team members....gives the patient help without making them feel guilty or inadequate" (pp. 299-300). But through enumerating these every-day, rather unremarkable features of nursing work, in entirely ordinary language, DeFrino (2009) foregrounds the invisible, unquantifiable labour, "the relational knowledge work...the procuring of clinical information, teaching, giving information, communicating with the patient, 'rapport talk'...the work that connects knowledge to a larger picture that makes the whole process occur"(p. 304). The occurrence of the whole process is founded on an understanding of the whole person. Here, Rheanne tells us about the centrality of this understanding to the caring encounter.

> Interviewer: And so can you just expand a little bit on the emotional aspect to that because I mean you said something about the value of getting to know the story and getting to know the individual and that does that draw you closer to people when you know something about them?
>
> Rheanne: Yeah I would say that it it gives you an avenue, it gives you a connection with that person because if they see you as somebody who would actually uh, take the time to know them, before they got into long-term care, that you know their story, that gives them the feeling of this person can connect with me, I will be, I can see they're more comfortable if I engage them in something that they are, they are familiar with and that they are comfortable with, yeah. And it gives me an opportunity to provide better care for them because I can assess them better, they can be cooperative towards me and I can give them their pills like they will respond better.
>
> Interviewer: Okay. So let me just ask you uhm then, on the one hand you're saying that this is like your general approach, that you see in the resident here, a kind of an image of your grandfather and you want to get to know them and you think this is a strong part of nursing, and then on the other hand you also reference the fact that you, in doing so you are also able to, like they are more cooperative with you, they're more willing to engage, to allow you to provide care for them. So I'm wondering if you think about whether or not uhmm, what you're doing is a way of gaining their cooperation? Like are you thinking about it in, as something instrumental where if I do this then they'll be more cooperative and the care is going to be easier? or is it just something that naturally comes to you and as a side-effect they are more cooperative?
>
> Rheanne: I think well, if, when I get to know them I don't have that in mind that I will do this or that, I'm not thinking of that, that they will cooperate with me, because I have, I have known

> some residents too, even if I thought I built a relationship with them, they can still be uncooperative. Like I said they are in their condition, they are in the condition where they probably won't remember you engaging with them and they can react to you responsively, you might not gain their trust. So for me it's more like I (emphasized) want to get to know them, coz I want to know who I'm caring for, and what their needs are and I think the cooperation is just secondary, so it's, for me, the cooperation is just secondary.

One can read Rheanne's critical reflection on her practice as the type of knowledge work that ensures mutual empowerment: a salient item to add to DeFrino's (2009) quotidian list. Here, in the scene of care, self-knowledge and knowledge of the other is intended not as a mechanism for eliciting cooperation, but as the intended outcome, an outcome redefined. A redefined outcome is of particular note in the context of long term care where the narrative arc of care and relationality privileges duration and repetition over the exigencies of plot. A study in character, then, and of particular note, because what is required may not be known, or knowable, may inhabit the margins of what can be knowable on any given shift. Minerva articulates this in the following way.

> Uhmm yeah, I think that when people are sick when you go to the hospital, I mean myself, sometimes, I was a patient, to go to the clinic and the hospital, that's the most vulnerable time for you. And you're so, you're weak, you're sick and you need help and for healthcare workers including me, should be, should be very thoughtful and sensitive for, you know, to detect the person, what they need, even you know sometimes you cannot tell. You know, when I am sick and I don't know what I need here, so the nurse should be able to tell. That's for me a caring relationship for the elderly people at, at work. They mostly, they have dementia, they don't know what to say to you, so you have to find out. You don't uhh, don't just, you know, do your routine jobs and go home. You have to take a moment to think to find out—if you really care about this person about your job...

Here, the mutual empowering is informed through a sustained act of the imagination. Minerva centres the vulnerability of the resident through recalling her own. She attenuates the boundary of self to include the other. That is to say, the labour of care is not merely performative—a finite set of routines—then home. Instead it is a perpetual and linked series of moments—that demand the fullness of attention to discover what is needed, wanted, desired, in the interstices of language: an outcome redefined—a boundary renegotiated.

We witness this attentiveness in the way that Zara describes her approach to caregiving.

> The resident is my priority. I'm here for them to advocate for them. Sometimes they can't speak, can't tell you what they need or what they want. So I need to figure out what they need. My focus is on providing total care. It's not only giving medications, sometimes they just want to talk. They feel lonely. Even if you don't have the time, I'm here, I'm listening, I'm not just task-oriented. I'll do the best I can today. I consider the person more the total person—I need to be flexible to give holistic care and emotional support not just medications. Sometimes it will be by using touch, or sometimes singing.

When Zara says, I'll do the best I can today, one implicitly understands the multiple registers at play through this attentiveness to the self and circumstance. Thus we can read her response as an articulation of what she, herself, has the emotional and physical capacity to accomplish today, but also what is possible out of the many acts that could be carried out, and also what can be done today, in particular, that she didn't or couldn't do yesterday—that was not needed from her or demanded of her—but might be now. Zara's sympathetic calibration to what is required in any given moment—her use of feelings to navigate the relational gap between self and other also instantiates an aspect of self achievement—the third category of relational practice (DeFrino, 2009).

4.6.3 Self Achievement

In the scene of care, feelings surface in proximity to the daily regimen of bodily needs. For instance

> there was one resident...she's total care so we spent tons of time with her and she's picky about her things. So when you spend 20-30 minutes in the room, just alone with her, in the room in the evening. And there was one day, one evening, she said "Minerva I feel like you are my family". It was really something for me, the first time I had heard this. I gave her a kiss. Like you're my family too. That moment is real, was so, it was so profound. Even it felt like she is my grandma, but I didn't even see my own grandma. But that moment it's like (laughs) she's my grandma. I was thinking oh you're my, you know sometimes I would get mad with her too, she's so picky she's "I want this, no I want that no, no, that" so you get, you get, you got mad but at that moment it's just, she's so, it's like she said that and pulled me to her. Yeah it was a really warm moment for me and I guess for her too, yeah, it was just an emotional moment.

We might say that something remarkable has transpired here, in the 20 or 30 minutes it took to provide the type of care that facilitates a transition from a state of wakefulness to one of sleep. Minerva describes it as something real and profound, a warm moment, an emotional moment. We might say that what has transpired here has the ring of the familiar—a certain ease; “she’s so picky”. And this is also how Minerva articulates it. Minerva says, “she's my grandma”. We might say that what is being described here are the feelings that surface in proximity to what a body needs, in all of its dependent vulnerability—what it means to be ‘total care’. But something else is happening in these moments. An understanding is being cultivated—about the self and the other. “She’s so picky”, is the first flicker of it, the brief annoyance that Minerva experiences in its wake, is another. The attachment leavens the annoyance: “she said that and pulled me to her”, Minerva says. What we witness in the scene of care is how knowledge is gathered through emotional receptivity. You enter a room and close the door and are present in that place for a period of time. Just the two of you. And everything in that place is telling you something about who you are and who you’re with. Indeed, DeFrino (2009) tells us that “the nurse uses feelings as a source of data to understand and anticipate reactions and consequences to care” (p. 300). So, feelings are a source of data—instances of information—gathered not only through processes of cognition, but also affect, and somatic vulnerability. Feelings and data: the pairing appears dissonant. But what is a scene of care if not a specific time and place within which the embodied and self-aware caregiver is called upon to fully attend to every possibility?

> I think I said I feel like she’s my grandma. I didn't have a chance to look after my grandma. Me and my grandma, and this woman lying here. I wash her face. I give her a good wash. She’s beautiful. And I change her pad. I make sure I wash her properly. There’s no smell. Every fold, you know, I wash and dried. And you feel like, oh I did something, even though my grandma’s not here, but I was able to do something, you know, something like my grandma, for somebody else (animatedly) I feel like I contribute something nice...

Thus, feelings are a source of data that lead to a specific set of attentive acts: “every fold, you know, I wash and dried”. That all of this takes place behind a closed door in the public/private interstices of the resident’s room is of some significance, because as DeFrino (2009) reminds us “relational work is invisible knowledge work” (p. 303). By contrast, the visible labour of the nurse are the normative tasks and actions

that define any given shift, easily stereotyped and invariably subject to vertical substitution (DeFrino, 2009).

"The persistent invisibility of nursing work makes it immeasurable and intangible to the group with power that organizes what counts through the biomedical framework of health care. There is no external, measurable value to nurture" (DeFrino 2009, pp. 303-304). Instead, Minerva invites us to consider what it might mean to be regarded as family. Regarded thus, because of how she washes a body that has no capacity to wash itself, but can, nevertheless, bear witness to how it is washed, and with what gentleness and care. We are let into the room through a language of care and attentiveness. Here we discover the many meanings of relational work, and the invisible labour that precedes and makes possible the visible labour recorded in the nursing notes and checklists and care plans. How would you know what blouse she wants to wear and with what slacks if you never made time to accommodate her pickiness, which is another way of saying her own attention to detail, which you can appreciate because it mimetically echoes your own. How would you know what blouse she wants to wear if you didn't vouchsafe her humanity through your feelings (as a source of data)?

When we are let into the room, what we see is the nurse and the resident. Minerva tells me that "this is a time for just the two of us. I know no one is going to call me [the staff communicate via mobile devices that also sound should a resident activate their call bell], so I don't worry about my phone, or what else might be going on. It's just, it's just me and them, and I have time, time to, time for them, for both of us. It's what I look forward to". Before this moment a colleague would have been present to assist with the transfer of the resident from her wheelchair to the toilet then to the bed. After that the colleague leaves the room and carries on with their own tasks, or to attend to the care of another. There is always work to be done. Minerva will leave when the care is complete, exiting from the hushed light of the room, into the flood of light that suffuses the hallway and towards a new set of demands.

Sometimes, the nurse finds herself drawn to some residents and not others and this too is a form of data gathering filtered through the sediment of affect. Here, Rheanne tells us something about this experience.

Rheanne: Uhhh I don't know, it's more like how you feel (with emphasis) towards them, it's your emotions, you can't point a finger, yeah it's, it's just the way you interact with them. It's kind of hard (laughs), it's hard to box in this relationship and there are times that you, there are a, residents that you totally can't connect with them, like you feel the other way. There are people who can, like, push your button and oh, no, I can't (laughs) I can't connect with this person…..

Interviewer: So what's going on there, when you feel like you can't connect with them.

Rheanne: It's just that the interaction is not as, like, it's not positive, it's more on the negative, their reaction to you is more negative, and it's constant like you just see it and yeah so.

Interviewer: So it is dependent to some extent on the resident?

Rheanne: Oh yes, oh yeah, oh yeah, oh yeah, they're a big part. I'm the one who, I mean I can control my emotion, I have the ability to think, think through things, they are the ones who, they might not be able to, you know, make, control their emotions, they might not be able to, they're not able to control their emotions at this point they give you what they feel...

Rheanne reminds us that the nurse must constantly draw on a reservoir of emotions, emotional intelligence and self-awareness to navigate the relational complexity woven into and through the scene of care. It's a complexity that vexes, exhausts and is problematized in equal measure. Here, Kelly tells us something about what is required of her, on any given shift—the effort and the restraint—the perpetual calibration of feeling and insight.

Kelly: there are days that there's lots of challenging residents right. Sometimes like now it's like I have a resident, it will take me half an hour to stay with him because he wants only the nurse, even just for little things. Sometimes you get frustrated, I get frustrated sometimes for the reason that I'm explaining to him that he's not the only one that I look after for. It's like I also have to give care to other residents that care aides cannot do right, yeah so sometimes you try to explain to that resident and sometimes he just wants to hold you back, right, yeah. But it's normal. Like sometimes I'll go out, breathe a little bit, and then, or I'll tell him I'll come back later a few minutes after, and then it's like nothing happened. Then he's happy, we joke it's like nothing happened.

Interviewer: And is it important for you to take that time with him?

Kelly: Uhmm, yes, if possible. You know I think he needs one-on-one obviously, but if possible, if possible you want to give everybody time to be with them. But of course you're only one nurse, the ratio is like 36 residents you look after. So sometimes you explain to them that you need to leave because somebody is waiting for me on the other side as well and you're trying to explain to them, yeah.

Interviewer: Right. And so this idea of care and a caring relationship how does that fit into your nursing practice?

Kelly: How does it fit into my nursing? For me it's always part of it, right? And then later-on, then let's say, like I said I will go out. If I have a, the time, I will go back again, just like nothing happened. You talk with them again. Even I will be the one to initiate the conversations, just to make them happy, because we know that it's not only that they're here or they're sick or anything, they also need somebody to talk with them or to be with them and that's part of caring.

All of this is work, of course, entering the room, then leaving the room, the intake of breath—the settling of thoughts—then returning to the room, once again. All of this is an aspect of the relational labour that is a response to the singular demands of one resident. There is something exceptionally unglamorous about this. Just the daily, difficult, unvarnished labour of care that is the authentic narrative of the shift. “We joke—it's like nothing happened.”

I want to close this section by looking at the following exchange with Amanda. Like the preceding one, with Kelly, it illustrates how relational work requires an insight into, and response to, the needs and requirements of the resident, but also an attunement to the emotional registers of the self. The utterances of Kelly and Amanda highlight how relational vulnerability engendered in part, through the vicissitudes of care, but also as a condition of life itself, (Vaittinen, 2015), requires constant self-management and regulation.

Interviewer: Like you described that situation where this person [a resident] is swearing at you and they [other staff members] are hearing it

Amanda: Oh yeah yeah yeah

Interviewer: How do you think they interpret the word [love] itself?

Amanda: They would interpret? I think they think uhh, they thought of it as I'm just trying to be funny, maybe, or uhmm, I'm just saying that just so that he will stop swearing at me. But I think the number one reason why they reacted that way, why they were laughing, it's probably they didn't even think that I would say that to him considering that I was being put down by the resident. I think that's the main reason. It's like oh, my gosh, you're being sworn at and then you are saying "I love you" to him, can't believe that, something like that. I think that's the reason why they were laughing at me, that's okay I don't care.

Interviewer: Why don't you care?

Amanda: I don't care because I know that what I said was sincere, and I know that if I say it from my end it helps ease the pain, if I will ever let that get across me.

Interviewer: Can you say more—what do you mean?

Amanda: Actually if I am, if during the time, if I would be maybe, if really too how to say it, if I would be too tired, maybe or, or maybe, if mentally I am pressured, maybe if there are so many things I needed to do, so many concerns from residents if I could not handle it, maybe I could have just said something to him. I'm not sure if I would be able, if I would just snap at him or ignore him or maybe just explode, I'm not sure. But for me, that was my way of lowering down or simmering whatever is potentially that could instantly explode in me, so at that point in time I took control of myself and just made it in a way that I will just have to enjoy the situation, you know, change the situation myself now, rather than that situation change me.

Interviewer: Ok, so in that particular instance the word love is, is designed to…?

Amanda: Ohhhh uhhh yeah. The emotion is not that much as when I say it to this lady "I love you", after giving her her pillow or after giving the other guy his meds, that was more like, I would say, more heartfelt. This one, I said it, yes, there's an element of love too, but it's more of protecting myself, preserving myself, my emotions, yeah.

Here we witness Amanda first recognizing that the verbally aggressive behaviour of a resident has triggered her—then choosing, deliberately, to respond with a familiar, familial trope, readily drawn from her repertoire of relational skills. It's a decision that preserves a relational connection with the resident while transmuting her own volatility into something manageable—a simmer.

4.6.4 Creating Team

DeFrino (2009) identifies creating team as the fourth category of relational practice, noting that [t]he nurse creates the background conditions in which unit work and outcomes can flourish" (p. 300) I'd like to think of Minerva in that room as an embodiment of this, a particular instance of creating team. Her presence in that moment is foregrounded by the labour of others. They know not to call her, that the care the resident requires will take time and space. The time affords a space for a relational environment to flourish. That is to say, what Minerva accomplishes on an evening shift in the provision of bedtime care, shapes, in part, how the subsequent day unfolds. The mood of morning care leavened and eased by the fact that the right blouse has been carefully folded across the back of the chair for the care-aide to gently slip the resident's arms through.

There are times, of course, when the best possible outcome is nothing at all—only that you found a moment to sit with someone when what you wanted to do was to assist them with the care they couldn't seem to manage. Zara reminds us that sometimes the relational is constituted through a capacity to hear a refusal of care as something other than a reason to repeatedly persuade.

> We have this one resident, a woman in her sixties. She has, you know, she had a difficult life, she had been homeless. Sometimes you go to see her to help her with care at bedtime and she'll just turn you away. She doesn't need a lot of physical help, but she needs good mouth care and some days she won't let you. I usually will try four or five times. Sometimes I'll just sit with her. You are there to help them [the residents] and they have a right to refuse help. Sometimes it's difficult, you feel like you're not achieving what the residents need and then you're also thinking about the next shift and maybe it will be some added work for them.

Here, Zara is conscious of how an act of omission might be seen by her colleagues as neglect, a shirking of duty, but also as failing the resident even as she recognizes that her ability to help has encountered the resident's right to refuse that help.

DeFrino (2009) suggests that what is central to the practice of creating team is the cultivation of interdependence. In the facility, each act, word, gesture, intervention, is

an instantiation of this phenomena. What is achievable on any given shift is based on what may or may not have transpired the shift before and who may or may not have been present: staff, resident, family, volunteer, stranger. We might say that a team is constituted through and by those whose presence informs the scene of care. And of each resident encountered there, “the nurse affirms [their] individual uniqueness through listening, respecting, and responding” (DeFrino 2009, p.300). As Naima tell us

> one of the most important aspects is that when we go for the shift we always think about the residents. We always think about, this is our shift, we are going to make the best of it and we're going to provide them good care. And like, uhh, because uhh, I’m like the primary nurse and I have a care aide that is working with me, so our team, so we do our best. And we have our assignments, we give them reports, we tell them how we going to prioritize a day. So we do the best that we can do for all the residents. We always think of the residents as our priority.

4.6.5 The Central Concern

DeFrino’s (2009) central concern is that the relational practice of nurses is at perpetual risk of being erased—written out of the scene of care. DeFrino (2009) argues that this is due to a biomedical model that privileges outcome over process. No one witnesses the nurse attending to the body: the meticulous care with which a wound is cleansed and dressed, unguents applied; discomfort eased. Nothing you read in the nursing notes will tell you that the nurse warmed her hands before first touching the skin or what foreknowledge sensitized her to the necessity of that act. In a telling tautology, DeFrino (2009) notes that

> If knowledge work is invisible, then the nurse’s knowledge is invisible. A profession is marked by its relationship to the knowledge it has in its domain. If the profession’s knowledge is hidden and not explicit, it has no assigned external value. If the relational, hidden connecting work of nurses is not quantified or recognized, it is invisible (p. 304).

One might argue that DeFrino’s (2009) framework is an attempt to retrieve the relational and render it legible—to reinscribe it onto the scene of care: that is to say, to prioritize it. In so doing, DeFrino (2009) echoes the sentiments of Naima when she states, “we always think of the residents as our priority”. Put another way, we might say

that Naima's intention to prioritize the resident, is an explicit enactment of DeFrino's (2009) theoretical imperative.

The act of prioritizing the resident, of centering them in the scene of care, is founded on a relational interplay between the subject of the centering and the subject who initiates the centering: that in centering the resident the nurse also centres themselves. While DeFrino (2009) pointedly argues that the relational work of nurses is often subject to processes of epistemic erasure—Naima invites us to reconsider the meaning of visibility and relational work from an anti-systemic perspective. In so doing, Naima suggests that these relational acts and interventions are always apparent to the recipient of care. For instance, when the resident says to Minerva "I feel like you are my family" we understand this statement to signify an act of recognition—of a nurse made visible by and through her relational work. One imagines an entire shift unfolding in this manner, a set of discrete moments sutured together by the relational imaginary the nurse carries with her from room to room, place to place, and floor to floor, the way Rheanne describes the following:

> I see that person light up when I see him, occasionally, when I visit the floor. I think that you can see that he, he also cherishes that, that relationship, the emotional connection between the two of us. So I would say that, I would say that for sure some of the residents especially those who didn't really have a good relationship with their own family, and they see that here they can have that interaction, that emotional connection that bond with the staff, I see it as, I see it as beneficial for them as well. Like because uhm, yeah, there was one person on the 4th, where I was before, that he, I remember him saying to me that he regretted not being married, because he didn't have a family, but he's happy that he sees the other residents here having families. Happy and sad, because, because he doesn't have his own, but he does, he knows that the staff here is his own, like, people that he can relate with or talk to and share emotions with and so yeah I see they are, they also have, they have benefited from the emotional connection they have built with the staff.

That Rheanne happens to encounter the person who lights up in her presence, is incidental to the reason that she ran up the flight of stairs—to the floor above. But to the person who lights-up in her presence, it's an incidental encounter that restores him to an embodied subjectivity, as someone who is known to another, as someone who has the capacity to be cherished and seen.

Relationality, DeFrino (2009) poignantly notes, is seldom seen “as a skill to use in caring more effectively for the patient but as a gendered silliness that makes nurses’ work easier” (p. 305). Instead, DeFrino (2009) argues, the institution invariably sifts, elides and expunges the relational. What remains then, is the work itself, the official record of what occurred, a residue of fragmentary tasks and the coordinates of the supposedly quantifiable (DeFrino, 2009).

DeFrino’s (2009) framework sets out to remap the scene of care with the four categories of relational practice serving as a means of surveying and surfacing the labour of the nurse. What DeFrino (2009) makes clear is that the relational work of nurses is not confined to private spaces, “behind drawn curtains” (Manojlovich, cited in Defrino, 2009, p.303) and closed doors, but can be traced through space and the interstices of the biomedical landscape—a palimpsest written over by a set of standardized policies and procedures.

For DeFrino (2009), this act of remapping takes on a particular urgency in the contemporary moment, marked as it is by the use of increasingly intrusive technologies of care, decreased hospital stays and increased patient load, each of which “threaten the nurse–patient relationship and the ability of the nurse to engage in relational practice” (p. 305). DeFrino (2009) notes that the nurse who loses herself in a biomedical landscape that repeatedly erases the landmarks of relational labour, invariably reorients herself through a turn to task. And the consequence of privileging task over relationship, is moral distress, burnout and the erosion of compassion and empathy for the recipient of care (DeFrino, 2009).

4.6.6 From Hospital to Long Term Care

DeFrino’s (2009) *theory-cum-framework* situates the nurse in a hospital setting and invites us to read their (relational) labour through its imagined wards and units. The (relational) work of the nurse in a hospital is understood as parenthetic. DeFrino (2009) wants us to look at this work, to bring this work to light, to retrieve it from its status as invisible labour. There is a moral urgency to this invitation. We can also extrapolate from DeFrino (2009) and consider the relational work of a nurse in long term care. For

instance, the emergent themes and concepts in the current study can be mapped onto the scene of care through the orienting statements that delineate the four categories of relational practice.

What we can say is that the (relational) work of the nurse in a hospital is informed by spatiotemporal systems and forces that are entirely dissimilar to those which inform the relational work of a nurse in long term care. For one, the encounter between the nurse and the resident is not subject to the same time constraints that delimit the encounter between the nurse and the patient. Nor, indeed, is this encounter mediated through an array of technologies in the way that it often can be in a hospital (DeFrino, 2009). Instead the encounter between the nurse and the resident is shaped by and through repetition and the daily rituals of relational care. In addition, the totalizing tendencies of the biomedical model in the hospital (DeFrino, 2009) are, in the context of long term care, fruitfully disrupted by and through the countervailing, discursively reproduced, concepts of family and home.

If the forces shaping the relational work of the nurse in a hospital might be said to differ in substantive ways from those that shape the relational work of the nurse in long term care, the one factor DeFrino (2009) identifies that influences the labour of both, is that of short-staffing. Indeed, the nurse can often find themselves alone on a night shift. It's an aloneness that mirrors the loneliness of the resident—a loneliness founded, in part, on the structural aloneness of the staff, the chronic under-staffing that deprives the resident of the conversation and engagement they desire (OAS 2017a; OAS 2017b). Nevertheless, in and through this solitude, the nurse in long term care traverses the hallways and the lounges, the rooms and the alcoves, the many scenes of care, engaged and engaging in the daily, recuperative rituals of relational work. That certain gestures and words are repeated, shift after shift, over weeks and months, and occasionally years, does not, and perhaps cannot, render the relational work of the nurse more systemically visible—but like the spectral image on a strip of exposed, untreated film—sensitizes us to its long-negated presence.

One might say that the crucial distinction between the relational work of the nurse in the hospital and the relational work of the nurse in long term care, is that here, in the facility, the scene of care is not limited to the confines of a room or what transpires within

a compressed space, cordoned off by the faded pastel corrugations of a threadbare curtain. Instead it is to be found in all the places traversed by the nurse, on any given shift: hallway, lounge, room, alcove. I had witnessed this on my first morning at the facility, poised on a black leatherette stool, across from the nursing station. The corresponding field note reads as follows:

> I watch how the nurse moves seamlessly between the medication cart, and the landline to call the doctor, the chart and the computer screen, then gently cuff the upper arm of a woman whose skin seemed as delicate as the word itself. I watch the glint of the systolic/diastolic reading alight in a crimson flicker on the surface of her glasses, partially obscuring the keenness of her gaze. I saw her talk with a woman eating toast, then wheel another to the elevator for Catholic service. I saw her carefully apply a thin transparent dressing on a skin tear, while she joked with a man who had wheeled himself along the endless corridor on a quest for apple juice. In the hallway, in the lounge, in the rooms and in the alcoves—the relational was everywhere, because the scene of care was everywhere, if you were looking, and not looking away (field note, October 2, 2019)

4.6.7 Looking

The findings in this study are surfaced through the act of looking (and not looking away)—of paying exquisite attention to the intersectional complexities that inhere in the scene of care, and in thoughtful consideration of that foundational question: 'what is happening here?'. One response to this question has been to consider the data inductively—to look at what can be drawn from and said to coalesce through a set of field observations, personal interviews, and solicited diaries—and to then consider the data deductively through a four-fold framework of relational practice advanced in the work of DeFrino (2009). Looking at the data through both processes adds a depth and richness to the relational enactments discursively re/produced and embodied in the scene of care. It also affords one an opportunity to reflect on how a single piece of data, a statement, for instance, by Kelly, about sitting with the family of a resident—in contemplation of their imminent passing—might be read, inductively, as an instantiation of a death-bed scene, a hauntingly familiar, familial tableau *and* a boundary limned, or perhaps, briefly crossed while, simultaneously constructed and viewed as an episode of preserving work (after DeFrino, 2009): "beyond tasks and technical definitions of the job" (p. 299). Thus, the multiple valences of the act of sitting—how a certain sublime moment can reveal its many meanings through looking (and not looking away).

Chapter 5

Discussion

This Chapter begins by revisiting Woodward's (2012) discussion of the scene of care. It will be followed by a summary of the qualitative findings related to the central themes of home, family, care and boundary, and how these themes relate to the literature reviewed to inform this study. Finally, some limitations of the current study will be enumerated.

5.1 The Scene of Care Revisited

The purpose of this study was to think critically with and about the relational encounter between the nurse and the resident—and to do so through the deconstruction and critical examination of the scene of care, distilled in the work of Woodward (2012). Woodward's reflection on the scene of care begins with a photograph. It's an image of "an old woman sitting alone, head bowed, body enclosed by a walker (Woodward, 2012, p.18). She is outside, on a bench. The image is cropped such that the woman occupies the margin of the scene—along the left frame. The sturdy wooden bench on which she is seated occupies much of the rest of the image. A garbage can along the right frame mirrors the marginal presence of the woman. An unadorned brick wall foregrounds the bench, the woman, her walker, and the garbage can, then the curb, then the street. The visual grammar of the image is easily decipherable. Woodward (2012) tells us as much, when she writes, "there is such a thing as a solitary old person, in need of care, concern and connection to a vital intimate world. For this woman there is no home in sight to provide a trusted shelter for care. She does not seem to belong—anywhere" (p. 19). She is unseen, because no one is looking: "a public secret the public choses to keep from itself" (Woodward 2012, p. 19).

How do we tell the story of this woman at the edge of the frame—this public secret—how do we retrieve her story in all of its complexity? Woodward (2012) suggests that we do so not by attending to the woman in her solitude, the specificity of her

isolation, but in relation to those who care for and about her. In doing so “we become witnesses to the experience of everyone involved in the scene of care” (p. 35).

Woodward (2012) conceives of the scene of care not as an inert bricolage of objects and people along a continuum of interdependence, but as a dynamic relational environment. That is to say, the scene of care does not precede its discursiveness—cannot be said to exist prior to the narrative that brings it into existence. Here, Woodward (2012) reminds us of the value of a narrative that draws the caregiver and the older adult together—or perhaps more to the point —brings two people together in a dynamic of relational caregiving. An older adult on a bench, on a sidewalk in the middle of a day is a sleight of hand and eye. It's entirely possible that her companion, or her daughter, or her sister, is there, just beyond the sliver of frame where she’s napping—at the shops, gathering the ingredients for a meal they will share as the evening approaches. A story, Woodward (2012) notes, can “lift caregivers and elders out of the one-dimensional frame of victimhood” (p.46). Woodward (2012) suggests that storytelling serves to foreground the “narrative turn in gerontological studies, one that pushes the framework of gerontology itself to embrace the question of caregiving across the generations and in the context of globalization” (p. 45).

The scene of care is the consequence of this narrative turn: “an assemblage of many moving parts in a neoliberal global economy” (Woodward 2012, p. 35). For Woodward (2012) the many moving parts refers to all the people who animate a given scene: those who circle its periphery, transiently passing through, and those within the frame, who facilitate the frame, and whose labour is productive of the frame—like the nurse.

The nurse who arrives at the facility, to begin her shift is an embodiment of this assemblage—a moving part in the neoliberal global economy. She came here from the Philippines. Her name is Rheanne. She tells me how she has to park her car on the street—having driven from a suburb some thirty kilometres away. On a weekday, she’ll have to move her car every two hours to avoid receiving a ticket for violating a parking by-law the city seems keen on enforcing. When I arrived at the site one morning, I watched her walk towards the grey cement building, that in this residential neighbourhood is itself an architectural instantiation of a public secret. You can’t

decipher the meaning of its brutalist aesthetic, it's functionality, until you reach the security doors: the intercom, the pin pad, the signs telling you to depart if you are the bearer of infection; or pause long enough to witness the slightly unsteady gait of a woman exiting the elevator for the dining room. Rheanne begins her day reflecting on the following:

> to be a nurse you really need that caring heart, and I know it's, there are times that you feel like it's too much, because you have, you have your personal, personal problems as well, and then you go to work and then you have to block those problems, right? So you have to have that nurturing, caring attitude, so that when you, you know, when to, ok it's time to focus my attention towards the people that I'm for caring right now. Whatever are my problems I have to set it aside and I've seen, I've seen people in my 12 years of working here, even in the Philippines when I worked there I've seen people who went into nursing because it's a good paying job and you see the quality of the work they do. It's, it's kind of disheartening for me to see people who are just in the profession just because they get a good pay, because at the end of the day you are like, you're not the only ones suffering it's also the the people you are caring for who are suffering coz there's no care there in that relationship that goes on.

Rheanne's words can be read as a means of cultivating the relational: begin with a caring heart—set aside personal concern—focus the attention on the scene of care, on the person who is present—the recipient of care. She says this with an understanding that a nurse in a room with a resident is not, in and of itself, an instantiation of relationality—cannot, in and of itself, facilitate relationality—does not vouchsafe a feeling of belonging—that "requirement of our blood and bones" (Woodward 2012, p. 44). A nurse in a room with a resident is sometimes just that, a description of the material circumstances of the moment. Rheanne says, "it's kind of disheartening for me to see people who are just in the profession just because they get a good pay". But it's also true that to be one of many moving parts in a neoliberal global economy is to be in a state of permanent dependency on the very system that is responsible for re/producing one's labour and the circumstances of one's labour. Thus, the relational is an achievement, not a given. It's an act of daily work that, as DeFrino (2009) reminds us, is at constant risk of being unwritten, undone, rendered invisible.

5.2 A Feeling of Home

The nurse arrives at the facility, which is also a home, or perhaps, more accurately, a constellation of home-like spaces. What the study reveals is that the word home is used to refer to the facility itself, but also to the rooms of the residents—and on occasion the lounge and the alcoves where the residents might pass an hour or two or sometimes longer. “It’s like their home and they are living in a long term care which means they are living in their home”, as Naima puts it, with a certain circular economy. Used like this, the word is purely descriptive of a material and existential reality: a structure designed to contain and configure space—to contextualize decor and furnishings, the light and sound, that recapitulate what we think about when we think about home (Chaudhury et al. 2018; Fleming et al. 2017;). Such explicit references were fleeting. On one occasion, during my observations, the nurse made note of the texture of the upholstered chair a resident kept slipping from—on another, how the daffodils in a painting matched the blouse a resident was wearing. A particular conception of home sometimes surfaced when a nurse, echoing the phrasing of the Office of the Seniors Advocate (2017a), would note that this place was in all likelihood the final one that the resident would be able to call or conceptualize as home.

In this study, the interview subjects also employed the concept of home as a way of situating the self in a specific time and place. Home was also descriptive of the kind of caring labour and relational work enacted on any given shift: intimate work, personal care, work that mimicked the labour that is performed before they arrive in the scene of care and then after; that work that informs this other work. It’s not just the nature of the tasks that have to be performed, but for whom. The fact that this caring labour is provided for a resident population, that over time will come to be seen as something akin to family, has some bearing on how this concept animates the scene of care. Home is a metaphor for what is left behind—when you left for work, when you left the country of your birth—the family that you care for now through the embodied strangers that become like kin, in the scene of care. The strangers that you cleave to and who cleave to you in the quietest of moments, at the hour of sleep. The facility is home because it also invokes a feeling of belonging—because for many of the nurses the hours they spend caring for this re-imagined community and imagined kin are greater, by far, than what they will have the time or inclination to offer their own loved ones.

Here, it is also instructive to return to Amanda's reflections on the idea of home. Recall how she reconceptualized its meaning as a consequence of a shift in her professional status. Initially dismissive of the word and its vernacular usage in the workplace, she revisits it in the light of new knowledge and a reappraisal of her role. She recognizes that the word, itself, carries a set of prefabricated meanings but is also a socially constructed signifier (Bourdieu,1996; Fitzgerald & Robertson 2006; Fleming et al., 2017). We see in Amanda's reflections of home the way in which the idea of it is intimately linked to, and conceptually interwoven with, a constellation of other relational phenomena: so that to invoke the idea of home is to simultaneously invoke an idea of family, and with it an idea of belonging and the material circumstances of caregiving, the materiality of it. More prosaically, the study suggests, we can think of the idea of home as a place of routine, a conceptual space within which interactions are fashioned and a togetherness is forged—as Minerva does. "It's like my half home too", she says "because I go there almost every day, it's half my life there...I feel like I'm home there too, and we're both in home so its a, and you have this interactions with them every day, it's like a family spend time together". Home as a place of togetherness. It is, thus, possible to think of home *qua* home as a scene of care whose shifting, malleable frame re-narrativizes relational practice, thus echoing the ideas found in the work of Karner (1998), Gubrium (1975) and Gubrium and Buckholdt (1982). Home is a space that structures the relationship between nurse and resident—furnishes and situates their encounters—allows for the proximity of caregiving and storytelling. What's noteworthy, and worthy of further consideration, here, is that the use of the word home to articulate a cluster of nuanced and emotionally resonant ideas like family and belonging—suggests that the rich conceptual valence of it is in no way underwritten by the institutional look of the exterior and aspects of the interior—the corridors, the colour scheme, the spare unadorned bathrooms—that replicate the total institution (after Goffman,1961).

The rather benign articulations of home in this study, also invite us to reevaluate the critique of gendered domesticity and neoliberal familialization advanced in the work of Fleming et al. (2017), but in particular that of Braedley and Martel (2015), when considering how the ideas of 'home', 'homeliness' and 'home-like', are deployed in the refashioning of long term care. It's not that a trenchant, intersectional analysis of gender is not a necessary element in any thoroughgoing deconstruction of long term care—but that such a discourse can obscure the ways in which the relational labour of the nurse is

itself a form of liberatory praxis, (after Woodward 2012). Furthermore, the idea that a facility can be ‘home’, can feel like home, to both resident and nurse, can serve to inaugurate a fundamental reframing and remapping of the scene of care, further substantiating its home-like qualities.

5.3 The Meaning of Family

I had been engaged in field observations for one week before I first heard the expression, *I love you*. I couldn't see which staff person had uttered the words, but I thought I recognized the voice. I remember being startled by it, in part because the intimacy it suggested was in notable contrast to the insouciant tone with which it was pronounced. I had heard other expressions of endearment prior to that. They were woven into every shift. You knew it was a part of the expressive grammar of a particular floor, on a particular day, when even the newest students began to echo the regular staff by referring to certain residents as “mama or papa”. As if they felt permission to do so even though, in all likelihood, they’d been admonished not to by their clinical instructor.

When I first asked Amanda why she said the words ‘I love you’, she invoked the idea of family. She told me she thought it made the resident feel as if they belonged. I mention this now, again, in the context of this discussion to illustrate how the meaning of an expression or a concept often precedes its comprehension. When I had first heard them, I understood the words ‘I love you’ to be some off-hand comment, half relational, half humorous, instead Amanda had uttered them to communicate the idea of family.

Like those words, the study revealed a number of salient findings about family that highlight the disjuncture, the slippage, between immanent meaning and after-the-fact comprehension. So much of what I observed on the floors of the facility, in the encounters between staff and residents and in particular between nurses and residents was how the immanent, the contingent, was what mattered and what was required in that particular moment.

I am thinking about this now, while reflecting on the fact that one of the most poignant findings to emerge from this study was that for a number of the participants

their own absent, or now deceased, family member was the reason they became a nurse or, if already a nurse, became a better one, a more thoughtful and compassionate one. The corollary to this was that having become a nurse they now saw in the residents they cared for, something of the person who had once inspired them: a father, a grandfather, a grandmother, an elder. That was a template they carried around with them, like some relational talisman.

You wouldn't know this, of course, couldn't know what Naima, for example, was thinking about as she spoke in a gentle whisper to the son of the woman who was dying. Indeed, when I look back at my jottings, I note that I had described her expressions as expressionless, what seemed to me, fleetingly anyway, to be a kind of indifference. Instead, I think of her face now as exhibiting a quiet, fierce determination to provide the best possible care for the resident, who for her, was now akin to the grandparent she had left behind.

The observational and interview data suggest that the concept of family is fashioned through the repetition of caring labour—its words, gestures, and actions. This, in turn, is reinforced through policies and practices that aim to preserve a continuity of care, ensuring the same caregivers for the same residents. The data also indicates that the concept of family is a modular metaphor, richly and variably descriptive and readily brought to mind in the scene of care. For instance, in each of the interviews the concept was deployed by the participant to describe their situatedness in relation to the resident.

This perpetual recalibration of the relational (as familial), is illustrative of the constant, emotional and cognitive labour the nurse must take on and exhibit. It's a powerful affirmation of what has been articulated in writing well-versed in the ethnographies of place (Gubrium, 1975; Gubrium and Buckholdt, 1982) but is also reflective of the ideas circulating through the literature that foreground social constructionist and discursively generated ideas about family (Bourdieu, 1996; Braithwaite 2010; Nelson 2013). This study also suggests that it is not only the residents who are constructed as family but colleagues as well—in particular those who are engaged in relational labour, whose identity is constituted by and through the scene of care. There is a refined taxonomy at play in the statements of the participants that differentiates between residents as family, colleagues as family and their chosen and

biological family even as the boundaries blur and elasticize over time or in response to the requirements of a moment. This surely warrants the attention of future scholars but the literature that informed this research was silent on these complexities.

The literature was also silent on how terms of affection and the language of care can facilitate relationality while also sublimating the pain and distress of certain incidents—how words can soothe a situation but can also be self-soothing. There is, I think, much more to be considered, here, about how certain phrases and terms are productive of a discourse of relationality, that while drawing nurse and resident together, also refashion the scene of care. There are, the study suggests, many meanings to the expression, “I love you”.

5.4 A Longing for Care

When I was first thinking about this study and the subject I was intending to look at, I had thought that it would be of particular utility to be able to shadow the nurse as they went about their day—plying well-worn routes from nursing station to resident’s room—to the dining room—to the lounge. Instead, I confined myself to the common areas of the facility, not wanting to intrude on the privacy of a particular scene of care, one that would have centered the resident and nurse. I had thought that I would miss something of note in not being present to witness those instances of caregiving. And, indeed, it’s quite possible that I did miss something. But I also got to hear about those moments, and to listen to what was said about those moments in a way that would not have been possible if I had been present. It also gave me an opportunity to deconstruct certain ideas about nursing care that I had been carrying with me since I had traversed the corridors of this very place.

What struck me, during my observations, and while I was interviewing the research participants, and later, combing through their transcribed words and diaries—what struck me most profoundly—was the fact that the gestures and acts of caregiving were present in every space and in every moment. Indeed, the entire shift was woven together with the rituals of care, each of which was tailored to the particular needs of the resident—offering a counter-narrative to the idea that care in long term care is

possessed of a certain uniformity (Armstrong et al., 2016; Banerjee & Armstrong, 2015; Lowndes & Struthers, 2016; OSA, 2017b). What was gathered through the data was the very embodiment of person-centred care (Kontos et al. 2017; McGilton et al. 2012b). This was true even in instances that were difficult, where attempts at relational care encountered resistance, where the nurse felt a sense of disconnection from the resident, or disappointment in the way they (the nurse) had been treated—in each of those situations the relational was privileged over the merely pragmatic. The nurses in the study sought out moments in a shift to tell stories about themselves and to listen to the stories they were being told—in whatever language was available to the resident—to make time for the friendly conversations that the Seniors Advocate (2017b) noted were not being had as often as they might.

Listening to the words of the participants during our conversational interviews and again, repeatedly, while transcribing the recordings, their words in my mouth, the stop-go of the play-back, what began to coalesce was the idea that the intimacies of care, the discrete set of gestures and acts that could be quantified as such—that were somatically and emotionally reparative—were also conceptually generative of home and family: care leading to a feeling of home leading to a sense of family, like a set of relational nesting dolls. There are echoes of this schematic in the work of Karner (1998) and more obliquely and poetically so in Doane and Varcoe (2007) who invite the practitioner to delve beneath “the surface(s) of people, situations and relationships—beyond the ‘iceberg’ pattern of interaction where a substantial portion of the elements shaping the interaction [between nurse and patient] is unseen and/or ignored” (p.198). The current study suggests that the conceptual fluidity that underpins the caring encounter might be productively revisited in future studies that may yield yet more complex understandings of how care is experienced. I say this because one of the central issues that emerged as the study unfolded was the invisibility of relational care—and the attempts to retrieve and fashion it into something legible, so as to reduce the deleterious effects of moral distress (DeFrino 2009).

The reference to the invisibility of care work echoes, of course, the theoretical framework of DeFrino (2009) and the ideas of Woodward (2012)—both of whom invite us to think critically and imaginatively about the recentering of reproductive, relational labour. Indeed, Woodward (2012) ends her essay by suggesting that what we need are

“scholars without borders in age studies, scholars who understand that it is important not just to think globally and act locally but also to think locally and act globally—and who will call attention to the public secret of the caregivers of frail elders” (p. 46). This, after saying that she suspects that

> stories with a documentary and auto/biographical impulse that are drawn from everyday life...will serve us better; it is as though these modes...draw us closer to what is real, bringing what is generally understood as private into the public domain. Moreover, stories that embrace a broad spectrum of feeling, stretching beyond sympathy, have more power to engage us (p. 46).

In thinking about Woodward’s (2012) ever-expanding repository of strategies aimed at reframing the scene of care and DeFrino’s (2009) remapping of the relational practice of nurses—it's possible to conclude that the attempt to retrieve the relational and render it legible may be untenable and, perhaps, undesirable.

Relational practice is, of course, “more than an affective ethical state: it involves material engagement in labours to sustain interdependent worlds” (de la Bellacasa, 2012, p.198). It is the functioning of these interdependent worlds that is one of the central concerns of this study, attentive as it is to the matrix of relationality that is constitutive of the scene of care. Relational care is a skill and a form of knowledge work (Banerjee & Armstrong, 2015; DeFrino 2009). The states of (inter)dependence forged through its nuanced enactments are “something to strive for” (DeFrino, 2009, p. 296). What is of note, here, in this study, is that relational practice is work and that “the social understanding and relationship with the patient make up the site of *work*” (DeFrino, 2009, p. 302). This work is fashioned in the public and private and interstitial spaces that coalesce around and through the scene of care—that might be said to be constitutive of the scene of care. Nurses like Naima and Kelly remind us that what transpires in these spaces are acts of recognition and care—the relational labour that addresses the person in and through the fullness of their humanity and not merely as a cluster of symptoms to be medicated or behaviours to be managed (DeFrino, 2009; Doane & Varcoe 2007; Sabat, 2008).This is of particular significance for older adults with dementia for whom an embodied selfhood and “a ‘generative grammar’ that finds its locus in the expression of the face, the play of the eyes, the movement of other parts of the body and the tone of voice” (Kontos, 2011, p.337) can be read as corporeal signifiers through which social

connectedness and relationality are preserved (Kontos, 2011; Sabat & Harré, 1992). As Kitwood (1993) poignantly notes “[s]o many gestures have passed un-noticed, or been ignored or discounted; so many communicative acts have been aborted; so many gross impositions have been made upon the dementia sufferer from others' frames of reference” (p. 65). The counterpoint to what has ‘passed un-noticed’ is repeatedly encountered through the relational practice of the nurse. The mutual empowering (after DeFrino, 2009), for example, embodied in the professional satisfaction derived from taking time to know the resident even when, as Rheanne notes, “they probably won't remember you engaging with them”

Kontos and Naglie (2007) suggest that

> achieving person centred dementia care is dependent upon health practitioners’ imagination to recognize that selfhood persists despite the presence and progression of cognitive impairment…[and] that when health practitioners’ imagination is informed by shared bodily experiences with their care recipients and the ways in which selfhood is expressed through social habits, gestures, and actions of the body, even greater sympathetic connection can be made (pp. 551-552).

These acts of imagination are woven through the statements and actions of the study participants. We see it in how the people living in the care home are reflexively re-imagined as embodiments of a loved one—a family member—so that the ‘shared experience’ is both immanent and spatially and temporally, transcendent. As Doane and Varcoe (2007) observe, “reflexive and intentional” (p. 200) relationality enables the nurse and caregiver to “come into closer proximity with suffering, uncertainty, and/or conflict” (p. 201). Thus, it becomes possible to encounter the scene of care open and alive to every relational possibility that inheres within it. “Framing difficulty as an inherent feature of nursing relationships paves the way, for more “ethical…effective and efficient nursing relationships” (Doane & Varcoe, 2007, p. 201).

I think about Minerva in a room on an evening shift, carefully washing and drying the skin of a woman who might have been her grandmother—but isn’t—and who, instead, was a stranger—now, fashioned into kin through a discourse of the familiar—as an instantiation of the ideas of relational care advanced through the arguments of Doane and Varcoe (2007) and Kontos and Naglie (2007). I am, however, not convinced that this is a moment that can necessarily be made legible to a manager, or a technocratic

administrator—a maker of policy. As Bordo (cited in Tanner, 2006) notes, the body, in late capitalism, "has come to be understood not as a biological given which we have to learn to accept, but as a plastic potentiality to be pressed in the service of image—to be arranged, rearranged, constructed and deconstructed as we choose" (p. 3). But to the nurse, charged with caring for the embodied individual, in their sometimes abject, often inscrutable circumstance, the 'biological given' is a biological imperative, a corporeal reality they must navigate through the daily relational rituals of care.

Perhaps what matters most, is that the act of relational care is legible to the resident. The research findings suggest that this is, indeed, the case. All of the study participants described specific moments when they felt recognized by residents with whom they had interacted: a smile, an attempt at a name that would have been unfamiliar and perhaps difficult to pronounce; a vague recollection, a sense of trust, a willingness to take the hand that was proffered. It mattered to *them*. Would some form of institutional recognition be of equal value? Would the words of a manager who recognized a seemingly incidental act, as an instance of relational care and said as much, matter, to the nurse, the resident, the scene of care in its entirety? Perhaps this is the wrong set of questions to be asking, in light of the study findings that clearly identify the significance of relationality to the wellbeing of nurses and residents, alike. Furthermore, McGilton et al. (2013) note that

> [n]urses have identified 'relationships' as the primary reason for continuing to work in a nursing home. While personal relationships between nurses and residents are in themselves rewarding and provide an incentive to stay, such relationships are also the basis for how the work gets done. Resident relationships are a source of personal fulfilment and an impetus for regulated nurses to stay in their current employment situation (p. 774).

We might ask, instead, whether a shift in organizational culture would facilitate the legibility of relational care, make visible the craft of relationality in all of its exquisite nuance. McGilton et al. (2013) suggest that "new models of care" (p. 779) are required to ensure that regulated nurses, and in particular registered nurses, are able to engage in full-scope clinical practice, while remaining connected with and to the lives of those living in care—in all of their somatic and existential complexity. While McGilton et al. (2013) see the need for "organisational support, such as ward clerks, to assist with the multiple administrative responsibilities of the regulated staff nurse [noting that] [t]hese initiatives

will also serve the purpose of minimizing emotional exhaustion" (p.779), it is clear, as Kontos and Naglie (2007) perceptively note, that "resources by themselves are…insufficient to ensure the provision of high-quality care if such resources are deployed in an organization where practitioners assume a loss of personhood in the advanced stages of dementia" (p. 566).

Of course, a loss of personhood is not solely limited to the experience of particular residents. One can also *imagine* (after Kontos & Naglie, 2007) what losses to personhood are incurred by practitioners as a consequence of the moral distress identified in the work of DeFrino (2009); or to imaginatively consider what it might mean for Minerva to have her vacation request denied without explanation: how "passion escaped from my chest". This is not to equate these forms of loss, but is illustrative of Tronto's (2010) suggestion that in care settings "there are many sets and levels of needs" (p. 168), and thus "institutional care is better understood in the context of conflict" (p.168). Tronto (2010) perceptively notes that

> [t]his possibility of conflicting ends within institutions is a long-established problem with viewing institutions as single-purposed and single-minded. Just as all individuals have many ends, so too individuals within organizations have different ends and organizations have many ends. Furthermore, what we think of as 'needs' changes. They change over time for particular individuals, they change as techniques of medical intervention change, they change as societies expand their sense of what should be cared for, and they change as groups make new, expanded or diminished demands on the political order. The demands placed upon institutions change. Within institutions, as the particular individuals within the institution change, they have different needs. Workers within institutions have their own needs. There is a large discussion of how professionals create and assess needs Determining needs is complicated. (p.168).

Determining and addressing these various (competing) needs in thoughtful, productive and holistic ways, will require the collective input of all the many moving parts, voices and bodies situated within the scene of care (Kontos & Naglie, 2007; McGilton et al., 2013; Tronto, 2010).

What might be said with some measure of certainty is that the need for relationality is shared by both nurse and resident. It is a need which invariably draws the two together. It is from this drawing together, this relational pull, the intimacies of it, what is revealed in such moments about mutuality and vulnerability and recognition, the idea

of home and family, in the scene of care, that a definition of relational care begins to coalesce. I say coalesce because Mol et al. (2010), remind us that "we need to juggle with our language and adapt it…[because] the most difficult aspect of writing about care is not finding *which* words to use, but dealing with the limits of using *words* at all (p. 10). Furthermore, what matters in the scene of care, is what we don't see, what we can't see, what is inaccessible to us—the relational intimacy of two or more bodies in space—caregiver(s) and recipient. As Vaittinen (2015) reminds us "there are no autonomous subjects without needs, only degrees of embodied vulnerability that continue to elicit political relatedness" (p.104). So what we might say, in the context of this study, is that relational care involves the drawing together of nurse and resident, in need, in states of embodied vulnerability, in relatedness and mutuality, in a moment in and through which an act of care is initiated, the legibility of which is apparent only in its aftermath—through moments of mutual recognition that are woven through the shift, and the shifts to follow. "Perhaps when articulated, when put *in so many words*, care will be easier to defend in the public spaces where it is currently at risk of being squeezed. Perhaps care practices can be strengthened if we find the right terms for talking about them" (Mol et al., 2010.pp. 10-11.

5.5 A Boundary Is Not a Line

The first time I thought of the concept of a boundary in the care facility was on the first day of field observations. It was in the context of the design of the floor that appeared to simultaneously maximize and collapse space around the nursing station. I remember thinking that every time the nurse entered the nursing station it was as if they had crossed a boundary. It functioned that way. Even the residents seemed to know not to cross it. There was one woman, who had a penchant for ice cream and a need for cigarettes and who frequently wheeled herself to its threshold to relay her requests—but she never crossed it. I made a cryptic note about what I had been thinking, it read: 'social space vs professional space'.

I hadn't thought to ask about boundaries when I conducted my interviews, but the concept surfaced anyway—and kept surfacing throughout the study. It surfaced in ways that spoke to the complexity of the concept itself, but in the main it was employed to

describe and differentiate ways of being in the scene of care—the relationship of the nurse, in that moment, to the scene of care. For instance, for a number of nurses a boundary was a way of distinguishing between their professional identity and self, and their relational self. On occasion they would describe having to shift, in the moment, from one identity to another, setting aside their relational self as a way of protecting their professional self. Sometimes the nurse would have to explicitly communicate this, to signal that the shift was happening, or was about to: that certain behaviours or words had crossed a boundary of what was acceptable. Sometimes the boundary was enforced through language, other times through silence, or an internal recognition of what could or couldn't be enacted or spoken in a particular situation. For instance, In the findings, I had made note of a brief diary entry by Minerva. In it she had mentioned that the vacation days she had applied for had not been granted and, as a consequence, a planned overseas visit was now in jeopardy. She begins to feel disconnected from the residents. “I was quiet during the shift”, she writes. Her quietness functions like a boundary. It afforded her a certain disconnection. One might say that much of the hidden work of the nurse, on any given shift, involved the navigation or articulation of boundaries.

What is of particular interest in the context of this study are instances when a boundary is dissolved or elasticized—recognized then breached in order to retrieve the relational or to cultivate it or to distance oneself from it and reconnect with the self. Throughout the study we see instances when a nurse chooses to reveal aspects of their personal life or who respond to the needs of a resident with well-rehearsed expressions of endearment despite their proscription in policy. What is the nature of a boundary crossed when a scene of caregiving momentarily dissolves into a scene of the familial—when the resident feels as if the nurse is like a daughter, and says as much, and the nurse reciprocates in kin(d). It’s a question that also surfaces in the scene of care, when Rheanne, for example, speaks to how, in a sense, she steps in and out of her role as a nurse,(or, perhaps, more accurately, is constantly recalibrating her professional identity) in response to what is demanded of her in the moment. That is to say that only intermittently, in any given shift, is this the singular identity she assumes. Otherwise she is situated like family, relates as if kin, moves through the space of the facility as if it were home. There are parallels here to the professional care-giving work that takes place in the home (Barnhart et al., 2014; Karner, 1998; Woodward, 2012). Indeed,

Barnhart et al. (2014) note that professional caregivers employed by a family to care for young children or older adults occupied an “ambiguous position [within the family] described by informants as a liminal status…characterised by the ambiguity of being ‘betwixt and between’ two culturally defined social positions” (p. 1686)—included in certain family activities, excluded from others.

What becomes clear in the current study, is that a boundary is easily prone to dissolution—that it requires ontological certainty to give it form and that that kind of certainty is not to be found in the scene of care. Instead what one encounters is an embodiment of what the literature on this theme describes as human vulnerability and interdependence (de la Bellacasa, 2012; Doane & Varcoe, 2007; Tanner 2006; Vaittinen, 2015). de la Bellacasa (2012) reminds us that in this sense

> the meanings of caring are not straightforward. Interdependency is not a contract but a condition; even a pre-condition. For all this, we must be careful not to become nostalgic for an idealised caring world: caring or being cared for is not necessarily rewarding and comforting. A feminist inspired vision of caring cannot be grounded in the longing for a smooth harmonious world, but in a vital ethico-affective everyday practical *doings* that engage…with the inescapable troubles of interdependent existence (pp.198-199).

A boundary is a concept that threads itself through these inescapable troubles and allows for a quietness to descend as a balm, for a moment, when passion escapes from one’s chest and the relational work that is the practice of nursing is rendered invisible.

5.6 Limitations

This research study has a number of limitations that warrant mentioning. While each limitation may be said to have a specific significance and impact on the outcome of the research, these first two are perhaps the most consequential for the study itself. Emerson et al. (2011) note that “the ethnographer’s presence in a setting invariably has implications and consequences for what is taking place” (p. 4). It’s a presence that can give rise to what Emerson et al. (2005) refer to as “*reactive effects* (that is, the effects of the ethnographer’s participation on how members [study participants] may talk and

behave)" (p. 4). While a sustained and substantive argument can be advanced to suggest that "the ethnographer can both have an effect and *by doing so* tap into valuable and accurate data" (Monahan & Fisher, 2010, p. 358)—the reactive effect and its consequences may indeed inform, inflect and simultaneously distort the scene of care and the normative dynamic that obtains between nurse and resident. A tangentially related limitation is the fact that while this study has been explicitly mindful of the complexities and nuances that inhere in the scene of care, its exclusive focus on the nurse in the nurse-resident dyad might serve to elide the impact of staff, residents, families, friends, and volunteers, who necessarily shape and inform the relational dynamic between nurse and resident in potentially significant and consequential ways. Future research might first more fully reckon with the situatedness of the ethnographer and to thoughtfully consider how "informants' performances—however staged or influenced by the observer—often reveal profound truths about social and/or cultural phenomena" (Monahan & Fisher, 2010, p. 358), while at the same time critically reflecting on how the scene of care is shaped by all who pass through and/or are present within it, even while focussing on the nurse and how they imagine and cultivate relationality with the resident.

The study sample was drawn from one, not-for-profit, unionized, long term care facility in Vancouver. This will necessarily limit the generalizability of the findings to other sites in other jurisdictions, across the province and the country. As the Sars-Covid 2 pandemic has amply demonstrated, the structural conditions in a facility, like the one chosen for this study, are not insignificant factors in facilitating a relationally nourishing environment for staff and residents, alike. In addition, a study sample drawn from more than one site would have allowed for an intra-health authority comparison, while creating a more complete picture of relationality in long term care. It is also worth noting that this was a convenience sample which included nurses who had more than five years of experience working in this sector. These were nurses who were confident and secure in their professional identity. Including nurses with less than five years experience would have resulted in a more nuanced portrait of the scene of care. In addition, a consideration of how the relational practice of a licensed practical nurse (LPN) might be said to differ from that of a registered nurse (RN) is a salient issue that this study did not pursue. Indeed, Amanda makes explicit reference to how her understanding of the idea of 'home' and her role within it shifted, substantively, when she became an RN after

having first practiced as an LPN. Furthermore, McGilton et al. (2012a; 2013), suggest that RNs, in long term care, (can) play an important leadership role in facilitating relational practice. Future studies, would benefit from considering these limitations and, in particular, attending to the experiences of newly graduated nurses and those who are in the first five years of their nursing career, while also critically differentiating the findings drawn from LPNs and RNs.

The potential for bias is an additional limitation in this study. I am a registered nurse and had previously worked at the site where the research was conducted. This familiarity with the structural features of the building and with the general ambience of a long term care setting certainly enabled me to focus on what I considered to be of significance during my field observations but might also have caused me to overlook certain telling moments that I would have viewed as entirely normative. An additional bias may be found in my employment with the British Columbia Nurses' Union. I am not involved in labour relations, but I certainly possess a bias in favour of union work environments and the rights of workers. Future research would do well to compare the phenomena of relationality at unionized and non-unionized facilities, to determine, in part, whether extrinsic factors like remuneration, for example, might influence the relational behaviour of staff.

Chapter 6

Conclusion

> *Caring and relating thus share conceptual and ontological resonance. In worlds made of heterogeneous interdependent forms and processes of life and matter, to care about something, or for somebody, is inevitably to create relation. In this way care holds the peculiar significance of being a 'non normative obligation'...it is concomitant to life – not something forced upon living beings by a moral order; yet it obliges in that for life to be liveable it needs being fostered. This means that care is somehow unavoidable: although not all relations can be defined as caring, none could subsist without care (de la Bellacasa, 2012, p. 198)*

The aim of this study was to think critically with and about the relational encounter between the nurse and the resident living in long term care. Data was collected through site-specific field observations, participant diaries and qualitative interviews with seven nurses, in order to address the proposed research questions. Four central and interconnected themes were read into and drawn from the data. The results of this study provide a thoughtful and nuanced contribution to current knowledge and research about the often overlooked experiences of nurses working in long term care. By way of a conclusion I will begin by offering a set of responses to each of the research questions listed below and will then close with some thoughts about the implications of this study for future research.

6.1 What is the meaning of relationality to nurses in long term care?

This study suggests that there is no single meaning of relationality to nurses in long term care, in part, because relationality is itself a contingent phenomenon, practiced in a given scene of care. The scene of care is also contingent, produced through an instantiation of the social and political coordinates of persons and place, the "many moving parts in a neoliberal global economy" (Woodward 2012, p. 35). Relationality announces itself through words and actions and gestures, in the scene of care. But outside of this transient space, it is unwritten. Its legibility is accessible to us only as a consequence of what we are told about a moment of caregiving or what we witness

ourselves and happen to register as such. Relationality cannot be said to exist in and of itself. We know something about it because “beings do not preexist their relatings” (Haraway, cited in de la Bellacasa 2012, p. 200). A nurse will tell you something about the meaning of relationality to them: a feeling of family for instance, or the idea of home, the scaling of a boundary. Through these episodes and narratives, we create a composite image, a provisional meaning. You will see its afterimage in the smile of a resident, or the preference for one voice out of many when it's time for them to go.

6.2 How is relationality practiced by nurses in long term care? Do they believe this has an impact on the residents they care for or with and if so, how?

The data from this study suggests that relationality is practiced in the scene of care through every action, gesture, glance, and touch. Alternately, we might say that relationality is not practiced but rather emerges through the repetition of care, day after day, shift after shift. Each of the participants in this study had anecdotes and stories to tell about ordinary moments that transcended the ordinary, even as they remained rooted in the rituals of caregiving. Even when the care that is codified in a care plan is refused, there are other forms of caregiving that now have the space to flourish. That a woman refused assistance with mouth-care at bedtime doesn't mean that you cannot sit with her, and cultivate a sense of relatedness, as Zara demonstrates. This is why it is possible to say that relationality is not practiced but, rather, emerges.

The central challenge is one of determining how to quantify the unquantifiable. So much of nursing work in long term care takes place in the interstices—between explicit and easily quantifiable acts like giving out medications and the off-stage moments when you ask about the sepia photographs that line a wall of the resident’s congested room. This is why Zara, for one, was keen to say that her primary commitment was to the resident as a whole person and not merely as a recipient of pills. Relationality is practiced in many ways but in many ways the practice of relationality is obscured.

In a crucial sense we can say that it is the recipient of care who becomes an embodiment of how the relational is practiced—how it emerges. The data from the study

suggests that nurses believe that the practice of relationality does have an impact on the residents they care for. We see this in the way the subjectivity of the resident is centred in the participants' descriptions of caregiving. Centred thus, the intention of the act of care is to facilitate a sense of belonging, an idea of home and a feeling of family. It's true, of course, that not every resident is drawn into the ambit of relational care with the same degree of feeling. Some circumstances are invariably challenging, the push and pull more centrifugal. But the practice of relationality is also founded on forms of self-awareness and the use of feelings as data (after Defrino, 2009)—irrespective of the feelings themselves.

6.3 What contextual factors shape the relational practice of nurses in long term care?

This study suggests that relational practice in long term care is shaped by three key contextual factors: time, team, and leadership. Each of these factors can be conceptualized as distinct phenomena, but like much that obtains in long term care it's equally possible to view them as constitutive and deeply interconnected.

Time is, of course, of the essence. I witnessed the tyranny of it during field observations. In DeFrino's (2009) framework, time and its scarcity is understood as an inevitable aspect of a biomedical model that places a premium on efficiency. So little time, then, for the nurse in a hospital setting to engage in relational practice. In long term care, the emphasis is on repetition and continuity of care. A day shift may be dense with demands but an evening shift can offer a precious sliver of time to accomplish the extraordinary—alive to a fragment of biography that shapes the care you will deliver tomorrow.

Relational practice takes time. Nurses need time. Not just a stolen moment away, but a way of looking at and conceptualizing care work that centres the relational. To reframe the scene of care so as to privilege relational practice requires a recognition on the part of one's colleagues on the care team and the managers and administrators, alike, that this work also matters—this restorative caring labour. This may account for why the participants in the study made reference to the centrality of their co-workers to

the work that they do—the work that is possible to do. It is this support that enables them to take the time that is needed to engage in relational practice.

6.4 Does the practice of relationality lead to an experience of kinship?

The data from the study suggests that the practice of relationality leads to an experience of kinship. This is because the labour of care through which the relational comes into being also gives rise to feelings of home and family, both of which are constitutive sites of kinship. Based on Nelson's (2013) typology we might understand certain relationships in the scene of care as instantiating forms of situational or intentional kin. But for the participants in the study, the appropriate nomenclature would be beside the point. Indeed, each of the study participants described themselves feeling as if they had a family-like relationship with the resident's they provided care to and with. I remember going back to the transcripts to see if I had used the word as a metaphor or motif to seed their response—but in each case it was they who had furnished their descriptions of the relational with recourse to the concept of family. Nelson (2013) tells us that "[t]he use of family as metaphor or explicit simile (''like a brother'') may also tell us as much about how individuals want to see themselves (as people who act in a loving and conscientious way towards others) as it does about how people actually act in their daily lives" (p. 278). In the circumstances of this study it is possible to say that how these nurses wish to be seen is akin to how they act in the scene of care.

6.5 Implications and Future Research

The findings from this study offer a set of critical insights into the nature of relational work in long term care. That this write-up is occuring in the midst of the SARS-Cov-2 pandemic only adds to its import. COVID-19 has graphically foregrounded the devastating consequences of a systemic failure to adequately fund and staff long term care. It has also highlighted the need for a fulsome recognition of the labour of care that informs the relational practice of nurses. The findings from this study suggest that nurses in long term care privilege the relational, seek out opportunities to fashion familial-like relationships with residents and find, in hands-on care, opportunities to build and

strengthen a feeling of home and connectedness with the people that they care with and for.

These findings have profound implications for the type of staffing skill-mix best-suited to the needs and concerns of residents in long term care. This is particularly salient now, when the need for increased personnel in long term care settings has come to dominate the public discourse on care for older adults. The type of systemic change that is required cannot be achieved merely by increasing the level of staff (though this would be of unequivocal benefit). Indeed, what is required is a philosophical re-orientation that first and foremost retrieves and centres the relational.

The findings from this study suggest a number of potentially productive avenues for future research. This research would be based on a sample population drawn from multiple long term care sites, would aim to include nurses at various stages along their career path and would begin by addressing the following questions: in what way do nurses experience the workplace as home; to what extent do facility policies and procedures inhibit the cultivation of kin-like relationships between nurses and residents; how can acts of relational care be made more legible in the scene of care. The findings from these future studies will add to an already substantive body of research and knowledge that retrieves and re-centres the relational. It is this work that will provide the theoretical basis for refashioning care for older adults.

The invisibility of relational work in long term care is structured by and through the invisibility of the older adult in the public realm. Both are unimaginable. The SARS-Cov-2 pandemic has merely confirmed what we already know. There are, of course, other forms of knowledge, and other ways of knowing and this study has highlighted how nurses employ relational practice to come to know something of value about the person they are caring for and with. Our task, now, is to reimagine the scene of care, and make visible the art and science of relational practice in a workplace that both nurse and resident call home.

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Appendix 1.

Consent Form

STUDY TITLE: Nurse and Resident: Fictive Kinship in Long term Residential Care
PRINCIPAL INVESTIGATOR: Hanif Karim MA CANDIDATE […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: BARBARA MITCHELL, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY SHARON KOEHN, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

A. PURPOSE

The following research project aims to develop a greater understanding of the relational dynamic that exists between nurses and residents in long term residential care settings. You are invited to participate in this research project because you are a nurse working in long term residential care. I am inviting you to participate in this research to help me better understand your relational experiences with residents. I am also interested in whether these caring relationships can lead to feelings of kinship between nurses and residents.

B. PROCEDURES

If you agree to participate in this study, you will take part in two semi-structured interviews. Interview one will take approximately 60-90 minutes. Interview two (member checking) will take approximately 30-60 minutes. The principal investigator will check in with you during and after each interview to make sure you are comfortable with proceeding. He will also collect your demographic details such as gender and age in order to compare and understand differences between participants. Provision of demographic details is voluntary. You will receive a $20 gift card for participating in this study.

The interview will take place in a location of your choice. The location will be private, so that you will not be overheard by others (e.g., other staff/management,

residents). Anything that you tell me will not be shared with anyone (e.g. other staff/management, residents) in a way that would allow them to identify you. You will also be asked to keep a diary about your involvement in the study. This diary will invite you to record your thoughts and reflections about the caring relationship between yourself and the resident for whom you provide care. When you are recording your thoughts and reflections about this relationship you will be asked to not include any personal details about the resident(s). Select quotes may be taken from these diaries and used as data in the study. To protect your identity, I will remove or replace (with a pseudonym— "false name"— or general information) anything you state in your diary that would allow somebody else to identify you. Your diary will be returned to you following the study.

In addition, the study will involve observing you in your workplace with a particular focus on your workplace interactions. As the principal investigator I am primarily interested in your interactions with residents, but the study may also include references to interactions with other staff. To protect your identity and those of the people you are interacting with, I will remove or replace (with a pseudonym— "false name"— or general information) anything I observe that would allow somebody else to identify you or any other individual(s) involved in the interaction.

Your participation in this research project is completely voluntary. The researcher, Hanif Karim does not currently work for _____or the Health Authority and, as a result, has no influence on the circumstances of your employment. The researcher, Hanif Karim does work for the British Columbia Nurses' Union where he is employed as a human rights equity and health policy officer. He has no involvement in labour relations and though previously employed at _____ has no current involvement with _____

You can withdraw from the research project at any point without penalty or consequences. If you withdraw from the study, any data and recordings will be destroyed immediately. You are free to refuse to answer any questions during the interviews. All interviews will be audio recorded and then transcribed. Only I, Hanif Karim and Dr. Sharon Koehn (my thesis supervisor) will have access to the recordings. To protect your identity, I will remove or replace (with a pseudonym— "false name"— or

general information) anything you tell us in the interview that would allow somebody else to identify you. I will destroy the original recording of your interview as soon as it is transcribed. I will also assign a pseudonym to identify your file. You have up to six months after completion of your interview to request that we remove information that you have provided from the transcript. After that time, we will destroy the list that links your real name to the pseudonym used for the transcript.

After the interview, I will provide you with a summary of what you told me to make sure that I understood you correctly. I will be in touch to talk about the summary and your reaction to it. De-identified data from your interviews may be used in future publications and presentations. At the end of the study, a summary report will be sent to you. You may also get a copy of the full report and/or your transcript, upon request.

Confidentiality

All identifiable research materials will only be accessed by Hanif Karim, the principal investigator and Dr. Sharon Koehn, advisor to the principal investigator. They will only be shared via secure means, i.e. in password protected files on an encrypted memory stick sent by secure mail. After the recording is transcribed, codes will be assigned to different parts of the stories you tell us. This allows us to compare your experiences with those of other people that we have interviewed. We will keep electronic versions of transcripts and reports of coding in password protected files on a password protected computer on a secure server at SFU. Similarly, all printed versions are kept in a locked room (in a locked cabinet) at SFU at all times. This material will be destroyed following the completion of the research project (August 2018)

C. RISKS AND BENEFITS

This research will give you an opportunity to talk about the relationships you experience as a nurse with the residents for whom you provide care. The results of this study will contribute to a developing body of research that highlights the value of relationality in residential care settings and the importance of having the necessary time and staffing levels to facilitate this. It is possible, however, that participation in this

project may bring up sensitive and personal areas of your life, and so you may choose to ask for a private meeting with the researcher to discuss any concerns that may arise during the interviews or stop your participation at any point during the process. Overall, the risks regarding emotional distress are acceptable given the value and benefits of the research.

D. CONSENT

Participant Consent

My signature on this consent form means:

□I have read and understood the information in this consent form.

□I have had enough time to think about the information provided.

□I have been able to ask for advice if needed.

□I have been able to ask questions and have had satisfactory responses to my questions.

□I understand that all of the information collected will be kept confidential and that the results will only be used for scientific purposes.

□I understand that my participation in this study is voluntary.

□I understand that I am completely free at any time to refuse to participate or to withdraw from this study at any time, and that this will not change the quality of care that I receive.

□I agree to have the interview for this research project audio recorded.

I acknowledge that this audio recording will be destroyed following its transcription

□I agree to have quotes from my interview used in future presentations, workshops or written publications related to this research project.

□I agree to have quotes from the research diary used for the purposes of the study, and in future presentations, workshops or written publications related to this research project.

□I understand that I am not waiving any of my legal rights as a result of signing this consent form.

□I understand that there is no guarantee that this study will provide any benefits to me.

□I would like to receive a summary of the report – optional

□I would like to receive the full report - optional

Please send me the report and/or summary (as selected above) by

Email at _____

OR

By mail to

_____
_____

_____
_____

I have signed this form on this date

_____ (year, month, day)

Participant Name (or initials) Signature

_____

Researcher Name Signature

Please keep one signed copy of this form for your records.

For more information, please contact:

Hanif Karim (contact info at top of consent form)

If you have any complaints about your rights as a research participant and/or your experiences while participating in this study, you may contact the Office of Research Ethics at SFU.

Appendix 2.

Ongoing Consent

STUDY TITLE: Nurse and Resident: Fictive Kinship in Long term Residential Care
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In order to ensure that participants consent to participation on an ongoing basis, I will begin each contact with the following script, even if I have already obtained written consent for the same participant. This process will remind participants of our respective roles and will take into account their feelings on a day to day basis.

I would like to talk to you about your experiences, opinions and feelings about the caring relationship between you and the residents you are providing care for. There are no right or wrong answers. You don't have to answer any questions you don't want to.

I would like to tape-record our interview so that I don't forget what you say. If you don't want me to, that is okay. I can take notes instead. Our conversation will remain private and confidential.

If you agree to participate in this interview, you can stop the interview at any time and it won't affect you. If you feel tired and/or emotional, we will take a break until you feel ready to continue.

Do you have any questions?

Do you mind if I talk with you today?

Appendix 3.

Recruitment Poster

STUDY TITLE: Nurse and Resident: Fictive Kinship in Long term Residential Care
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Participants Required For A Research Study

Image removed due to copyright considerations.

"The Enigma of Arrival and the Afternoon"
Original painting by Giorgio de Chirico…

•Are You A Full/Part Time Nurse At_____?

•Are You Interested in Participating in an Interesting Research Study?

If so I would love to talk to you about participating in a study looking at the caring relationship between nurses and resident

Participants will receive a $20 gift card as compensation for their time.

Appendix 4.

Letter to Executive Director

Dear Mr_____

My name is Hanif Karim. I am a master's student in the Department of Gerontology at Simon Fraser University. I have recently completed the ethics approval for my final research project (under the supervision of Dr. Barbara Mitchell and Dr. Sharon Koehn)—which will explore the phenomena of fictive kinship in the nursing care of the older adult population.

I am writing to inquire about the possibility of conducting my research at_____ This is a facility with an excellent reputation, staffed by a diverse workforce who provide high quality care and support for an equally diverse resident population. Such a setting would serve as an ideal caring environment within which to explore, and draw a set of conclusions about, the relational dynamic between nurse and resident.

My intention, during the active research phase would be to spend approximately 136 hours (17 shifts x 8 hours) at the facility—observing the interactions between nurses (eight in total) recruited for the study, and residents. Further arrangements would be made with these nurses to interview them (outside of work-time) to further explore ideas of relationality and (fictive) kinship in the context of care.

It is my sincere hope that it will be possible to undertake this research project at_____. To that end, I would be happy to answer any additional questions you have. I look forward to hearing from you.

With appreciation,

Hanif Karim

Appendix 5.

Interview Protocol

STUDY TITLE: *Nurse and Resident: Fictive Kinship in Long term Residential Care*
PRINCIPAL INVESTIGATOR**:** Hanif Karim MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS**:** BARBARA MITCHELL, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY SHARON KOEHN, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

1. How long have you worked at this facility?
2. What drew you to work in long-term residential care?
    a. Probe: are there other areas you've worked in – can you talk a little about how these areas differ to where you are now?
3. Can you talk about what your shifts are like?
    a. Probe: what tasks do you have to perform?
    b. Probe: what else do you have to do during the shift that's outside your job description/role?
    c. Probe: what matters most to you as you go about your shift?
    d. Probe: can you talk about the differences between days, evenings, nights (if applicable)?
4. There's quite a bit of nursing literature that talks about the importance of caring relationships in nursing work, what are your thoughts about this?
    a. Probe: how does that idea fit into your nursing practice?
5. Can you talk a little about your interactions with your colleagues during a shift?
    a. Probe: are these professionally focused? Are there opportunities for more personal exchanges?

6. Can you talk about your interactions with residents?
    a. Probe: what are you thinking about during these exchanges?
    b. Probe: what about emotions/feelings during these interactions?
7. Can you tell me about the words you typically use when you are addressing a resident?
    a. Probe: what does that expression mean to you?
    b. Probe: how do you think it's understood by the resident?
    c. Probe: how might it might be understood by another staff member/manager?
8. Are there residents you feel particularly close to – emotionally connected with?
    a. Probe: what did that relationship feel like?
    b. Probe: how do you think the resident experiences this relationship
9. Probe: are there other relationships in your life that have a similar quality to them?
    a. Probe: If you were to think back over the last few years can you talk about other residents who you've close to?
10. I'm also interested in whether you are thinking about your own family when you're providing care to the residents. For instance some nursing literature describes how workers are thinking about their own parents or other loved ones who are 'back home' as they are caring for residents – what are your thoughts about this? Is this an experience you have had?
    a. Probe: Can you say a little bit more about how you feel when this happens?

Appendix 6.

script to be read to residents

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Thank you very much for giving me an opportunity to speak with you. My name is hanif karim. I am a master's student in the department of gerontology at Simon Fraser University and I am also a nurse currently working full-time at the British Columbia Nurses' Union. I am about to start the research phase of my studies and have received permission to carry this out here – at X facility – and I wanted to tell you a little bit about my research and what I will be doing here.

The focus of my research will be to look at the type of relationships that develop over time between nurses and folks like yourselves – who live in long term care facilities. In my previous work – I was a nurse in a long-term care facility. Over time I got to know the residents very well and I used to look forward to going to work to see them. When I decided to further my studies, I thought it would be interesting to look at the kind of relationships that develop between nurses and residents in places like this. So, my research is looking at relationality. As a nurse – I'm curious about the experience of other nurses in these settings. So, this look at relationality and relationships is going to be from the perspective of nurses. How am I going to do this? Well, firstly, I am going to observe how nurses interact with the people who live and work here. Secondly, I am going to talk these nurses and ask them about their experience of relationality at work. And thirdly, I am going to ask them to keep a diary about their thoughts and feelings about their work and the caring relationships they have with the residents.

One of the reasons I want to do this study is because there has been very little research looking at the thoughts and experiences of nurses with respect to relationality but the research does seem to suggest that one of the factors that contributes to nurses remaining in long term care positions are the relationships they are able to forge.

What will my presence here mean for you? Well, hopefully I won't be a bother. You might see me sitting or walking in various areas around the building. I will probably be carrying a pen and notebook. You might see me making notes in my notebook. I want to reassure you, that I will not be mentioning any names or any other information that would make it possible to identify any of you. I have had to pass this entire process through the Office of Research Ethics at Simon Fraser University and have made it clear that all identifiable information will be removed from the data I collect.

I am looking forward to spending the next few weeks here. I would be happy to answer any questions you have – either now or whenever you see me. Again, I would like to thank you for giving me an opportunity to speak with you and to permitting me to be here – in your home.