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RESEARCH

Long-Term Care in Rural Alberta: Exploring Autonomy and Capacity for Action

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Context: Since the 1990s, Alberta, Canada has seen considerable restructuring to health and long-term care (LTC) services. Most LTC research is conducted in urban centres. As a result, little is known about the effects that restructuring has had on rural LTC homes.
Objective(s): In this article, we outline our findings related to autonomy and capacity for action in rural LTC homes.
Method(s): We conducted a multi-site comparative case study. Using rapid ethnography, we conducted weeklong site visits at three rural LTC homes. This involved two types of data collection: semi-structured qualitative interviews and field observations. We used a feminist political economy lens to analyze the data.
Findings: Our findings offer insights into how rural LTC staff are empowered to create change and/or constrained from doing so. We outline these findings at macro, meso, and micro levels of analysis and conclude that a combination of site-level and systemic factors contribute to a LTC home's level of autonomy and capacity for action.
Limitations: Our findings reflect experiences and observations at three LTC homes at three distinct points in time. Though the data provide rich descriptions, they do not provide an exhaustive account of the strengths and challenges of rural LTC.
Implications: Community resources, local industries, and other socioeconomic and organizational factors contribute to a community's response to LTC restructuring and their ability to make change and ruralize their LTC provision. These factors, and the heterogeneity of rural communities, should be taken into consideration during decision-making about rural health policy and service provision.

Keywords: Long-term care; rural; autonomy; Alberta; Canada

Introduction & Background

Since the 1990s, the Canadian province of Alberta has seen increases in both the demand for long-term care (LTC) services and the complexity of residents' health care needs (Suter et al. 2014). During this same period, the province's health system and continuing care sector have experienced considerable restructuring. In 1994, the provincial government abolished over 250 local hospital, long-term care, and public health boards and replaced them with 17 regional health authorities. In 2008, the regional health authorities were amalgamated into Alberta Health Services (AHS), a single provincial health authority. These developments were consistent with ongoing national and international trends towards reducing public spending on health care and a centralization of services (Bourke et al. 2012; Coburn, 2008; Joseph & Chalmers, 1996). Several scholars have documented challenges that the continuing care sector experienced following these transitions. For instance, they identified lower staffing levels, care worker burnout, decreased job satisfaction, rushed client care, and omitted tasks because care staff do not have sufficient time to meet the demands of their work (Keating et al. 2003; Cummings, Hayduk & Estabrooks, 2005; Knopp-Sihota et al. 2015; Chamberlain et al. 2018).

It is noteworthy that most LTC research is conducted in major urban centres. As a result, little is known about the state of rural LTC. This is concerning given that 17% of Alberta's population lives in rural communities (Statistics Canada, 2012) and rural health is 'much more than merely the practice of health in another location' (Bourke et al. 2012, p.499). Other Canadian scholars (Hanlon et al. 2007; Skinner & Joseph, 2007) have demonstrated that health care restructuring has had distinct implications for rural communities. For instance, restructuring has led to health care service centralization in urban centres, a withdrawal of government support services, and a limited amount of data on rural health and health services (Hanlon & Halseth, 2005; Fiske et al. 2012; Leipert, Leach & Thurston, 2012; Williams & Kulig, 2012). These changes have influenced the extent to which decisions about health and

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long-term care services and provision reflect the needs of rural Canadians (Herron & Skinner, 2018). Additionally, there are fewer LTC homes in rural regions and there are a number of rural-specific health care issues. Broadly, these can include: few transportation options, moving residents out of their home communities in order to access the first available and appropriate LTC bed, spouses or partners unable to find housing options near one another, challenges with recruiting and retaining health and LTC professionals and other staff, and the aging of rural workers and communities (Hanlon & Halseth, 2005; ICCER, 2013; ACCES, 2011).

Despite these issues, many rural communities demonstrate considerable resilience and provide excellent care and support for older adults (Keating & Eales, 2012). These strengths, as well as the challenges and opportunities of rural LTC, are underexplored. Our purpose in this comparative case study was to address this gap by exploring the care work performed in Alberta Health Services' (AHS) owned and operated LTC homes in rural parts of the province. In this article, we outline our findings related to rural autonomy[1] and capacity for action. These findings offer new insights related to how staff in rural LTC homes are empowered to create change and/or stifled and constrained from doing so.

Methods

In order to address the gaps identified above, we conducted a multi-site comparative case study (Yin, 2014). This permitted us to explore rural LTC at multiple sites and develop a rich understanding of the diversity of rural communities.

Site selection

After receiving ethical approval from our institutional ethics review board (Pro00067720) and operational approvals from AHS, we conducted weeklong site visits at three rural LTC homes. We purposively selected LTC homes located in Southern, Central, and Northern Alberta, respectively. We selected these specific sites because of the variation in terms of size (ranging from ~20 to ~50 beds), geography, local industries, and health zones within the provincial health authority. In order to maintain confidentiality, we do not name the sites. Participants were informed that we would not name the care homes or reveal individual identities, but that some potentially identifiable information about the locations might surface in the data. Eligible sites met the following inclusion criteria: they were self-identified as 'rural', met the Statistics Canada (2001) definition for 'rural and small town' (a population under 10,000 and at least a 60-minute commuting distance from major urban centres), and were receptive to participating in the research for one week.

Rapid ethnographies

For the weeklong site visits, we conducted rapid ethnographies (Baines & Cunningham, 2013; Armstrong & Lowndes, 2018). This form of ethnography involves collecting data from multiple sources over a relatively short period of time (Charlesworth & Baines, 2015). This method is beneficial because it reduces the burden of case study research on health care organizations (Charlesworth & Baines, 2015).

Prior to data collection, the Principal Investigator (PI) contacted the management at each care home and sent information about the study for managers to share with staff and residents. Upon arriving at each site visit, the research team introduced ourselves to the staff at morning report or shift change, and introduced ourselves to residents at mealtimes. The site's agreement to participate included agreement to being observed for the week. Those who were not interested in speaking with us directly did not volunteer for interviews. Our process involved two types of data collection: in-depth interviews (n = 90) and field observations (~200 hours). We conducted semi-structured interviews with anyone who provided paid or unpaid care in the LTC home and was willing to participate. We informed participants about the study and their rights, and then asked them to sign consent forms prior to their participation in interviews. The interviews were approximately 30–60 minutes in duration, digitally recorded, and later transcribed verbatim. Participants were asked about how care work is organized, care team dynamics, and the role of the LTC home in the local community.

For the duration of each site visit, we had rotating shifts of two research team members (investigators and Research Assistants [RAs]) observing the day-to-day activities and dynamics of the care home. Observations took place between the hours of 7am-11pm, concurrent with the interviewing. Our observations were confined to public areas of the home (hallways, dining areas, social and event spaces). As unobtrusively as possible, we observed the use of physical and social spaces, the rules and routines of the home, the daily events and activities, the décor and signage, public documents such as schedules or policies, and interactions between people. We did not shadow individuals. We recorded field notes related to our observations, interviews, and reflexive processes.

The multiple forms of data collection allowed us to both hear people's accounts of the care home dynamics and observe these dynamics in action. By spending full days in the care homes, we quickly built trust and rapport with staff and residents. We used concurrent member checking at each site to ask participants if our observations seemed accurate. Interviews were transcribed by a professional transcriptionist. Members of the research team reviewed and then coded the transcripts and field notes using Braun and Clarke's (2006) approach to thematic analysis.

Each of the investigators had both personal and professional experience with continuing care settings. All of us had done research in urban long-term care homes. Our disciplinary backgrounds are in health policy, nursing, and therapeutic recreation and our student RAs came from nursing, social work, and public health. We reflexively acknowledged that our training provided us with a range of contextual knowledge and also informed our analyses of these cases. We navigated this through daily team debriefs at our 'shift change', incorporating reflexive notes into our field notetaking, and a lengthier debrief after each site visit. The mix of disciplinary knowledge and professional experience led to rich conversations where we were able to offer one another critical insights about

the data and also question certain assumptions. We identified key themes for each site. We then used those themes and the methodological lessons learned to refine the research design and interview guide for subsequent sites (Yin, 2014). When all three site visits were complete, the PI and co-investigators performed a cross-case comparison of themes (Yin, 2014). This involved mapping out the three to five main themes from each site visit, discussing the similarities and differences, and identifying overarching themes across the data sets.

After the site visits, one of the three sites invited us to return to share our findings. After sharing the findings with this care team, they told us that the themes we had identified resonated with their experience. We also shared our findings with members of the AHS rural continuing care leadership team, who similarly indicated that these findings reflect the issues that they observe in their work. In this article, we examine the findings related to one of the overarching themes: rural autonomy and capacity for action.

Methodology

A feminist political economy (FPE) framework (Armstrong & Armstrong, 2005; Mutari, 2000) informed this research. FPE was used in determining the area of research focus (rural care work), case study method, and theoretical analysis of the findings. We chose this framework because it calls attention to divisions of labour, intersections of formal and informal labour, and the conditions in which work is performed. Feminist political economists emphasize the contexts and constraints within which people work, as well as the tension between structure and agency (Mutari, 2000). This tension highlights the reality that people make choices about their work and their lives, but not in social, economic, or political conditions of their choosing (Armstrong, 2001). This perspective is particularly appropriate for exploring LTC work in the context of rural health care restructuring:

> 'Since the late 1980s, political-economy approaches have become a common means of understanding how institutional, political and economic structures shape both provision of and access to care in rural areas' (Herron & Skinner, 2018, p. 269)

The divisions between formal and informal labour and personal and professional life can be ambiguous in rural settings (Simpson & McDonald, 2017). As a result, rural dynamics can amplify or ameliorate some of the care work challenges identified in urban settings. Rural settings also tend to have more traditionally gendered workforces, with women doing the majority of the health and LTC/social care work (Leipert, Landry & Leach, 2012). By examining our findings through this lens, we were able to identify matters of power and autonomy at multiple levels of insight (Vosko, 2002).

Findings

In this section, we share participants' accounts of navigating the tension between structure and agency in rural LTC work. Participants at the first site predominantly told a story of empowerment and adapting policies and practices to suit local needs. Whereas, we heard from participants at Sites 2 and 3 that they felt more constrained. The participants in these latter sites described urban-focused policies and practices that did not meet their needs and a growing centralization of services in larger city centres. Participants at all of the sites indicated that they were affected by changes in macro structures (see below), but they each navigated this in their own distinct way. In what follows, we discuss our findings at macro, meso, and micro levels of analysis.

The macro level context for care

Across all three sites, participants spoke about macro level issues that influenced rural LTC. These included the closure of rural health care services, the centralization of services in larger urban centres, and the impact of local resource industries.

Closure of rural health and LTC services

Over the past three decades, economic restructuring and urban-based efficiency models have led to the closure of many health and social services in rural Canada (Halseth & Ryser, 2006). At Site 1, we heard several times about the closure of a nearby LTC home that had provided specialized dementia care. Several staff members and residents had migrated from that home to Site 1's LTC home as a result of the closure:

> 'I've been here 40 years. In that time, I had the opportunity to work at [site] which was a dementia unit, but was closed down here about four years ago' (Manager, Site 1).

> 'I'm still annoyed with [former premier] for closing down [rural LTC home in the region]. They gave it a clean bill of health, wonderful facility, the patients and families loved it, and then just shut it down. They just do things without realizing the ramifications. The people in small towns, they're there for a reason. They don't want to live in the city. And it makes it difficult for the families' (Family Member, Site 1).

This neighbouring LTC home was closed because the building required upgrades that the health service agency determined were too costly. The loss of this LTC home with specialized dementia care and the relocation of its residents had implications for families who wanted to visit residents regularly and for residents who wanted to be close to home and in familiar settings. When speaking about the need for more LTC funding, the manager of Site 1's care home spoke about how dementia care requires additional investment. Site 1 did not have a secure dementia unit.

> 'So any behaviour problems, any wandering, confusion, that kind of thing, takes a lot more resources and that's not recognized. We need more resources to handle those. And we're getting more complex patients and more dementias [sic] in long-term care than we've ever had in the past' (Manager, Site 1).

Site 1's staff members provide care for residents with dementia to the best of their abilities, but when their needs exceed the site's capacity to meet them, those residents must relocate to a privately owned and operated LTC home nearby or seek out other arrangements. The closure of the public LTC home in the neighbouring rural community meant a loss of specialized care services and reduced capacity for the region to care for residents who have more complex care needs, sometimes requiring them to move to other communities.

In short, the closure of rural LTC homes can have profound impacts on their communities and the surrounding regions. Our findings reinforce concepts from the extant literature about the neoliberal logic regarding investment-worthiness and efficiency that informs health care funding and policy decisions, and its implications for rural settings (Brassolotto et al. 2018). The closure of rural care homes can reduce the autonomy of rural citizens because it limits resident and family member choice about where to live in order to receive necessary care.

Centralization in urban centres

At Site 3, we heard a great deal about the centralization of services in urban centres. For instance, several participants told us that staff scheduling, residents' laundry, and even residents' petty cash were all managed by 'others' in larger cities. The managers of various disciplines were also located elsewhere. For instance, the manager of housekeeping services and the manager of rehabilitation medicine and therapies were located in a city two hours away. The recreation therapist informed us that she reports to an offsite manager with whom she only speaks monthly, and who does not have a good understanding of what therapeutic recreation is. With respect to the offsite staff scheduling, we heard:

> 'It's called electronic scheduling and it's out of [major city] and they don't get how we [work or what we need]. First of all, we don't have pools of people [to call in from a casual pool], but when you have two separate units, you need two nurses. They're still having problems understanding this – and they'll just phone you and say, "Well you only have one nurse tomorrow"' (Registered Nurse, Site 3).

This scheduling arrangement meant that staff at Site 3 often worked short-handed. Participants reported that the centralization of services and management led to feelings of frustration because they felt distant managers lacked understanding of 'how things work in rural'. Staff members at Site 3 also expressed feelings of disempowerment due to their limited capacity to address problems that surfaced in the care home. Several Health Care Aides (HCAs) mentioned that because residents' laundry was cleaned offsite, items of clothing would regularly get lost or take weeks to be returned. Residents and family members would complain about this, but there was little that the staff could do to remedy the situation.

Similarly, at Site 2, one of our research team members noted the frustration expressed by staff members who were required to confer with administrators in a larger centre as a part of day-to-day operations

> 'There are questions about a newly admitted resident's medications, and [nurse] asks, "didn't [City] fax that?" (with an exasperated tone). I heard some of this yesterday as well…[City] is talked about like a person, and not a very well-liked one at that. "I suppose we will have to check with [City]" "I suppose that [City] thinks we will just have to figure that out on our own" "What did [City] say?"' (Site 2 Field Notes, Co- investigator).

Several Site 2 participants expressed similar frustrations about how individuals and organizations in larger urban centres make decisions that trickle down to them. They indicated that instructions and regulations came from larger cities and were not always applicable in the rural context.

> 'I also believe that there are policies that are made wherever that don't even apply here. And it's like, okay, well, great, that's a wonderful policy, but it doesn't even apply to us. But it's a policy that we need to know and conform to' (HCA, Site 2).

In sum, the centralization of services in urban centres may have had benefits in terms of cost-savings and efficiency, but several participants suggested that these arrangements had negative implications for their job demands and their autonomy in addressing common workplace challenges in LTC settings. These participants were constrained from adapting policies to suit their local needs and limited in their ability to address problems at the site level.

Impacts of the local resource industries

Resource extraction industries such as oil and gas, logging, mining, or agriculture can have considerable health, social, and financial impacts on rural communities (Hanlon & Halseth, 2005). However, these impacts are rarely discussed in the context of continuing care provision (Brassolotto et al. 2018). At Sites 2 and 3, we heard about how changes in the local resource economies affected their communities and LTC homes. These changes had implications for staff retention, community resources, and the survival of the communities themselves.

> '[our town] is getting smaller and smaller where it kind of looks like maybe one day the hospital will be all that's here. I don't know, it's kind of become a ghost town in the last few years… Stores on [the main street] have been closing down…a lot of people have no reason to move up here. When this place was booming it was because oil was booming, you know? Now you drive around and there's houses for sale on every street. People aren't buying in this area. People don't want to buy in this area; they have no need to live here' (HCA, Site 3).

> 'The area was established as a mining town. So, I think for the most part, [town] has held on to that history of mining. Though the mines within [town] itself are now closed... The largest employer right now in [town] is our health care facility' (Zone Director, Site 2).

In both of these cases, there was concern expressed about loss of growth and future investment in the community. At Site 3, several participants mentioned that because their town was fairly remote and perceived as being in decline, there was a fair amount of staff turnover at the LTC home. One participant told us that some nurses would use this site as an opportunity to get a 'foot in the door' with Alberta Health Services and then later transfer to larger centres. This contributed to challenges with staff retention.

The primary industry for Site 1's community was agriculture. This site benefited from having a more stable local industry and, therefore, additional community resources. They had more well-resourced charitable organizations and more longstanding staff members than Sites 2 and 3. During our visit, Site 1 was undergoing renovations for an expansion to the care home's health complex. The expansion would not have been possible without community fundraising (Manager, Site 1). Additionally, several staff members who were also local farmers had worked at Site 1 for over 30 years. This provided considerable institutional knowledge, strong community connections, and consistency at the site. These factors empowered Site 1 staff and supported them in making changes that they felt were necessary at the care home. The ample community resources made them less reliant on the larger health system and created a number of informal caring systems and supports within their community.

In short, the local resource industry at each site had implications for their capacity for action. In the setting where resources were plentiful, capacity was enhanced. In contexts where the local industries were in decline, the care homes also experienced social and economic effects. Thus, the socioeconomic context exerted considerable influence on the level of agency that managers and care staff members had in these care homes.

Meso level: local health care needs and responses

At the meso level of analysis, we considered the formal and informal programs and actions taken to support care needs. Local health responses include health services, programs, perceptions of need, and the availability of resources and infrastructure (Bourke et al. 2012). We noted that perceptions of need and the availability of resources varied considerably across these three communities. In particular, the degree of volunteer and community involvement and the proximity to other support services constrained or enabled a LTC home's ability to respond to local needs.

Involvement of volunteers and informal carers

In the context of ongoing fiscal restraint and austerity, the LTC sector relies heavily upon informal care work to supplement and enhance formal care (Baines, Charlesworth & Daly, 2016). This was reflected in our findings. Site 1 had a robust volunteer workforce, primarily made up of women, that enhanced quality of life for residents and increased programming capacity. We heard about and observed support from several local community groups such as 4-H (a youth leadership organization), faith-based organizations, Rotary, Lion's Club, and others. This allowed the site to offer exemplary programming and social activities for residents and alleviate some of the strain on paid care staff.

> 'Oh we have amazing volunteers, we really do... We have people that volunteer in the garden; they come and help us with a big clean-up in the spring, clean-up in the fall. They visit with the residents. We have the Ladies Auxiliary, some of them come help out with birthday parties... They're so awesome to donate their time. We also have a group of ladies that come in and they sing. And they're all friends. They usually know one of the residents, or have known them in past, and they'll come by and volunteer and stay and have a drink and visit with the residents. They are amazing' (Recreation Therapist, Site 1).

The informal care work at Site 1 was described by several participants as being the result of the LTC home acting as a community hub. It was not described as conscripted care, in which staff or family members were obligated to fill gaps in formal care. This volunteer work was described as supplemental and an enhancement to care. For instance, a housekeeping staff member told us:

> 'And even if I didn't work here, I'd always come visit and stuff. I come here when I'm not working too. And lots of the other ladies do too. Like, I know when I'm working on weekends some of my coworkers come in and just check in' (Housekeeping, Site 1).

This sense of the LTC home as a community gathering place increased the capacity of the site to engage volunteers in the life of the home. By way of contrast, Site 2 did not have many volunteers, and participants framed community more as a limited external pool of volunteers than as a social nexus of which the care home was an important part. They had a greater perception of need and less ability to meet it.

> 'We would love more volunteers. We have so minimal and it would be great to have more because we need – that's where the residents really need that extra piece to help when reading a story or playing music or be there when they're just visiting and we don't have as many as we'd like. I think because you have such a small community... people get volunteered out. There's only so much of a pool of those individuals that can be that supportive and I'm not finding that we have that' (Manager, Site 2).

Not having volunteers is significant because these informal care providers can, and do, make a difference to the health and well-being of residents in LTC (Barken & Lowndes, 2018; Casiday, Kinsman, Fisher & Bambra, 2008). As our participants noted, volunteers in LTC augment the care of residents by providing a variety of services specifically aimed at meeting residents' social, emotional, and spiritual needs. Though care staff members recognize the importance of meeting these needs, they often feel unable to engage in these tasks, which may be considered to be 'above and beyond' what is required due to time constraints and work-priorities. As a result, these resident needs can go unmet, which can also cause moral distress for care staff. It is for this reason that a robust volunteer program has implications for improving living and working conditions in care homes.

A resident at Site 3 told us that being in an isolated community meant that a lot of responsibility for care is placed on community members instead of on the health care system. She used the example of exercise bikes that were available to residents, but could only be used with the supervision/support of family members or volunteers. Only people who had visitors could use this equipment and, as a result, it did not get used most days. This was confirmed in our observations and other interviews.

In short, the availability of volunteers can shape a LTC home's capacity for action and significantly influences care staffs' perceptions of need and ability to meet those needs. As Skinner (2008) notes, the growing dependence on voluntarism in rural LTC 'will only exacerbate the uneven geographies of health and social care across rural space' (p. 119). As such, inequities such as the ones we observed between the three sites, will be amplified.

Location and access to regional health care resources

Each of the three sites experienced some degree of geographic isolation but there were differences in their proximity to larger centres and the availability of other services (e.g. mental health supports, dementia care units, and rehabilitation services). Site 1 was within 1.5 hour driving distance to two larger cities, which made accessing specialists and other services relatively easy. There was also a private LTC home nearby to which they could refer residents who demonstrated complex behavioural and psychological symptoms of dementia. Site 2, however, was at the edge of the provincial boundary and rather isolated from the provincial health authority. Their town is accessed via a highway that would often close during inclement weather. This had implications for staff attendance and emergency preparedness.

> 'We get impacted by weather – storms, forest fires... There's no way to go in or out., So, I mean a good example is that huge grass fire [we had] and we're on evacuation notice. We didn't know if we're going to be evacuating or not... And it's roads. Some [staff] can't make it, so then you're dealing with whoever's in town. If there's a really bad blizzard, they can't drive on the roads. And so rurally, it's hard to get to work. So then, they're scrambling to find anybody who can work that's in the town. It's difficult' (Manager, Site 2).

A member of the maintenance staff similarly described difficulty with getting tradespeople out for service work in this area and an HCA said the same about health care specialists. As a security staff member said, 'I think it's just our isolation, we're like a forgotten part [of the province] and the population has declined here' (Security, Site 2).

Site 2 did not have any other care homes nearby and, as a result, they had no choice but to accept residents with a wide range of needs. For instance, they admitted a number of residents with mental health diagnoses who could not receive adequate support in the community or in supportive living homes (Manager, Site 2). The manager noted that the site often required assistance from the psychogeriatric team, but that it could take six to eight weeks to get them out from the city for a visit. Furthermore, there had been no additional mental health training or education for their nurses and HCAs. Participants at this site reported having fewer resources available at their disposal and a great perception of need.

Site 3 was the most geographically isolated. This had implications when residents required services beyond what the LTC home and auxiliary hospital could provide:

> 'Access to specialized care is unfortunately limited by our location. Say for example, a client needs to go to [major city] for an appointment. If you were located in [major city], then you hop into a bus or whatever, and 20 minutes later you're there. Whereas for our clients, it's a six hour drive in a bumpy ambulance. Six hours one way and six hours back, that's taxing for a person who is healthy not requiring care, but a person who is requiring a high level of care already has chronic pain, already has tons of anxieties, that's almost an insurmountable amount for many of our clients' (Occupational Therapist, Site 3).

Considerable travel distance to many health and social services limited their ability to meet specialized care needs. In short, geographic location and access to regional health care resources affected care staff's capacity to deliver programming, address site needs, and meet the diverse care needs of residents.

Micro level experiences of rural LTC work

At the micro level, we heard about individual experiences of providing care in these rural LTC contexts. The micro level responses generally fell into two categories: ruralisation and rigidity. Ruralisation reflected a pattern of willingness and adaptability around practices to suit the needs of rural LTC. Rigidity reflected a pattern of care provision in a context of constraint.

Ruralisation

At Site 1, we were introduced to the term 'ruralisation.' We were told that ruralisation is the process by which the care home has opportunities, within AHS guidelines and

standards, to customize policies and practices to the rural context. These changes were seen as necessary to meet the community's needs and be consistent with the facility's resources. Site 1 also benefited from having their manager involved with the Program Specialists office for Seniors Health in rural regions; this provided them with a connection to the provincial health authority and a voice at the regional level. In this role, the manager was directly involved with developing a Rural Continuing Care Policy and Procedures Manual (a ruralised document related to palliative and end of life care). In addition to reviewing this document, we heard about more informal ruralisation practices, such as doing away with set visiting hours and permitting community members to visit at any time. As a result of the agency that Site 1 was able to exercise, participants expressed fewer perceptions of unwelcome centralised organisational oversight:

> 'Somehow you don't feel [micromanaged] so much here. You don't feel that overhead, that big brother staring at you. We go to one manager or the other and then they deal with all the upper management [from AHS]. I think when you work in the city in a bigger centre it just feels very corporate. When I worked in [large city] it was very different' (Registered Nurse, Site 1).

Site 1 demonstrated considerable agency in the face of rural restructuring and they adapted policies and practices to suit their needs. Although we had heard that working short-staffed was the norm at Sites 2 and 3, Site 1 participants reported that this was rare for them. Their management came up with a range of ruralised strategies to avoid this:

> 'Another thing that we do in rural, just so you know, is we allocate a pocket of money so that if we hire someone that has no HCA certification, we provide it for them. They can do it on the job. It's on their time to do the studying, to write the exams, but when they come in to do their practical exams, we'll pay them that day to do that and we pay for the tutors… because we weren't getting HCA certified people out in rural, right? You just couldn't hire them' (Manager, Site 1).

The manager also implemented a practice of extending shifts to avoid working short-staffed and built the related overtime hours into the budget. There was a sense that the care home operations were not micromanaged by the provincial health authority and participants perceived that they were trusted to make decisions to best serve their community.

Rigidity

At Site 2, we observed more restrictive management approaches, adherence to hierarchy, territoriality, and risk aversion. We witnessed restricted autonomy for residents, family members, and staff. For instance, there were care home policies prohibiting anyone from bringing in outside food (HCA, Site 2), barring residents from folding towels for the stated purpose of infection control (Registered Nurse, Site 2), and disallowing resident use of the outside courtyard without a companion (and as a result, it did not get much use) (Occupational Therapist, Site 2). At Site 2, the hierarchical approach that participants described at the organizational level was reproduced in power dynamics at the site level (amongst management, nurses, HCAs, and residents).

> '…there's the big RN vs. LPN clash and there's a real hierarchy system going on here. So that's a huge challenge… And I do find that with a lot of RNs here. And then we run into "Well, I'm going to report you for insubordination [for disagreeing about the appropriate use of an antipsychotic medication]"… Like, just because you're an RN and I'm an LPN? I'm just as much a professional as you are. So, that's one of our huge challenges here' (Licensed Practical Nurse, Site 2).

Furthermore, Site 2's recreation therapy program emphasized 'therapy' over 'recreation'. The program was the exclusive territory of the recreation therapy staff, largely because of an operant assumption that every activity had to be therapeutic (i.e., rehabilitative) in nature. There were fewer social and/or spontaneous activities to simply enhance residents' experience of joy and quality of life, and no latitude to include other staff in activities. This territorial approach seemed to be inextricably intertwined with the need to maintain some level of control in a chaotic environment. The disempowering effects of this approach, however, were expressed as feelings of moral distress by several participants at this site. Participants expressed sadness at their inability to do what they felt to be right by their residents, because of constraints in the environment. Participants from all demographics expressed a sense of constraint, for example:

> 'Give the frontline care workers latitude to do what they think is best, and that's totally different [than what they do] right now. Everything's got to be by the book… but scrap that, do what's right' (Family Member, Site 2).

> 'We've had a recent cut in the budget. So, we've lost some LPN lines. We did get that reduction. I did reduction in my RNs too. So, budget cuts have been huge. It's harder and harder to get things for the residents. Like, okay, we need to get mattresses because all mattresses are old, but we have no money. There's no money in the budget. So where do you get this money from? It's just really hard to get stuff that I need for the people who we care for. And there are budget cuts as well as within staffing and equipment and resources too' (Manager, Site 2).

We observed that creating contexts of empowerment, trust, autonomy and respect for rurality had profound implications for the staff and residents in LTC homes.

When such contexts were nurtured, staff felt empowered to solve problems, able to shape their work to be responsive to the needs of residents, and residents experienced a richer, more vibrant life inside their home. By way of contrast, contexts that were more focused on control resulted in disempowerment, territoriality and hierarchy in care provision, and restrictions on the variety of experiences for residents—all in response to a perceived lack of trust to meet accepted standards of care without central oversight. Our participants were aware of problems but many of them did not feel that they had the power or resources to effectively address them. This is not divorced from the meso and macro level contexts discussed earlier.

Discussion

Our findings suggest that a combination of site-level and systemic factors contribute to a LTC home's level of autonomy and capacity for action. These findings reinforce the extent to which rural communities are not only distinct from urban settings, but also from one another. Ramp (1999) describes rural settings as 'contexts for action', emphasizing opportunities to make change and the benefits of smaller size for civic and community engagement. This was reflected at Site 1, which provided a positive example of what is possible for rural LTC. However, the comparative case study provides context for why particular strategies may yield different outcomes in other rural communities. Geographical differences certainly played a role in shaping LTC home autonomy, but a feminist political economy lens drew our attention to other important considerations as well, that is political, social and economic factors that shaped the agency of local actors. Community resources, local industries, and other socioeconomic and organizational factors contribute to a community's ability to make change and to ruralize their LTC provision. Experiences of restructuring will thus be diverse and context-specific.

At the macro level, our findings are very consistent with the themes identified in the rural health literature regarding the implications of cuts to care services, closures of rural care homes, centralisation of services in larger urban centres, and an economic environment that leads to increased reliance on unpaid care from family members and volunteers. (Herron & Skinner, 2018; Hanlon et al. 2007; Fiske et al. 2012; Joseph & Chalmers, 1996). Health care restructuring is part of a larger political and policy shift in the Global North associated with an increasing withdrawal of state support, growing privatisation, and the shifting of responsibility for care to communities and families. 'Although the impacts of restructuring are not specific to rural populations, the characteristics of rural communities … can significantly exacerbate problems and rural–urban disparities' (Thein & Dolan, 2011, p. 27). This was evident at the meso level, where we observed that communities who heavily rely on resource extraction are affected by boom/bust cycles and changes in the global economy, which then have implications for their LTC homes. Proximity to other regional health services was also significant for rural LTC homes' ability to support residents' changing needs. Sites 2 and 3 had residents with more complex care needs because of the lack of other services (e.g., mental health supports) in their regions, but they were not provided with additional resources or training to support these diverse needs.

Our findings also reinforce the increasing reliance on unpaid and volunteer work in LTC. Site 1 benefited tremendously from the involvement and labour of non-profit groups and volunteers. As our participants noted, most of these volunteers were women. Since women perform the majority of paid and unpaid care work in rural settings, they are the ones most affected by health care reforms (Thein & Dolan, 2011). 'Urban-oriented policies often assume not only the existence of family members to assist in care (typically women), but also the existence of various community facilities which in actuality may or may not be available or supportable in rural localities' (Ramp, 1999, p. 8). Indeed, we observed a systemic expectation that when health care resources are limited, informal family, community, and volunteer services will fill in the gaps. The ability to do so depends, of course, on the resources of that community. As we saw, only one of the three communities in our case study was able to fill these gaps in a sustainable way. Individuals and communities with more resources and in closer proximity to services will be better able to respond to changing conditions and rural restructuring; however, inequities at micro and meso levels will be amplified as a result. The organization of LTC work at a sectoral level will thus have distinct implications in rural settings.

At the micro level, we observed the tension between structure and agency at work. We identified the ruralisation approach as a promising way to exercise agency within urban-oriented policies and systems. However, site personnel may not be aware of their abilities to ruralise policies and procedures. Although ruralisation was commonplace at the first site, Sites 2 and 3 appeared to be unfamiliar with the term 'ruralisation' and did not have any such documents or practices. When residents, family members, and staff members at Site 1 were trusted by their site leadership and the health service agency to exercise choice and be involved in decisions about the home's policies and practices, we witnessed much more investment in the work and better quality of life for those who lived and worked there.

As Thein & Dolan (2011) have pointed out, '[p]ower is implicated in relations of health and place' (p. 36). Though there has been a devolution of responsibility for care to rural communities, there has not been a corresponding increase in authority. We observed that at sites where power flowed down a hierarchy, there were constrained and disempowered participants, moral distress, low morale, and a focus on managerial and sector level priorities. When power was distributed through collaborative ruralisation efforts, residents participated in decision-making about their lives and their activities, staff were flexible and responsive to local needs, and care teams worked together to address challenges in creative and/or innovative ways. Power can thus be enabling in rural settings,

'… where the actions and leadership of individuals can change models of care, alter approaches to practice, develop innovative projects, or, at a structural level develop improved health systems and/or demand political recognition and resourcing. Existing political, economic, cultural and social structures provide established systems of action, ways of communicating and ways of knowing which are simultaneously constraining and enabling' (Bourke et al. 2012, p. 501).

Study limitations

Our findings reflect experiences at selected rural care homes during a snapshot in time and they are not representative of all rural Alberta. Our use of rapid ethnography meant that we spent less time at each site than we would in traditional ethnography. However, given the travel required to get to these rural sites, longer stays and repeat visits were not feasible. Additionally, we only visited AHS-owned LTC homes. For all these reasons, we know that the fit of our findings with other settings and points in time is an open question. Notwithstanding these limitations, this research is an important addition to the literature related to rural LTC.

Conclusion

In this study, we undertook rapid ethnographies at three rural care sites to examine rural perspectives on LTC issues. Our findings suggest that LTC homes are crucial for and closely entwined with rural communities. LTC planning needs to account for rurality not only as a geographic consideration, but also as a social determinant of health that, if left unconsidered, may exacerbate the effects of socioeconomic disadvantage, limited service availability, and more hazardous environmental and transportation conditions (Smith et al. 2008). A feminist political economy framework provides us a way of understanding rural LTC as integrated with broader systems, structures, and ways of knowing. We have identified macro-, meso- and micro-level factors of rurality that, from the perspective of the sites in this study, need to be explicitly considered when organizing rural LTC services. In addition, we have developed an understanding of the contexts shaping care work in these three settings that can be compared to other rural services to develop a more specifically rural LTC evidence base.

Note

[1] When we speak about 'autonomy', we are not referring to 'isolated, self-reliant moral selves' (Mahon & Robinson, 2011). Instead, we refer to a form of relational autonomy that is common in critical rural health scholarship (Simpson & McDonald, 2017; Herron & Skinner, 2018) and in care work scholarship more broadly (Thein & Dolan, 2011; Daly, 2013). This concept of relational autonomy accounts for the fact that (particularly in rural settings) individuals, communities, and systems are interdependent; a matrix of relationships informs our decision-making and thus shapes and/or constrains actions at macro, meso, and micro levels.

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Competing Interests

The authors have no competing interests to declare.

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