Recreation Services and Quality of Life in Continuing Care in Alberta

Submitted to Alberta Health

27 August 2015

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INSTITUTE FOR CONTINUING CARE EDUCATION & RESEARCH

UNIVERSITY OF ALBERTA

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ACKNOWLEDGEMENT

The Research Team would like to thank Alberta Health, Continuing Care Branch for their financial support in order to conduct this study.

Alberta Government

RESEARCH TEAM

Principal Investigators
Dr. Gordon Walker, University of Alberta
Dr. Robert Haennel, University of Alberta
Project Management
Ms. Sandra Woodhead Lyons, Executive Director, ICCER
Research Assistants
Ms. Maya Hari-Kishun, University of Alberta
Ms. Emily Dymchuk, ICCER
Ms. Janet Mayhew, ICCER
Dr. Heather Moquin, University of Alberta
Ms. Taoting Li, University of Alberta
Ms. Anne Le, Bethany Care Society
Research Team
Ms. Francine Drisner, CapitalCare
Ms. Renate Sainsbury, Lifestyle Options
Ms. Jennifer Grusing/Ms. Marilyn Willison-Leach, AgeCare
Dr. Vincella Thompson, Keyano College
Ms. Gail Thauberger, Bow Valley College
Ms. Bev Suntjens/Dr. Craig Hart, NorQuest College
Ms. Sarah James, Alberta Therapeutic Recreation Association

EXECUTIVE SUMMARY

Background and Methodology: In 2014, Alberta Health asked the Institute for Continuing Care Education and Research (ICCER) to develop a research proposal examining recreation services and quality of life (QOL) in supportive living (SL) and long term care (LTC) facilities in Alberta. After ethics approval was obtained, three separate studies were conducted.

Study 1 investigated who specifically provides recreation services in Alberta CC facilities using an online survey. To do so, a list of CC facilities was generated using the Alberta Health accommodation search page in conjunction with personal contact of CC facility operators by ICCER representatives. Of the 65 sites that participated, 38 (58%) were SL, 21 (32%) were LTC, and 6 (9%) were both. Results indicated that the majority of Full-Time Equivalent employees providing recreation services were, respectively, Recreation Therapy Assistants/Aides (31%), Health Care Aides (24%), and Recreation Therapists (17%). In contrast, the majority of Part-Time Equivalent employees providing recreation services were Recreation Therapy Assistants/Aides (52%) and Health Care Aides (23%).

Study 2 investigated how frequently CC residents participated in various types of recreation; who organized/facilitated their recreation services; and how satisfied residents were with their recreation. In addition, residents reported their QOL in terms of positive (e.g., calm) and negative (e.g., sad) affect, and life satisfaction. Statistical analyses were conducted to ascertain what factors impacted CC residents' overall recreation satisfaction as well as what factors influenced their QOL. To do so, an on-site survey was developed and then modified based on recommendations from two focus groups composed of CC recreation staff. Invitations were sent to CC facilities through various sources (e.g., Alberta Continuing Care Association, Alberta Seniors Housing Association, Alberta Health Services, Seniors' Health Zone Directors, ICCER membership). Trained research staff collected survey information from CC residents.

A total of 359 participants (SL, 47.1%; LTC, 52.9%) provided sufficiently complete information for the planned statistical analyses. Participants reported that: (a) they most often engaged in media activities, followed by social, relaxing, and exercise activities; (b) the recreation activities they participated in were most frequently organized by the resident staff, followed by self-organized, and then by family and friends; (c) their social and relaxation recreation needs were the most fully satisfied; and (d) overall, positive affect was slightly above the "Sometimes" mark; negative affect was slightly above the "Seldom" mark; and life satisfaction was marginally closer to the "Slightly Agree" than the "Neutral" mark. Consistent with recreation and QOL research (Kuykendall et al., 2015) and theory (Newman et al., 2014), frequency of recreation participation overall was found to have a significant, substantial, and positive effect on recreation satisfaction overall, above and beyond various socio-demographic factors. Also having significant and positive impacts on recreation satisfaction overall were (in decreasing order); whether: (a) the resident organized the recreation activity but the recreation staff facilitated it; (b) the resident organized the recreation activity on their own; and (c) the recreation staff organized the recreation activity. These findings suggest that residents might not only benefit from more frequent recreation participation but also by how their recreation services are organized/facilitated. The latter proposition is further supported by the finding that, if the resident organized the recreation activity but his or her family and/or friends fostered it, the resident's recreation satisfaction overall decreased. This may have been because residents perceived their autonomy was being "thwarted" (Deci & Ryan, 2000)—an issue that potentially could be ameliorated by having recreation staff trained in facilitative techniques work with residents' spouses, children, etc. Finally, overall recreation satisfaction was found to have a significant, substantial, and positive influence on both positive affect and life satisfaction, above and beyond various socio-demographic factors.

Study 3 investigated CC recreation staff's perceptions of residents' recreation and QOL. To do so, seven focus groups were conducted across Alberta. Six major themes were identified, with: (a) funding related issues (e.g., lack of funding); (b) staffing related issues (e.g., lack of staff, inconsistencies in staff training and education); (c) role clarity related issues (e.g., recreation activity provision vs. therapeutic recreation interventions, how recreation therapy differs from occupational therapy and physiotherapy therapy); (d) professionalism related issues (e.g., recreation being perceived as being "shunned and discredited"); (e) program related issues (e.g., diverse and complex populations); and (f) a lack of consensus on what QOL is and how it relates to CC residents' lives. Based on focus group findings, funding appears to be the overarching issue for CC recreation staff, regardless of role or organization, as it has a direct effect on staffing and programming and, in turn, it impacts role clarity, professionalism, and QOL.

Summary: Recreation services play an important role in improving or maintaining residents' quality of life. Recreation activities need to be resident-value driven and not organization-value driven. Results from this study suggest that within continuing care recreation services are provided by a host of non-regulated health care providers with diverse training. Further, findings suggest that there is value in employing trained individuals in providing recreation services. To improve the quality of recreation service and recreation therapy across the province, government needs to take steps to determine the core competency needed to provide the various recreation services and recreation therapy. To achieve this goal there needs to be collaboration between Professional Associations (e.g., Alberta Therapeutic Recreation Association, Therapy Assistant Association of Alberta) and post-secondary institutions including colleges (e.g., NorQuest, Bow Valley) and universities (e.g., University of Alberta) with the goal of setting educational standards for recreation therapy assistants and therapists.

Practice Related:

1. There is a need for additional staff resources to provide more recreation opportunities directly, as well as to facilitate residents' self-organized recreation. Recreation staff must have the training and advanced education to successfully do so.
2. Recreation staff need to provide guidance to residents' friends and family members on how to facilitate residents' recreation without the former being perceived to be thwarting the latter's independence and autonomy.
3. Recreation staff need education and support on how to provide meaningful and effective information on residents at multidisciplinary case conferences.

Government Policy Related:

4. Alberta Health, Alberta Innovation & Advanced Education, and Alberta Health Services need to be engaged in work to align education, roles and responsibilities, and job descriptions of recreation services to ensure consistency throughout the province.
5. Alberta Health and Alberta Health Services need to review funding policies for recreation services in order to better support quality of life in all streams of continuing care and to provide an overarching vision for recreation services in continuing care.

Provider Organization Policy Related:

6. Provider organizations need to provide ongoing education to all staff on the importance of recreation activities to residents.
7. Provider organizations should encourage culture shifts that support all staff supporting recreation activities 24/7, not just when recreation staff are at work. This would require a shift from the clinical focus to the social realm.

Education Related:

8. Post-secondary institutions and Professional Associations/Colleges in Alberta need to work together to ensure better integration of training and education for recreation staff (assistants and therapists), other therapies (OT & PT), health care aides, and regulated nursing staff.
9. Colleges in Alberta need to work together to provide consistent learning outcomes for recreation assistants/aides.
10. Post-secondary institutions in Alberta need to examine how they can improve quality of life in continuing care by better preparing health discipline students.

Research Related:

11. Recreation service modes have not been examined previously, nor have their effects on recreation satisfaction. Further research on this concept is therefore necessary, especially given it appears to have both positive and negative impacts. Moreover, if the latter finding is confirmed, then applied research on how recreation staff could educate residents' family/friends to reduce the likelihood of autonomy thwarting could prove beneficial.
12. Although life satisfaction and positive and negative affect are the two most commonly researched dimensions of QOL, there are others. "Eudaimonic" well-being, for example, focuses on feelings of vitality, meaning and purpose, personal growth, etc. Given recreation has also been found to effect this QOL aspect, future research on this relationship in CC facilities is recommended.
13. A longitudinal follow-up to this study should be conducted to examine the same variables, but over multiple points in time, in order to confirm our study's findings.

BACKGROUND

In 2013 the Institute for Continuing Care Education and Research (ICCER) developed the Community Needs Driven Research Network (CNDRN) to identify needs from the perspective of front-line workers in continuing care (ICCER, 2014). One of the issues identified was the need for more research looking at the impact of recreation and rehabilitation staff in continuing care (CC), specifically in relation to how those staff are funded. In the fall of 2014 Alberta Health asked ICCER to develop a research proposal to examine recreation activities in supportive living (SL) and long term care (LTC) facilities in Alberta, and to identify the relationships among the frequency and nature of recreation activities, the five dimensions of recreation satisfaction, and the impact on quality of life of individuals in SL and LTC.

Little is known about the impact of recreation services and interventions on the quality of life (QOL) of individuals in the continuing care sector. Moreover, based on a review of the literature, most of the research that has previously been conducted to date has not been as comprehensive as what would be ideal; that is, where services are provided, to what degree, and by whom; how do recreation staff perceive the relationship between what they do and what effect it has on their residents; and how do residents themselves benefit from satisfying recreation participation in terms of QOL.

METHODS

Ethics Approval

Ethics approval was received from the University of Alberta Research Ethics Office in July 2014.

Studies' Purposes

Three separate studies were conducted, each of which focused on different aspects of CC residents' recreation and quality of life and CC recreation staffs' perceptions of recreation and QOL.

Study 1 - The purpose of this study was to gain a better understanding of who specifically provides recreation programs and services in CC facilities in Alberta.

Study 2 - The purpose of this study was threefold. *First*, to gain greater insight into how frequently CC residents participate in various types of recreation activities; who organizes the recreation programs and services residents engage in; how satisfied residents are with their recreation; and how residents evaluate their QOL. *Second*, to ascertain what factors impact CC residents' overall recreation satisfaction. And *third*, to determine what factors influence CC residents' QOL.

Study 3 - The purpose of this study was to gain a better understanding of CC recreation staff's perceptions of residents' recreation and QOL.

Data Collection

A three-fold approach to data collection was used.

Study 1 - An online survey was designed and administered using FluidSurvey (see Appendix 1). Section One of the survey asked about the name of the site, its location, the number of beds, and what type of site it was (i.e. LTC or SL). Section Two focused on the number and types of staff (e.g. recreation therapists, registered nurses, etc.) who provided recreation programs and services in the facility, whether they were full-time or part-time, and the percent of time committed to recreation

programming. Section Three explored the types of recreation activities provided in the facility, and Section Four asked whether recreation staff support or coordinate resident-directed activities. Section Five allowed participants to provide additional comments concerning the effects of recreation activities on the QOL of residents in CC facilities. The final section determined whether the site would be interested in having their residents participate in an on-site survey that examined the effects of recreation participation and satisfaction on QOL.

A list of CC facilities was generated using the Alberta Health accommodation search page[1]. An invitation to participate in the survey was sent via email to different facilities including long term care, supportive living, and assisted living across the province. In addition, operators of seniors' living facilities that are ICCER members and co-investigators on the study were asked to send the electronic survey to their contacts in CC facilities.

Study 2 - The on-site survey measured recreation participation, recreation satisfaction, recreation service modes, and QOL (in terms of both positive and negative affect and life satisfaction), over the past three months (see Appendix 2). Mobility limitations and demographic information was also requested, and residents were given the opportunity to provide input on the types of recreation activities they would like to see increased or established by their centre in the future. In order to refine the questionnaire, and to help with plans to administer it, two focus groups were held with recreation staff in Edmonton (1 for LTC, 1 for SL) (see Appendix 3). Based on the input from the focus groups, revisions were made to the survey and plans for administering it were refined.

The survey's measures were based on pre-established concepts and scales, including:

- **Recreation participation** - McKechnie's (1975) inventory, revised to include contemporary activities as well as those emphasized by focus group members.
- **Recreation satisfaction** - Beard and Ragheb's (1980) leisure satisfaction scale, less the aesthetic sub-dimension which is better construed as a measure of recreation facilitation rather than satisfaction.
- **Recreation service modes** - a new, continuing care-specific scale developed based on Rossman and Schlatter's (2008) leisure service continuum
- **Positive and negative affect** – from Tsai's (2007) inventory, which conforms with Russell's (1980) circumplex model. Specific emotions were selected based in part on focus group members' comments.
- **Life satisfaction** - Neugarten et al.'s (1961) Life Satisfaction Index A, shortened based on Hoyt and Creech's (1983) factor analytic investigation.
- **Mobility limitations** – scale used previously in studies conducted by the Co-PI, Robert Haennel.

Invitations to complete the survey were sent through a variety of sources, including: (a) Alberta Continuing Care Association; (b) Alberta Seniors Housing Association; (c) Alberta Health Services, Seniors' Health Zone Directors; and (d) ICCER membership. Each organization then sent out the information letter to sites via email. Reminder notices were sent twice. Efforts were made to ensure as much as possible near equal numbers of SL and LTC centre residents, as well as representation throughout Alberta.

After the data were collected, entered, and cleaned, descriptive—to address the first two objectives—and predictive—to address the third objective—statistical analyses were conducted. As outlined in the literature review section, the third objective's variables were organized based on existing frameworks,

[1] http://standardsandlicensing.alberta.ca/search.html?val=Long-term%20care&st=C

which theorize that: (a) overall recreation participation frequency has a positive impact on overall recreation satisfaction which, in turn, decreases negative affect and increases positive affect and life satisfaction (even after certain sociodemographic factors, mobility limitations, and facility characteristics are taken into account. E.g. Beard and Ragheb, 1980; Newman, Tay, & Diener, 2013; Spiers & Walker, 2009); and (b) the type of recreation service mode (Rossman & Schlatter, 2008) could also enhance residents' recreation satisfaction and QOL (e.g. Bergland & Kirkevold, 2006).

Study 3 - Focus groups were conducted with recreation staff in CC across Alberta to discuss recreation therapy activities with residents in SL and LTC, and to discuss staff attitudes/opinions on recreation activities and its benefits to residents. The focus group protocols are shown in Appendix 4.

Locations and Number of Participants

Table 1: Location and number of participants in focus group

Location	# of Participants
Fort McMurray	3
Grande Prairie	4
Edmonton and area	4
Edmonton and area	7
Calgary and area	6
Calgary and area	10
Lethbridge (including Medicine Hat)	5
Total	**39**

Focus groups participants were from recreation departments in both SL and LTC facilities and included recreation therapists (RTs), recreation managers, recreation therapy assistants, recreation therapy attendants, and recreation therapy aides (RTAs).

Analysis

QSR NVivo 10 software was used for data analysis tasks. A coding scheme (matrix) was developed according to emerging data and was then used for all focus groups. This coding scheme served as the initial node structure in NVivo 10.

Data analysis was conducted in two phases. In the first phase a manifest content analysis of focus groups transcripts was performed in order to determine the frequency with which each particular theme emerged in the data. The themes were used as initial coding categories (nodes) and were then applied to all focus groups by three coders. New emerging themes identified by two research assistants and by the project manager were added, leading to a refinement of themes. The first phase was then discussed with the focus group facilitator to corroborate the themes according to focus groups' notes. In the second phase, a latent content analysis was performed in order to explore the meaning of these themes and the issues related to each one of them according to coders.

RESULTS

Online Survey

After online surveys that were either duplicates or had extensive missing data were deleted, 65 surveys remained. Of this total, 13 surveys had a small number (i.e. less than six) of staff data missing, and therefore mean substitution was employed in these cases.

Of the 65 sites in this study, 38 (58%) were SL, 21 (32%) were LTC, and 6 (9%) were both. In total, these sites had 8,959 beds.

Table 2 shows the number of full-time equivalent (FTE) and part-time equivalent (PTE) staff who provided recreation programs and services in the CC facilities in this study, by type. Also shown in this table is the percent of the total FTE and PTE staff doing so, again by type.

Table 2: Staff involved in recreation by type and full-time equivalents

Type of Staff	Full-Time Equivalent (FTE)	Percent of Total FTEs	Part-Time Equivalent (PTE)	Percent of Total PTEs
Recreation Therapists	27.0	17%	11.0	7%
Recreation Therapy Assistants/Aides	48.7	31%	82.6	52%
Activity Coordinators	15.1	10%	3.8	2%
Nurses (RNs, RPNs, and LPNs)	6.3	4%	3.7	2%
Health Care Aides	37.9	24%	36.9	23%
Occupational Therapists / Physiotherapists	0.3	0%	1.2	1%
Rehabilitation Assistants	4.1	3%	0.8	1%
Front-Desk Staff / Administrative Staff	3.7	2%	2.3	1%
Volunteer Coordinators	2.3	1%	3.5	2%
Other	10.8	7%	13.7	9%
Total	**156.3**	**100%**	**159.4**	**100%**

As reported above, the majority of FTEs providing recreation programs and services are, respectively, Recreation Therapy Assistants/Aides, Health Care Aides, and Recreation Therapists. In contrast, the majority of PTEs doing so are Recreation Therapy Assistants/Aides and Health Care Aides.

Issues

Some sites' email addresses listed on the Alberta Health accommodation search page were not up-to-date, and therefore 31 of the 217 emails that were sent out bounced back. The total number of hours FTE and PTE staff work each week could also vary across sites.

Resident Survey

A total of 419 on-site resident surveys were collected from across Alberta. After excluding those with more than five percent missing data (i.e. more than two items unanswered, both of which could not be from the same scale), we used mean substitution to ensure we could conduct our planned statistical analyses. Of the 359 remaining participants, 234 were female (65.2%); approximately half were widowed (48.8%) while another quarter or so were either married or common-law (24.2%); and forty-four percent had not completed high-school (versus 22.0% who had, with the remainder having had at least some college/university education). The average age was 80.1 years. Participants were split roughly evenly between SL and LTC facilities (47.1% and 52.9%, respectively). A majority (78.6%) reported having physical mobility difficulties and therefore requiring a walker, a wheelchair, or others' assistance to walk around their residence.

Table 3 reports our results regarding how frequently CC residents participate in various types of recreation activities. As shown, residents reported most often participating in media activities, followed by social, relaxing, and exercise activities. Recreation activities conducted outside of the facility, both outdoors and special events, were participated in the least. SL participants also appear to engage in some types of recreation activities, and recreation activities overall, more than LTC participants.

Table 3: Residents' frequency of participation in different types of recreation

Type of Recreation Activity	Mean Frequency: All Participants	Mean Frequency: SL Participants	Mean Frequency: LTC Participants
Outdoor (e.g. patio events, parks visits)	2.24	2.27	2.21
Games (e.g. playing cards, board games)	2.69	2.96	2.45
Social (e.g. visiting with friends/family)	3.61	3.70	3.54
Exercise (e.g. fitness classes, walking)	3.41	3.56	3.27
Media (e.g. reading, watching television)	4.19	4.24	4.14
Artistic/Creative (e.g. crafts, singing)	2.54	2.55	2.53
Special Events Outside the Facility	2.26	2.44	2.10
Relaxing (e.g. resting having a nap)	3.56	3.49	3.61
Spiritual (e.g. going to Church services)	2.88	2.91	2.86
Recreation Activities Overall	**3.04**	**3.12**	**2.97**
***Note*. 1**=Never. **2**=Seldom. **3**=Sometimes. **4**=Often. **5**=Very Often.			

Recreation programs and services can be arranged along a continuum depending on how they are delivered and by who (see Appendix 5 - Literature Review for more on this topic). As Table 4 indicates, the most frequent recreation service mode reported by all participants was Dependent – Staff (i.e. the resident staff organized the activities), followed by the Independent (or self-initiated) and Dependent – Non-Staff modes. The two least frequent modes were when the resident organized, but either resident staff or non-staff members facilitated, the recreation activities. Noteworthy here is that the Independent mode was much higher for our SL participants compared with LTC participants, whereas the opposite was true for the Dependent – Staff mode.

Table 4: Residents' frequency of participation in various recreation service modes

Recreation Service Mode	Mean Frequency: All Participants	Mean Frequency: SL Participants	Mean Frequency: LTC Participants
Independent (Resident organizes activities on his/her own)	2.00	2.36	1.68
Dependent - Staff (Resident staff organize activities)	3.96	3.73	4.17
Dependent - Non-Staff (Non-staff—e.g. family, friends—organize activities)	1.96	2.04	1.89
Interdependent – Staff (Resident organizes but resident staff facilitate activities)	1.59	1.74	1.45
Interdependent – Non-Staff (Resident organizes but non-staff—e.g. family, friends—facilitate activities)	1.51	1.57	1.45
***Note*. 1**=Never. **2**=Seldom. **3**=Sometimes. **4**=Often. **5**=Very Often.			

Table 5 reports the degree to which CC residents were satisfied with various aspects of their recreation, as well as their recreation overall. Generally, social and relaxation needs were best fulfilled, with our SL participants' mean scores appearing to be higher than our LTC participants' scores across all five recreation satisfaction dimensions.

Table 5: Residents' satisfaction with different aspects of their recreation

Type of Recreation Satisfaction	Mean Frequency: All Participants	Mean Frequency: SL Participants	Mean Frequency: LTC Participants
Social (e.g. My recreation activities helped me develop close relationships with others)	3.49	3.57	3.41
Psychological (e.g. My recreation activities gave me self-confidence)	3.12	3.20	3.05
Physiological (e.g. My recreation activities helped me stay physically healthy)	3.13	3.24	3.03
Relaxation (e.g. My recreation activities helped me reduce my stress)	3.44	3.56	3.33
Educational (e.g. My recreation activities increased my knowledge about things around me)	3.01	3.04	2.97
Overall Recreation Satisfaction	**3.24**	**3.32**	**3.16**
***Note*. 1**=Never. **2**=Seldom. **3**=Sometimes. **4**=Often. **5**=Very Often.			

CC residents' QOL, in terms of affect, is reported in Table 6. Overall, positive affect was slightly above the "Sometimes" marker whereas negative affect was slightly above the "Seldom" marker. Positive affect seems slightly higher for our SL participants compared with LTC participants, but negative affect is essentially identical.

Table 6: Residents' quality of life - affect

Quality of Life: Affect	Mean Frequency: All Participants	Mean Frequency: SL Participants	Mean Frequency: LTC Participants
Positive (e.g. calm, content, excited)	3.29	3.35	3.24
Negative (e.g. sad, nervous, angry)	2.30	2.29	2.30
***Note*. 1**=Never. **2**=Seldom. **3**=Sometimes. **4**=Often. **5**=Very Often.			

CC residents' QOL, in terms of life satisfaction, is reported in Table 7. Overall, participants' life satisfaction mean score was marginally inclined more toward the "Slightly Agree" than the "Neutral" marker, with this appearing to be most accurate in terms of our SL participants.

Table 7: Residents' quality of life - life satisfaction

Quality of Life: Life Satisfaction	Mean Agreement: All Participants	Mean Agreement: SL Participants	Mean Agreement: LTC Participants
Life Satisfaction (e.g. These are the best years of my life)	3.61	3.69	3.53
***Note*. 1**=Strongly Disagree. **2**=Disagree. **3**=Neutral. **4**=Slightly Agree. **5**=Strongly Agree.			

Statistical analyses were conducted to address our study's second objective, specifically: What factors impact CC residents' overall recreation satisfaction? Potentially predictive variables were entered in three separate blocks: the first consisted of a resident's sociodemographic characteristics and whether he or she lived in a SL or LTC facility; the second was composed of all of the variables in the first block as well as how often a resident participated in recreation activities overall; and the third was comprised of all of the variables in blocks one and two in conjunction with the five different recreation service modes. (Appendix 6 shows more detailed information on these statistical analyses' results.)

Although overall recreation satisfaction was significantly higher for female participants, the factor having the greatest positive impact on this variable was actually how frequently participants engaged in recreation activities overall. Above and beyond these two factors, many of the recreation service modes also influenced overall recreation satisfaction, with the Interdependent – Staff mode (i.e. The resident organizes, but resident staff facilitate, his or her recreation activities) having the largest positive effect, followed by the Independent mode (i.e. The resident organizes his or her recreation activities on his or her own) and the Dependent – Staff mode (i.e. The resident staff organize recreation activities). Conversely, overall recreation satisfaction decreased the more CC residents organized, but non-staff fostered, their recreation activities (i.e. the Interdependent – Non-Staff mode).

Statistical analyses were also performed to address our study's third objective; that is: What factors influence CC residents' QOL? Potentially predictive variables were entered in two separate blocks: the first once again consisting of a resident's sociodemographic characteristics and whether he or she lived in a SL or LTC facility; the second once again composed of all of the variables in the first block as well as how satisfied a resident was with his or her recreation overall.

Although neither blocks one nor two predicted negative affect (e.g. sad, nervous, angry), both did predict positive affect (e.g. calm, content, excited). The influence of physical mobility on positive affect was significant but small in size, with those able to walk independently higher than those who could not, whereas the impact of overall recreation satisfaction on this same QOL measure was significant but medium in size, with those having recreation satisfaction also having grater positive affect. (*Not*e. Effect sizes are based on Cohen's, 1991, benchmarks). Parallel results were found for life satisfaction.

Issues

There were three key issues concerning this study. First, although respondents were able to report their participation in "other recreation activities" that were not listed in the survey, this information could not be included in the statistical analyses. Thus, our mean recreation participation frequency scores may be under-estimated. Second, although theoretically based, our study was cross-sectional in nature (i.e. all of the data were collected at the same time). Thus, it is also possible that life satisfaction affects leisure satisfaction, or even that a reciprocal relationship exists. Third, data collection took place during the October–March time period. This meant some potential sites were unable to participate due to winter weather conditions and outbreak of flu and norovirus.

Focus Groups

Six major themes, as shown in Table 8, were identified through analysis of the focus group discussions. The findings are the perspectives of the recreation staff who participated in the focus groups.

Table 8: Major themes identified in the focus groups

Themes
1. Funding
2. Staffing
3. Role Clarity
4. Professionalism
5. Programming Challenges
6. Difference in Perspectives on Quality of Life

A description of each theme is provided below.

1. Funding

Funding related issues were the most frequently identified by all participants regardless of role or organization.

1.1 Budgets: Some recreation staff were well supported by their organizations in terms of budgets for supplies for programming, while others had budgets that are supplemented by resident/ family donations/fundraising. However, many recreation staff stated that they struggle to buy supplies or provide a variety of entertainment and recreation activities due to insufficient funds. One RT mentioned that, in over 20 years of working in the same site, she has never been made aware of the recreation department budget.

> "You want as many opportunities as you can for your clients or residents, and you have a cap; this is what you're given and that's what you have to use for the entire year and it's not necessarily enough."

> "So supplies, we need the supplies to get things for the programs and then if we want to have a party, there is so much that goes into a party, we need the entertainment, we need snacks for everybody, we need juice for everybody, we need napkins for everybody, we need cups to hold the juice and we need, you know, decorations and that goes on, and on, and on. So holding one event could be $200 and up, right? So that's one event a month and then you need the whole month budget. So going on outings, going on anything really, hosting a bingo, we have prizes for bingo, we have prizes for some other of our programs and snacks for programs, things like that so all of that adds up"

Due to lack of funding, some sites indicated that they had to share resources, such as buses and bus drivers for community outings. They may have been restricted in the number of bus trips per month because they couldn't afford their own bus and driver. As well, bus trips usually required more staff to porter and supervise, which implies an increase in salary costs and potentially limits the number of care providers remaining at the facility.

1.2 Funding model: The perception of focus group participants from both SL and LTC was that the current funding model does not support recreation services well and that more funding goes towards rehabilitation staff compared to recreation staff.

> "It's a rehab model and when you have people who are 90 and have, you know, acute dementia, you're not to rehab them, you're not; but the care is just as important, and takes just as much if not more time. And yet, we're not funded for that."
>
> "So I would say that's another barrier, a big one, is the funding model."

Lack of funding limits in terms of the number of activities and quality of recreation services. Programming tends to be geared more towards big group activities instead of towards smaller therapeutic ones. There was a shortage of qualified staff to provide meaningful one-on-one/small group therapeutic interventions, in part because their time was taken with the larger group activities.

2. Staffing

2.1 Lack of staff: Staffing varied amongst organizations; while no organization was overstaffed, some stretch their staff very thin. As previously mentioned, there was a lack of staff to provide one-on-one or small group therapeutic programs, or to escort residents to recreation activities. Recreation staff recognized that residents need more one-to-one or small group activities but there was insufficient staff to do so. Moreover, when regular staff were on vacation, there was usually no position cover off, which can leave a gap in program services that can be offered during the absence.

> "For me my biggest concern always is the staffing and what we are able to provide to people"
>
> "We make outcomes for them, and we try and make sure we succeed with doing those outcomes but because of lack of staff, it's very hard to stick to the outcomes…"
>
> "I need more therapy assistants that can be running different groups at the same time…."

Some facilities were unable to provide evening and weekend activities because they cannot employ staff to work those shifts due to insufficient funding. Other facilities were able to schedule recreation staff to work evenings/weekends, usually on a part-time basis.

According to the participants, it was a challenge to recruit and retain recreation staff. This is often due to lack of funding to hire additional staff. Also, many of the recreation positions are part-time or casual positions. Staff members often leave an organization for full-time positions elsewhere, or to pursue further education. This situation leads to a fairly high turnover rate in some facilities/locations.

2.2 Education and training: There are inconsistencies in the education and training of recreation staff. In Canada, qualification of recreation staff varies from recreation therapy assistant certificate, recreation therapy diploma, recreation therapy degree, or just on-site training with no formal education. In Alberta, some facilities hire individuals for a recreation therapist position with just a diploma, while others require a degree. Some sites hire recreation therapy assistants with or without educational foundations. Some college programs require an individual to have health care aide experience before becoming a recreation therapy assistant. Participants viewed this as encouraging a task oriented focus as opposed to a more holistic approach.

> "I've had, I've a terrible time keeping staff; I, in the past, I've usually ended up hiring people that have degrees, which is mainly why they don't stay and I'll either, right now I've someone who is very qualified and she is a rec. therapist and she is working as an RTA right now."
>
> "And it takes people with the education and the know-how: what to subscribe to them because otherwise, you know, you could be giving them something that's totally wrong, like harmful to them."

Once an individual becomes an RT, he/she usually seeks employment as an RT, rather than staying in an assistant role. While there are staff with RT degrees working as recreation therapy assistants, they usually leave once they get an RT position.

> "And even when you have volunteer run programs, there's still that element of supervision and training and…See we never let volunteer do a program independently. A staff is always there."
>
> "As you said, we need to give them a lot of training. In [] we tend to have a lot of younger people coming on the weekends, or evenings. So you really need to give them lots of training, otherwise they don't really follow your objective of the programs."
>
> "We have volunteer coordinators, but…so they train on a sort of the general thing, but then once we are, you know, given a volunteer to work with, then it becomes our responsibility."

2.3 Volunteers: In some parts of the province, finding volunteers to assist with recreation programs is a very competitive and challenging business. It can be difficult to recruit and retain long-term volunteers. As well, managing volunteers can be very time consuming. In some facilities RTs manage the volunteers, thus consuming time that could be spent running recreation programs, while at other sites, a volunteer coordinator is responsible for recruiting, screening, conducting orientation sessions, and organizing volunteer appreciation events. It was also noted that in some SL facilities, resident-volunteers run their own programs or help recreation staff to run activities. Volunteers are crucial to recreation departments; however, while in some facilities volunteers do run group activities independently, in other facilities they cannot run group programs. They are quite limited in the service they provide; nevertheless, they are highly valued and sought-after as they make up for the shortage of staff.

2.4 Locations: In non-urban areas, facilities rely on Alberta Health Services' RTs to do assessments and consultations. In metro areas, most organizations have their own RTs who do assessments and provide programming. Additionally, non-urban areas tend to have more trouble recruiting and retaining both professionals and volunteers. Because of the distances between communities, staff tends to be stretched even further than in the metro areas.

"I think it's just funding for the North is always lacking like it can be compared, if you compare to other facilities . . . yeah, other locations. It's about [community] size"

"We have some volunteers - very hard to come by for volunteers because we're such a transient city. So, we'll get you know, a good volunteer group, who are reliable and in terms of going motivated themselves, they'll come and be here for a short period of time and then they're gone like that, and you're searching again"

"And also though our licensing body, ATRA, we have an obligation to be safe and we have to treat and assess as appropriately as we can. Pick something that's completely inappropriate for that client if they're unable to walk, obviously we can't pick something that involves mobility because it's not possible, so…"

"Yeah, it's how we provide programming, again when you have a little bit of education background, you have better understanding of diagnosis and those kind of issues. We deal a lot with broader chairs, wheelchairs, even with our buses and outings. Again having a really good sense of maintaining resident's …we have a responsibility not only to, for us AHS, but to the clientele we work with to provide the safest possible programming."

2.5 Safety: Without adequate supervision from staff, bus trips and outings may entail significant safety problems, such as risk of falls.

Additionally, with a lack of qualified staff to provide individualized attention to residents with dementia or those who have mental/physical impairments, there may be a higher risk for those residents to decline and become more depressed and isolated. Residents with dementia may also become more agitated in large group events, which can lead to increased behavioural issues. Many dementia residents fare better in a calmer, quieter environment but with limited recreation staff, the needs of these residents are not fully catered for.

3. Role Clarity

3.1 Responsibilities: Recreation staff duties vary site-to-site, with some focusing on direct therapeutic recreation and others focusing on program coordination. Direct therapeutic duties include assessments and MDS reporting, interventions, managing waitlists and caseload, supervising therapy aides, attending family conferences and interdisciplinary meetings. At other sites, the recreation staff focused their time on planning group activities and field trips, coordinating volunteers, and reporting on attendance and participation.

> "I have to restructure my department so that I can get all the red tape all done and all the paper work and all the meetings and this and that, that I have to pull myself off the floor. So that the staff are actually the ones who are carrying out the programming, so that's one less person that's on the floor, right? And that is very, very challenging, right?"
>
> "We're also expected to not only run therapeutic programs, social programs, outings, special events and then we're all supposed to take care of all the building decorations for all the seasonal activities. So our expectations, the expectations are huge on us plus attend all the care conferences, attend all the ID meetings, I personally attend 6 ID meetings a week for about 1hr to 1and 1/2hr each one."

> "We had a discussion on how with talking to HR, OT/PT therapy assistant could go into the role of a recreation person, but a Rec T aide couldn't do the same…"
>
> "I feel like a lot of that is that recreation therapists still isn't well known, and therefore the roles are not clarified; like there is a role for rec. assistants, there is a role for rec. therapists and they are different roles."
>
> "Sometimes since recreation is kind of a newer therapy, maybe less common knowledge like as OT a lot of people know what that is than recreation. A lot of the individuals think well it's bingo! Or it's playing games type of thing. Maybe lack of knowledge from other disciplines, not like is a bad way, but it just might be nice if they knew a little bit more about the therapeutic sides instead of just the daily activities that we do, there's a lot more to it."

3.2 Confusion of the 'therapies': Participants reported that there was a lack of clarity as to how recreation therapy differs from occupational therapy (OT) or physiotherapy (PT). In many sites, OT and PT assistants run recreation programs, but recreation assistants are restricted in the type of exercise programs that they can provide.

Also, there are no definite titles for recreation staff; it varies depending on facilities across the province and across the country as well. They may be called recreation therapists, recreation therapy assistants, recreation therapy attendants, or recreation therapy aides. The distinction is usually based on educational background, although not entirely. Most RTs have a 4-year degree, however others have a 2-year diploma and are still called recreation therapists. The terminology of 'aide', 'assistant', or 'attendant' seems to be based more on organizational preference than on education.

Furthermore, volunteers, family members, OT assistants, PT assistants, nursing staff, health care aides and others also provide recreation activities depending on site; this demonstrates overlapping and poorly defined roles of recreation staff, i.e. if all these other people can provide recreation activities, then what is the role of recreation staff? There is also a lack of knowledge about recreation therapy scope of practice amongst healthcare staff and the public. Recreation staff are seen as "fun people who play all day". To address this issue, recreation staff educate other staff during orientation sessions, interdisciplinary meetings, and educate both staff and the public during Recreation Therapy month in February or whenever they have the opportunity to do

so. However, they are still struggling to establish themselves as professionals amongst other healthcare staff.

Participants stated that there tends to be a higher expectation on recreation staff; they are expected to provide recreation activities to all residents while OT and PT provide services to only 14% of the total resident population. Yet in most organizations, the number of rehabilitation staff is equal to or greater than the number of recreation staff.

3.3 Therapeutic recreation vs activities: There was further confusion regarding therapeutic recreation interventions and recreation activities, i.e. targeted interventions versus general social activities. Therapeutic recreation interventions are individualized with personal goals, objectives, and outcomes measures; whereas recreation activities aim to provide a calendar of general social programming that is available to all residents. The ratio of recreation staff to residents for an activity to be counted as a therapeutic intervention is 1:8 or less. For general activities the ratio varies depending on facilities; it ranges from about 1:50 to much higher. These higher ratios and large group sizes in general recreation activities are particularly problematic for residents with complex needs such as mental health concerns, responsive behaviours or dementia. The ratios in these general recreation activity groups highlight a perceived shortage of recreation staff and partially explains why it is hard to carry out therapeutic interventions with the residents.

> "So lot of places have hired activity coordinators who may or may not have education or have even a background therapeutic recreation, and there has been a really…we've spent probably 10 years trying to define the difference between a recreation therapist and a therapeutic recreation program and an activity coordinator and activity programs, so there is like two totally different things happening, and the problem with not having enough staff it's been challenging to actually carry out a therapeutic recreation program. "
>
> "So we've got audited recently and the programming - only people care planned for certain programs can be considered doing a therapeutic program. So even though we do 1 to 8, and it's, you know, in the cognitive round, it's not necessarily considered therapeutic to AHS, which we've just recently found out."

> "They have even gone as far as filling in our care plan information. And previous sites I've been at in LTC, they've filled in our MDS, and it's "No, I don't fill in your RNs stuff, I don't know anything about your RN, I'm not a nurse, so [don't fill out the recreation therapy section]."
>
> "Cause you have to divide the minutes for MDS by the number of participants in the program; so for us, we work with the MDS coordinator and we actually don't code any minutes because the minutes on MDS, it's not a workload measure."

3.4 RAI MDS 2.0 and RAI Home Care: In some LTC facilities, recreation staff do their own RAI data inputting, while in others they have designated people, such as the RAI coordinators. In facilities where nursing or RAI coordinators complete the recreation portion of the RAI without consulting with the recreation staff, participants indicated that the RAI data does not necessarily match what recreation staff are recording for their clients.

This is not yet an issue for staff in SL, as the RAI Home Care is not used as a basis for funding yet. They do worry that they will have the same concerns as the LTC staff in the future.

4 Professionalism

4.1 Recreation is "shunned and discredited": RTs are not regulated by the Health Professions Act, which is perceived as hindering their acceptance as professionals amongst other healthcare staff and the public. As indicated previously, there is a general lack of knowledge about what recreation staff actually do.

> "I wasn't even included in the care plan."
>
> "But I've been somewhat kicked out of a care conference, right? Because, "oh you don't need to hear this" and it's like "I'm a professional…You know I deserve to be here as much as you do, and maybe I can help"…So, that's a big thing and I've had, you know? Kind of stand off to the staff, like no I'm staying here."
>
> "They still have that stereotype we are doing just play. So we have to keep on correcting the thought and show them, I guess to show them."

Health care aides and recreation therapy attendants are the two persons closest to most residents, yet they are not usually involved in interdisciplinary meetings. Service provided by recreation staff is not considered as important to the health of residents as other professionals (such as nurses, pharmacists, and other therapists) and at times they are not even included in care plans; however, recreation staff claim that their approach is different from the clinical or medical model. Their approach is more holistic; they look at the individual's past and present interests, physical and mental abilities and then plan recreation activities to increase their physical, mental, emotional, social, and spiritual status.

> "…our professional association, Alberta Therapeutic Recreation, has submitted to the government that we become part of the Health Professions Act and so we are waiting on pins and needles for that, because I think that will be a big change for our profession."
>
> "I first received my certificate as an RTA at NorQuest as a rec. therapy aide and they didn't call it an assistant. I was told at the time that it was an assistant, so the terminology is really weird because when you talk with rec. therapists from older years, they have a different view point of assistant versus and an aide; so it's not about education, non-education per say, so that's something that just the effects of lack of knowledge perhaps on what's going on in the education area."

4.2 Regional variability: There are no Canadian standards for recreation professionals, which causes confusion for the public, health professionals and RTs themselves. Focus group participants shared their experiences with differing training and work conditions in recreation across the country. There are disparities across Alberta and other provinces in job titles, roles and scope of practice, and educational requirements.

Participants stated the need to have consistent job titles and education across Alberta and Canada. To be recognized as a regulated profession, the Alberta Therapeutic Recreation Association has submitted an application to government for inclusion in the Health Professions Act. Anyone entering the profession should have the educational background and recreation therapist should be a protected title; therefore no one should call themselves an RT if they do not meet the required criteria to do so.

Working towards this, RTs provide in-services to educate staff, residents, families, and the public on their role and scope of practice and the benefits of recreation therapy. They also have open houses, newsletters, and journals, and they hold a recreation month in February every year to celebrate and teach others about their profession. RTs believe that in order to get their profession recognized, the initiative should start at an academic level; there should be consistency and improvement in the recreation programs offered in educational institutes across the province and Canada.

5 Programming Challenges

5.1 Diverse and complex populations: The biggest programming challenge for the recreation staff is providing meaningful activities for a diverse population. Clients entering CC can have multiple comorbidities with varied levels of acuity and complexities, are from a wide age range and from different cultural and ethnic backgrounds. With the lack of funding, resources, and staff, it can be very hard to program activities that cater to the needs of this diverse group. Most recreation staff work in part-time or casual positions. Management tends to want "flashy events" and calendars that have a variety of programs even if they do not necessarily produce meaning for some residents. With the lack of staff and time, recreation therapists have to resort to larger programs instead of one-on-one or small group therapeutic interventions. These large group programs do not cater to the individual's specific needs.

"Programming for that many varieties of needs in one facility is so tough… It's the time to do that because you are going in and everybody has different needs."

"I have clients aged 26 to a 99 [year old] and you are like: "oh man! How am I going to do that?" And you know that the younger generation is even harder because the program is geared towards the older adults."

"We have an age range of 24 to 102 in that building so rec for us is a little bit challenging, sometimes to get all our people in wanting to come to programs. So we have a variety of different things that we offer 7 days a week programming to hit all the people. "

"I think the other thing that we've noticed too in the last couple of years, in terms of the admissions, like the type of residents that are coming into LTC, is really changing. "

"And you still, like your management is still kind of dictating what they want from you."

"We find that there's quite, it seems there's quite a variation in how frequently the HCAs get involved; in some facilities, some organizations, the HCAs they say if there's a program going on, HCAs say: "Oh, good. I'd go for a cup of coffee now!" and in others the HCAs are very much involved."

"Yeah, so it's like and I think people always look at recreation as just the fun parts and stuff…without actually understanding fact that we, the way we, our role is to help individuals gain quality of life and find ways to prevent any type of depression.."

"We've even had one Administrator going on outing with us this one year, and that was great, a very eye-opening experience for him, cause he thought: "Oh my god! You guys really work hard through the day." And he had no idea what to expect."

5.2 Staff and administrator attitudes: Some participants perceive management as interfering too much in recreation, telling them what activities should be done and how to run programs, without understanding why RTs approach their work the way they do. Also, RTs are busy inputting MDS (in LTC), doing assessments, programming, attending care conferences, and keeping record of attendance in programs, that they have less time to do what they are supposed to do, i.e. providing therapeutic recreation. Recreation therapy assistants run the programs and RTs only oversee them most of the time. Some focus group participants felt that they are not using the skills for which they have been trained, rather they are doing mainly administrative duties.

Other staff do not necessarily see the value of recreation therapy; there is a need to educate them on the goals and benefits of recreation therapy and encourage participation. Recreation staff are not there 24/7, but the need for

recreation and meaningful activities is there. In some facilities HCAs and nursing staff are on-board to provide recreation but in others, they are not. They are either too busy with their workload or lack interest in doing so as they have been trained to be task-oriented and it is hard to change their mindset.

Participants stated that the difference in staff attitudes towards recreation services can be similar throughout a facility (organizational culture), or the attitudes can vary between units/houses in a facility.

Moreover, recreation staff are unable to quantify the changes that they bring in the QOL or health of residents unlike PT and OT where the changes are more visible. They need to find credible outcome measures to back, justify, and validate the effectiveness of their intervention.

5.3 Volunteers: Volunteers enrich the programming but are restricted in the kind of service they can provide. It is also very difficult to find and keep long-term volunteers. This hinders the running of programs; some facilities rely heavily on volunteers to run activities with residents, but these activities are not therapeutic.

On the other hand, some facilities find it very useful to bring community groups in (e.g. a local quilting group may use the facility to hold their regular quilting meetings). This allows for more informal interactions between the community and residents and provides additional opportunities to engage the residents in meaningful activities.

"So everybody needs a volunteer and there seems to be fewer and fewer people volunteering and if they do it might be for one month or for shorter period of time."

"…and I connect a lot in the community. I tell my administrator it's bringing in the community into our community, so having scouts groups doing their thing, or a quilting group that does their quilting group at our facility, or you know, kids come in [from schools], so to me, when they say: "Well we got to get these people out in the community." I say: "well, the community comes to everybody so that 75 people can benefit instead of 6 people."

"…one large auditorium we use for the Adult Day Programs for residents from the community come in 4 days a week can use that. So my main space is used 4 days a week."

"We use the dining rooms as much as we can or our large dining room, and then down on the halls, just kind, you know could be those spot in the halls but that interrupts HCA pretty heavy and it's just loud and it's, it's challenging."

5.4 Programming space: In some facilities, recreation staff do not have a dedicated recreation room, instead they have to use common areas, hallways, or dining rooms. However, other staff also use the same areas, for example, OT and PT may use the same space for programming. Hence, recreation staff have to schedule around meal times and compete with other staff for these areas. As well, they cannot use these types of public areas to provide quiet, small group therapeutic interventions, as there are people coming and going and this disturbs the group. It is also hard to run sensory stimulation programs in noisy open spaces.

Some facilities are very old with long hallways and multiple floors; therefore it can be challenging and time consuming to get clients from one end of the building to where recreation is taking place, more so when there is already a shortage of staff and volunteers.

6 Difference in Perspectives on Quality of Life

There was a lack of consensus on what QOL is and how it relates to residents' lives. QOL varies on an individual basis depending on individual interests. It is a person-centered viewpoint, focusing on the individual's power to make choices in their lives. The level of engagement in social networking, community activities, food choices, and daily living affects QOL. To be able to enhance the QOL of residents, recreation staff need time to communicate with the residents and their families in order to understand individuals' interests and needs. QOL is about person-centred planning, person-centred care, and getting to know the client you are working with. It is also about giving the residents a sense of self-worth, purpose, and meaning in life. QOL is difficult to measure, due to the subjective nature of the factors that contribute to well-being. For instance, happiness is defined as an indicator of QOL, and what contributes to one person's happiness and resulting QOL may greatly differ from another's.

> "I think as an example many times over the years of being in care conferences where the pharmacist present the meds, and the nurse present the overall care plan and OT talks about fine motor tasks, and Physio talks about their gait and family members wait and what they are waiting for is therapeutic rec. staff because they want to know if their family member is happy. And I always feel like we had kind of the grand piece to present because I think overall what people want is their family members to be happy and to have that quality, I think that's the biggest part of the quality of life, and I feel like that comes through in the things that we do assess: past interests, or what do you do for relaxation, what do you do to challenge your mind, what do you do physically? I feel like we catch the vary spectrum that does equal quality of life."
>
> "I mean, you know, it's about the residents and their choice, their independence and what they want to or don't want to do."
>
> "I think if your mind and your body and spirit is active then I think your quality is enhanced."

Participants mentioned different philosophies of person-centred care could make a difference to QOL. Some sites use the Eden philosophy to enhance QOL of residents. This philosophy believes that there are three plagues in life: boredom, loneliness, and helplessness. The participants felt that if they are able to address these issues that are very prevalent in CC, they can enhance the QOL of their residents. Participants stated that QOL was also about valuing and respecting the residents for who they are and where they come from. By so doing, one is able to provide culturally competent care that will enhance the wellbeing of the residents. They saw the barriers to enhancing the QOL of residents including a lack of staff, a lack of funding, and the flaws in assessment tools that determine who gets OT, PT, and RT services. If residents do not meet the criteria for these services, it affects their QOL, as they do not get the extra help that they need to thrive in their new home. All they get are meals, nursing services, personal care and hygiene, and if they are physically able to do so, they can attend big social gatherings. Participants felt strongly that one way recreation staff can enhance the QOL of residents is by advocating for an increase in the type and number of staff and services provided.

Issues

The organization of focus groups and the participation of recreation staff were affected by Christmas and Alberta winter weather. Christmas is the busiest time of year for recreation staff and many facilities start their decorations/activities in November. This made it difficult to plan focus groups from November until January. As well, one focus group in central Alberta was postponed due to winter weather and was unable to be rescheduled.

DISCUSSION

Study 1 – The review of the literature did not identify any previous studies that had attempted to determine which specific staff members provide recreation programs and services in CC facilities. Thus, our results must be considered exploratory in nature. Having acknowledged this point, what is clearly evident is the critical role recreation therapy assistants/aides, followed by health care aides, and then recreation therapists, play in this process. Although this information may have limited utility on its own, it is important when discussing our Study 2 findings' in regard to the effects the facility-based recreation service modes had on residents' recreation satisfaction overall.

Study 2 – Examined holistically, frequency of recreation participation overall had a significant and substantial effect on recreation satisfaction overall—a finding consistent with the meta-analysis discussed in the Literature Review section (i.e. Kuykendall et al., 2015). While this suggests that residents would benefit from "just doing more", the recreation service mode results provide some insight into how this might best be accomplished. Specifically, staff could provide more recreation activities directly or, even more effectually, help facilitate those activities initiated by the residents or, ideally, both. This integrated approach (i.e. involving both staff and residents) would require additional full-time equivalent staff focused on recreation (see also Shippee et al., 2015) as well as ensuring these staff-members not only have the ability to offer more recreation activities but also the interpersonal skills and training to enable residents to realize the recreation opportunities they initiate. Noteworthy here is that direct and facilitative efforts by non-staff members do not appear to have the same benefits, possibly because, in the latter case, CC residents could sometimes view family members' assistance as being "autonomy thwarting" (Deci & Ryan, 2000). Potentially, this problem could be overcome by having recreation staff trained in facilitative techniques work with residents' spouses, children, etc.

Again, examined holistically, overall recreation satisfaction had a significant and substantial effect on two key aspects of QOL: positive affect and life satisfaction. These findings are largely congruent with those discovered in the meta-analysis discussed in the Literature Review; however it must be noted that Kuykendall et al. (2015) reported a single, omnibus QOL correlation which makes direct comparison difficult. Additionally, in our study overall recreation satisfaction did not significantly impact negative affect. This result is somewhat surprising as, for example, Lee and associates (2012) found that participation in fewer leisure activities (as well as higher stress levels and more mobility limitations) were associated with depression in the elderly. Regardless, given these results as well as the evidence outlined elsewhere in this report, it would seem prudent to facilitate CC residents' overall recreation satisfaction in order to maintain (and perhaps even improve) their QOL. How this could be accomplished is discussed briefly in terms recreation service modes in the previous paragraph, and reiterated and expanded on in our Recommendations section.

Study 3 – The six major themes identified in the focus groups are the perspectives of recreation staff in CC across the province. The issues reflect the experiences of these staff as they work to provide QOL to CC residents. Some of the issues are complicated – for instance, funding of recreation services in CC is not straightforward. While most people in CC would agree that recreation services are underfunded by the system, how the funding is actually allocated is complicated and confusing. There are differences between levels of CC[2] (SL 1&2 are funded differently than SL 3&4, which again is different than in LTC). When the researchers approached various provider organizations to ask about funding allocations, they

[2] Within Alberta's current continuing care system, supportive living has four different levels of care. Levels 1 & 2 are congregate living settings such as lodges and group homes. Levels 3, 4 & 4D (dementia) are congregative living settings but with more personal support services.

found that there is inconsistency across zones of the province and that there is a fair amount of organizational flexibility. LTC is funded through the Patient Based Care Funding model and each facility is given an envelope of therapy services dollars, the amount based on the complexity of needs of its residents. It is the facility/organizations prerogative to disperse the funds to best meet the residents' needs. This includes both professional and non-professional therapies, i.e. social work, OT, PT, recreation, respiratory, and nutrition. In SL 3&4 the system is currently in transition, but in the Edmonton zone, funding for RTs and RTAs depends on occupancy and the number of Designated SL living beds in a facility.

The funding issue appears to be the overarching issue – it has a direct effect on staffing and programming. These in turn affect role clarity, professionalism, and QOL.

RECOMMENDATIONS

Overall it is clear that recreation services play an important role in improving or maintaining residents' quality of life. Recreation activities need to be resident-value driven and not from organization-values.

Results from this study suggest that within continuing care recreation services are provided by a host of non-regulated health care providers with diverse training. Further, findings suggest that there is value in employing trained individuals in providing recreation services. To improve the quality of recreation service and recreation therapy across the province, government needs to take steps to determine the core competency needed to provide the various recreation services and recreation therapy. To achieve this goal there needs to be collaboration between Professional Associations (e.g., Alberta Therapeutic Recreation Association, Therapy Assistant Association of Alberta) and post-secondary institutions including colleges (e.g., NorQuest, Bow Valley) and universities (e.g., University of Alberta) with the goal of setting educational standards for recreation therapy assistants and therapists.

Practice Related:

1. There is a need for additional staff resources to provide more recreation opportunities directly, as well as to facilitate residents' self-organized recreation. Recreation staff must have the training and advanced education to successfully do so.
2. Recreation staff need to provide guidance to residents' friends and family members on how to facilitate residents' recreation without the former being perceived to be thwarting the latter's independence and autonomy.
3. Recreation staff need education and support on how to provide meaningful and effective information on residents at multidisciplinary case conferences.

Government Policy Related:

4. Alberta Health, Alberta Innovation & Advanced Education, and Alberta Health Services need to be engaged in work to align education, roles and responsibilities, and job descriptions of recreation services to ensure consistency throughout the province.
5. Alberta Health and Alberta Health Services need to review funding policies for recreation services in order to better support quality of life in all streams of continuing care and to provide an overarching vision for recreation services in continuing care.

Provider Organization Policy Related:

6. Provider organizations need to provide ongoing education to all staff on the importance of recreation activities to residents.
7. Provider organizations should encourage culture shifts that support all staff supporting recreation activities 24/7, not just when recreation staff are at work. This would require a shift from the clinical focus to the social realm.

Education Related:

8. Post-secondary institutions and Professional Associations/Colleges in Alberta need to work together to ensure better integration of training and education for recreation staff (assistants and therapists), other therapies (OT & PT), health care aides, and regulated nursing staff.
9. Colleges in Alberta need to work together to provide consistent learning outcomes for recreation assistants/aides.
10. Post-secondary institutions in Alberta need to examine how they can improve quality of life in continuing care by better preparing health discipline students.

Research Related:

11. Recreation service modes have not been examined previously, nor have their effects on recreation satisfaction. Further research on this concept is therefore necessary, especially given it appears to have both positive and negative impacts. Moreover, if the latter finding is confirmed, then applied research on how recreation staff could educate residents' family/friends to reduce the likelihood of autonomy thwarting could prove beneficial.
12. Although life satisfaction and positive and negative affect are the two most commonly researched dimensions of QOL, there are others. "Eudaimonic" well-being, for example, focuses on feelings of vitality, meaning and purpose, personal growth, etc. Given recreation has also been found to effect this QOL aspect, future research on this relationship in CC facilities is recommended.
13. A longitudinal follow-up to this study should be conducted to examine the same variables, but over multiple points in time, in order to confirm our study's findings.

APPENDIX 1 – ONLINE SURVEY

Note: the survey was conducted using designed and administered using FluidSurvey. The following shows the survey in Word format.

Recreation and Quality of Life in Supportive Living and Long Term Care in Alberta

This study is sponsored by the Institute for Continuing Care Education and Research (ICCER) through funding support from Alberta Health and has ethics approval from the University of Alberta. The purpose of this study is twofold; to gain a better understanding of: (a) the number of people providing recreation programs and services in supportive living and long-term care sites in Alberta; and (b) the amount of recreation programs and services provided in these same continuing care centres.

PRINCIPAL INVESTIGATOR:

Dr. Gord Walker, Professor Physical Education and Recreation, University of Alberta
(gwalker@ualberta.ca, 780-492-0581)

Please take the time to complete this survey. The survey should take approximately 15 minutes to complete. All responses will be kept confidential and anonymous. No results will be attributed to any individual. Your participation in the study is voluntary. You may decline to answer any of the questions and end your part in the study at any time. By agreeing to complete this survey, you are giving your consent.

If you have further questions or need more information about this survey, please contact Sandra Woodhead Lyons at scwl@iccer.ca or 780-248-1504. If you have questions about your rights as a research participant, please contact the University of Alberta Research Ethics Office at 780-492-2615.

Name of site: _____

Town/city in which site is located: _____

Number of beds/units: _____

Type of site:

Long-term Care ☐ **Supportive Living** ☐ **Level:** 1 ☐ 2 ☐ 3 ☐ 4 ☐ 4D ☐
Check all that apply

Do your recreation staff support/coordinate resident-directed recreation activities, such as Friday movie nights, etc.?

Yes ☐ **No** ☐

Question 1:

Who provides recreation services at your site? Please complete the following table.

Staff	Yes	No	N/A
Recreation Therapists			
Recreation Therapy Assistants/Aides			
Activity Coordinators			
Nurses: RNs			
Nurses: RPNs			
Nurses: LPNs			
Health Care Aides			
Occupational Therapists			
Physiotherapists			
Rehabilitation Assistants			
Front-desk/Administration Staff (Day)			
Front-desk/Administration Staff (Night)			
Volunteer Coordinators			
Volunteers			
Others–please specify_____			
Others–please specify_____			
Others–please specify_____			

Question 2 (a):

Please provide the number of staff who provides recreation services to residents in each category.

Staff	# of Full-Time Staff Providing Recreation	#Part-Time Staff Providing Recreation
Recreation Therapists		
Recreation Therapy Assistants/Aides		
Activity Coordinators		
Nurses: RNs		
Nurses: RPNs		
Nurses: LPNs		
Health Care Aides		
Occupational Therapists		
Physiotherapists		
Rehabilitation Assistants		
Front-desk/Administration Staff (Day)		
Front-desk/Administration Staff (Night)		
Volunteer Coordinators		
Volunteers		
Others–please specify_____		
Others–please specify_____		
Others–please specify_____		
Total		

Question 2 (b):

What <u>percentage of time</u> do they spend on recreation activities?

Staff	Full-Time Staff % of Time Spent on Recreation Activities	Part-Time Staff % of Time Spent on Recreation Activities
Recreation Therapists		
Recreation Therapy Assistants/Aides		
Activity Coordinators		
Nurses: RNs		
Nurses: RPNs		
Nurses: LPNs		
Health Care Aides		
Occupational Therapists		
Physiotherapists		
Rehabilitation Assistants		
Front-desk/Administration Staff (Day)		
Front-desk/Administration Staff (Night)		
Volunteer Coordinators		
Volunteers		
Others–please specify_____		
Others–please specify_____		
Others–please specify_____		

Question 3:

Please provide a copy of the last three months of your site's recreation schedule as an attachment (PDF or Word)?

Please list any recreation programs or services missing from these recreation schedules:

Activity Name	Number of Hours per Month

1.

2.

3.

4.

5…

Question 4:

Do you have any comments you would like to make regarding the effects of recreation activities on the quality of life of residents in long-term care and supportive living?

We will be surveying residents in both supportive living and long-term care sites. Are you willing to have your site participate in the survey that will examine the effects of recreation on residents' quality of life?

Yes ☐ **No** ☐

If yes, please provide the following information:

Contact Person :_____ **Phone #:_____**

Title/designation:_____ **Email: _____**

_____

APPENDIX 2 - RESIDENT SURVEY

Recreation and Quality of Life Questionnaire

The purpose of this study is to learn more about how often people participate in recreation activities and what effect it has on their quality of life. As a voluntary participant in this study, it will take you approximately 10 minutes to complete the survey. If you have any questions, please refer to the Participant Information Letter you were given.

Section A: The following statements assess how often you participated in various recreation activities over the past **three** months. Please circle the number that applies to you.

Recreation Activities	*Never*	*Seldom*	*Some times*	*Often*	*Very Often*
1. Doing outdoor activities, such as visiting parks or going to barbeques and patio events.	**1**	**2**	**3**	**4**	**5**
2. Playing games, such as cards, board games, table games, or computer games.	**1**	**2**	**3**	**4**	**5**
3. Doing social activities, such as having tea or coffee, or visiting with friends and family members.	**1**	**2**	**3**	**4**	**5**
4. Exercising, such as walking, fitness classes, carpet bowling, or doing a physical activity.	**1**	**2**	**3**	**4**	**5**
5. Media activities, such as reading, listening to music, or watching television.	**1**	**2**	**3**	**4**	**5**
6. Doing artistic or creative activities, such as crafts, singing, or dancing.	**1**	**2**	**3**	**4**	**5**
7. Going to special events outside the facility.	**1**	**2**	**3**	**4**	**5**
8. Resting or relaxing, by doing nothing or having a nap.	**1**	**2**	**3**	**4**	**5**
9. Spiritual activities, such as going to church services or reading the Bible.	**1**	**2**	**3**	**4**	**5**
10. Other activities, such as:_____ _____	**1**	**2**	**3**	**4**	**5**
11. Other activities, such as:_____ _____	**1**	**2**	**3**	**4**	**5**
12. Other activities, such as:_____ _____	**1**	**2**	**3**	**4**	**5**

Section B: The following statements assess who organized the recreation activities you participated in over the past **three** months. Please circle the number that applies to you.

	Never	*Seldom*	*Some times*	*Often*	*Very Often*
1. I organized the recreation activities I did on my own.	**1**	**2**	**3**	**4**	**5**
2. Staff members organized the recreation activities I did.	**1**	**2**	**3**	**4**	**5**
3. Non-staff members (such as friends or family) organized the recreation activities I did.	**1**	**2**	**3**	**4**	**5**
4. I organized the recreation activities I did, but staff members encouraged or assisted me.	**1**	**2**	**3**	**4**	**5**
5. I organized the recreation activities I did, but non-staff members (such as friends or family) encouraged or assisted me.	**1**	**2**	**3**	**4**	**5**

Section C: The following statements assess how often various needs were satisfied during your recreation activities over the past **three** months. Please circle the number that applies to you.

	Never	*Seldom*	*Some times*	*Often*	*Very Often*
1. My recreation activities increased my knowledge about things around me.	**1**	**2**	**3**	**4**	**5**
2. My recreation activities helped me develop close relationships with others.	**1**	**2**	**3**	**4**	**5**
3. My recreation activities developed my physical fitness.	**1**	**2**	**3**	**4**	**5**
4. I have had social interaction with others through my recreation activities.	**1**	**2**	**3**	**4**	**5**
5. My recreation activities gave me self-confidence.	**1**	**2**	**3**	**4**	**5**
6. My recreation activities helped me stay physically healthy.	**1**	**2**	**3**	**4**	**5**
7. I used many different skills and abilities in my recreation activities.	**1**	**2**	**3**	**4**	**5**
8. My recreation activities contributed to my emotional well-being.	**1**	**2**	**3**	**4**	**5**
9. The people I met in my recreation activities were friendly.	**1**	**2**	**3**	**4**	**5**
10. My recreation activities helped me reduce my stress.	**1**	**2**	**3**	**4**	**5**
11. My recreation activities gave me a sense of accomplishment.	**1**	**2**	**3**	**4**	**5**
12. My recreation activities were physically challenging.	**1**	**2**	**3**	**4**	**5**

Section D: The following statements assess how often you experienced various feelings over the past **three** months. Please circle the number that applies to you.

	Never	*Seldom*	*Sometimes*	*Often*	*Very Often*
1. Content	**1**	**2**	**3**	**4**	**5**
2. Depressed	**1**	**2**	**3**	**4**	**5**
3. Excited	**1**	**2**	**3**	**4**	**5**
4. Sad	**1**	**2**	**3**	**4**	**5**
5. Calm	**1**	**2**	**3**	**4**	**5**
6. Nervous	**1**	**2**	**3**	**4**	**5**
7. Drowsy	**1**	**2**	**3**	**4**	**5**
8. Angry	**1**	**2**	**3**	**4**	**5**

Section E: The following statements assess how satisfied you have felt about your life over the past **three** months. Please circle the number that applies to you.

	Strongly Disagree	*Slightly Disagree*	*Neutral*	*Slightly Agree*	*Strongly Agree*
1. As I look at my life, I am fairly well satisfied.	**1**	**2**	**3**	**4**	**5**
2. I am just as happy as when I was younger.	**1**	**2**	**3**	**4**	**5**
3. I expect some interesting and pleasant things to happen to me in the future.	**1**	**2**	**3**	**4**	**5**
4. I would not change my past, even if I could.	**1**	**2**	**3**	**4**	**5**
5. My life could be happier than it is now.	**1**	**2**	**3**	**4**	**5**
6. I have made plans for things I'll be doing a month or a year from now.	**1**	**2**	**3**	**4**	**5**
7. These are the best years of my life.	**1**	**2**	**3**	**4**	**5**
8. I have gotten pretty much what I expect out of life.	**1**	**2**	**3**	**4**	**5**

Section F: The following statement assesses your physical mobility. Please indicate which response best describes your situation by circling the corresponding letter.

1. **Which one of the following statements best describes how you usually get around inside your facility?**
   a. I can walk independently without the use of any walking aids.
   b. I require the use of a walking aid, such as a cane or walker.
   c. I require the use of a wheelchair.
   d. I require the assistance of another person to be mobile.

Section G: We need to know a bit about the people who complete this survey. Please provide us with some basic information.

1. **What is your gender?** **Male** ☐ **Female** ☐
2. **What year were you born?** _____
3. **What is your marital status?**

   Single/never married ☐ Married/common-law ☐ Widowed ☐ Other ☐
4. **What is the highest level of education you completed?** _____
5. **Do you generally read, write, and speak in English or in another language?**

   ☐ English ☐ Another language (If so, what is it? _____)
6. **What is the name of the facility you are living in?** _____
7. **How many months have you lived in this facility?** _____ months.
8. **Did you complete this questionnaire by yourself or did someone else help you?**

   ☐ I did it myself. ☐ I had help. (If so, what is the person's relationship with you? _____)

Section H: The final section may help your facility plan future recreation activities.

1. **Are there any new recreation activities you would like to start doing?**

   _____

   _____

2. **Are there any current recreation activities you would like to do more often?**

   _____

   _____

APPENDIX 3 - FOCUS GROUP TOOLS FOR FIRST SERIES (REVIEW OF RESIDENT SURVEY)

1. Focus Group Information letter and consent form
2. Focus group guide

INSTITUTE FOR CONTINUING CARE EDUCATION & RESEARCH

4-023 Edmonton Clinic Health Academy
University of Alberta
11405 – 87 Avenue NW
Edmonton, AB T6G 1C9
http://www.iccer.ca

TITLE: Recreation Therapy and Quality of Life in Continuing Care Study

SPONSOR: Alberta Health

PRINCIPAL INVESTIGATORS:

Dr. Gord Walker, Professor Physical Education and Recreation, University of Alberta
(gwalker@ualberta.ca, 780-492-0581)
Dr. Bob Haennel, Acting Dean and Professor Rehabilitation Medicine, University of Alberta
(bob.haennel@ualberta.ca, 780-492-5991)

CO-INVESTIGATORS:

Francine Drisner, CapitalCare
Jennifer Grusing, AgeCare
Craig Hart, NorQuest College
Renate Sainsbury, Lifestyle Options
Gail Thauberger, Bow Valley College
Vincella Thompson, Keyano College

PROJECT COORDINATOR:

Sandra Woodhead Lyons, Executive Director, Institute for Continuing Care Education and Research (ICCER) (780-248-1504)

This information letter is only part of the process of informed consent. It should give you the basic idea of what this research is about and what your participation will involve. If you would like more details, please ask. Take the time to read this letter carefully and to understand any accompanying information. You will receive a copy of this letter.

BACKGROUND

Little is known about the impact of recreation services and interventions on the quality of life for individuals in the continuing care sector. In 2012 ICCER identified the need for study and documentation of the benefits of recreation therapy services. Residents, clients, families, and front-line staff see the benefits from these interventions, but the way funding is provided in Alberta makes it hard for providers to justify hiring more recreation therapy staff. From the perspective of the front-line workers, engagement in therapeutic and recreational interventions and programs increases motivation, independence, functional capacity and quality of life. It also appears to decrease the need for certain types of medications and reduces challenging behaviors.

WHAT IS THE PURPOSE OF THE STUDY?

This study will examine recreation therapy activities in supportive living and long term care facilities in Alberta. The study will focus on the relationship between frequency, duration, and nature of recreation activities, the six dimensions of recreation satisfaction, and their impact on the quality of life. The results will potentially be used to encourage more funding for recreation staff in continuing care.

WHAT WOULD I HAVE TO DO?

You have been asked to participate in a focus group. The focus group will last approximately one hour. This focus group is specifically to talk about the survey the research team plans to do with residents in supportive living and continuing care. You will be asked to freely share your opinions about any issues, or ideas for administering the survey, and to comment on any other issues or needs that you think the researchers need to know or be aware of.

We would like to get your permission to audio-record the sessions to provide an accurate record of our conversation. Notes will also be taken.

WHAT ARE THE RISKS?

There are no known risks to participating in this study. Your job will not be affected in any way by your participation in this study or by the information you provide.

WILL I BENEFIT IF I TAKE PART?

There is no direct benefit to participating in this study although information collected will be used in the larger study on the effects of recreation therapy activities and quality of life for residents. The study may have an impact on improving recreation therapy activities in Alberta.

DO I HAVE TO PARTICIPATE?

Your participation in the study is voluntary. You may decline to answer any of the questions and end your part in the study at any time. Should you wish to withdraw from the study, please inform the researcher or contact the individual listed below. If you decide to withdraw, please be aware that your recorded comments and answers will not be coded in the transcriptions but can not be removed from the data up to that point.

You also have the right to ask questions and ask for more information whenever you like.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

You may be asked to participate in a follow-up interview if we have more questions for you.

WILL MY RECORDS BE KEPT PRIVATE?

During the focus group there may be individuals who know and recognize you. Although we request focus group participants respect the confidentiality of others in the group, we cannot guarantee it. Outside the group, your anonymity and confidentiality will be ensured in the transcribed data. You will not be identified by name in the transcription process.

The Project Coordinator, the research assistant, and any of the research team participating in the focus group are aware that you are participating in this study and therefore it may not be possible for you to take part in the study anonymously. The information that you provide, however, will be kept confidential. Code numbers will be used on transcripts and notes. Lists of participants along with the code number and consent forms will be stored separately from the data. All information from the study will be reported at a high level only meaning that your name will not be identified. Only principal and co-investigators, project coordinator, and research assistant will review transcripts and notes. All data collected will be stored in a locked cupboard at the University of Alberta for a period of five years.

Ideas and quotes from focus groups and notes will be used for interim and final reports, publications and presentations of research information, but at no time will you be known by your name or in any other way. Anonymity and privacy will be assured as much as possible. You may have a copy of interim and final reports.

This study has been approved by the Health Research Ethics Board, University of Alberta.

CONTACTS

If you have further questions concerning matters related to this research, please contact Sandra Woodhead Lyons, Executive Director, Institute for Continuing Care Education and Research (ICCER), 4-023 Edmonton Clinic Health Academy, University of Alberta, 11405 - 87 Avenue NW, Edmonton AB T6G 1C9 (780-248-1504 or sandra@iccer.ca).

If you have any questions concerning your rights as a possible participant in this research, please contact the Research Ethics Office, University of Alberta at 780-492-2615.

4-023 Edmonton Clinic Health Academy
University of Alberta
11405 - 87 Avenue NW
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CONSENT FORM

TITLE: Recreation Therapy and Quality of Life Study

PRINCIPAL INVESTIGATORS:

Dr. Gord Walker, Professor Physical Education and Recreation, University of Alberta (gwalker@ualberta.ca, 780-492-0581)
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Craig Hart, NorQuest College
Renate Sainsbury, Lifestyle Options
Gail Thauberger, Bow Valley College
Vincella Thompson, Keyano College

PROJECT COORDINATOR:

Sandra Woodhead Lyons, Executive Director, Institute for Continuing Care Education and Research (ICCER) (780-248-1504)

Do you understand that you have been asked to be in a research study?	❒	Yes	❒	No
Have you read and received a copy of the attached Information Letter?	❒	Yes	❒	No
Do you understand the benefits and risks involved in taking part in this research study?	❒	Yes	❒	No
Have you had an opportunity to ask questions and discuss this study?	❒	Yes	❒	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason	❒	Yes	❒	No
Has the issue of confidentiality been explained to you?	❒	Yes	❒	No
Do you understand who will have access to the information you give?	❒	Yes	❒	No
Do you understand that the focus group will be audio-recorded?	❒	Yes	❒	No

Continued page 2.

INSTITUTE FOR CONTINUING CARE EDUCATION & RESEARCH

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University of Alberta
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This study was explained to me by: _____

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness
_____		_____
Printed Name		Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Investigator or Designee	Date

FOCUS GROUP PROTOCOL

1. INTRODUCTION [approx. 5 minutes]

Welcome Everyone! I want to start by thanking all of you for coming today. My name is Sandra Woodhead Lyons and I will be facilitating the group today. I would like to introduce my colleague (X) who will be observing the session and taking notes.

I hope each of you have received information about the purpose of this meeting today. However, I will go over the purpose of this study and give you an overview of what we will be doing during this session.

First, I would like to cover some housekeeping issues.

I assume that you have all filled out the consent form already. If you arrived late and have not filled out the consent form, I will have to ask that you do so now before we continue.

Just a reminder that this session will be will be recorded on audiotape. One reason we do this is so we can identify key themes from the focus groups. However, I want to assure you that everything you say here will be kept anonymous. Your name will not be associated with anything that you say. Sometimes however one of you may say something that concisely captures a point that has been raised frequently. In that case, we may use your exact words as a quote. But we would NOT identify WHO had said these words.

Because we are taping the session, I have to ask you to speak one at a time. If several people are talking at once, the tape recorder cannot pick up what is being said and I might miss something important. As well, I do want to hear from everyone. And so I would ask that all of you be respectful of the thoughts and opinions expressed during the session; thus, allowing for an equal opportunity for everyone to speak and participate. I may try to draw some people into the discussion. But I don't want to make you uncomfortable. Hopefully you will feel free to participate – sharing as little or as much as you are comfortable with. Also, I would like to ask that what is said here stays here. Just as we will be respecting your confidentiality, we ask that you respect the confidentiality of others in the group. Please do not discuss what others in the group have shared.

How long will all this take?

Today, our session should last approximately an hour and a half.

During the discussion today, we would like to hear YOUR opinion. When we have discussions, we would like you to speak up and voice your opinion especially if it is different from the opinions already raised. We do NOT want everyone to agree with each other - rather we would like to hear all the varying viewpoints. In other words, it is certainly all right to disagree with something that someone else has said.

Purpose

The purpose of this focus group is to talk about the survey the research team plans to do with residents in supportive living and continuing care.
Today we want to identify any issues or concerns you might have based on your knowledge of the residents you work with. This information will be used to improve the administration of the resident survey.

2. PARTICIPANT INTRODUCTIONS [approx. 5-10 minutes]

We would like to start with introductions. We would like to introduce ourselves and we will ask you to do the same. Knowing each other will allow us all to feel comfortable in this enriching discussion.

3. QUESTIONS [approx. 40 minutes]

After the introductions, the team will share the resident survey (attached to ethics application form in documentation section), to encourage discussion and as a starting point.

1. *What's your overall impression of the survey?*
2. *Comment on the format and font size? Do you anticipate most of your residents will be able to read it? Understand it?*
3. *Do you have specific comments or concerns about any of the questions?*
4. *What will be the most effective way to administer the survey in your facility? (need info on type of facility and residents)*

Discussion is encouraged around how the group feels it can be most effectively administered. The team will provide background on specific questions as to why they were selected and why they were worded the way they are.

4. CONCLUSION AND WRAP UP

[5 minutes]

Facilitator will summarize some of the key issues or features of the discussion and will ask if any participants have any final comments or feedback in regards to the focus group.

Final thank you, wrap-up, and discussion of any further housekeeping issues.

APPENDIX 4 - FOCUS GROUP TOOLS FOR SECOND SERIES

1. Focus Group Information letter and consent form
2. Focus group guide

FOCUS GROUP PROTOCOL

1. INTRODUCTION [approx. 5 minutes]

Welcome Everyone! I want to start by thanking all of you for coming today. My name is Sandra Woodhead Lyons and I will be facilitating the group today. I would like to introduce my colleague (X) who will be observing the session and taking notes.

I hope each of you have received information about the purpose of this meeting today. However, I will go over the purpose of this study and give you an overview of what we will be doing during this session.

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How long will all this take?

Today, our session should last approximately an hour and a half.

During the discussion today, we would like to hear YOUR opinion. When we have discussions, we would like you to speak up and voice your opinion especially if it is different from the opinions already raised. We do NOT want everyone to agree with each other - rather we would like to hear all the varying viewpoints. In other words, it is certainly all right to disagree with something that someone else has said.

Purpose

The purpose of this focus group is to discuss recreation therapy activities with residents in supportive living and continuing care.

Today we want to

2. PARTICIPANT INTRODUCTIONS [approx. 5-10 minutes]

We would like to start with introductions. We would like to introduce ourselves and we will ask you to do the same. Knowing each other will allow us all to feel comfortable in this enriching discussion. Please be sure to include your role, for instance recreation therapist, or recreation therapy assistant.

4. QUESTIONS [approx. 40-60 minutes]

Thank you for the introductions. I notice that there were x number of (RTs, RTAs, etc). Is this representative of the people who provide recreation therapy activities in your organization?

Who else is involved?

What sort of activities do you include under recreation therapy? Do you do one-on-one activities with residents? Or only group activities?

How active are your residents in choosing activities they want to do? Do you supervise/support resident directed activities?

What do you consider Quality of Life (QOL) to be, particularly in regards to your residents? Do you see a relationship between what you do, in terms of recreation, and QOL for the residents? What effect does recreation have on your residents lives?

4. CONCLUSION AND WRAP UP

[5 minutes]

Facilitator will summarize some of the key issues or features of the discussion and will ask if any participants have any final comments or feedback in regards to the focus group.

Final thank you, wrap-up, and discussion of any further housekeeping issues.

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CONSENT FORM

TITLE: Recreation Therapy and Quality of Life Study

PRINCIPAL INVESTIGATORS:

Dr. Gord Walker, Professor Physical Education and Recreation, University of Alberta (gwalker@ualberta.ca, 780-492-0581)
Dr. Bob Haennel, Acting Dean and Professor Rehabilitation Medicine, University of Alberta (bob.haennel@ualberta.ca, 780-492-5991)

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Gail Thauberger, Bow Valley College
Vincella Thompson, Keyano College

PROJECT COORDINATOR:

Sandra Woodhead Lyons, Executive Director, Institute for Continuing Care Education and Research (ICCER) (780-248-1504)

Do you understand that you have been asked to be in a research study?	❒	Yes	❒	No
Have you read and received a copy of the attached Information Letter?	❒	Yes	❒	No
Do you understand the benefits and risks involved in taking part in this research study?	❒	Yes	❒	No
Have you had an opportunity to ask questions and discuss this study?	❒	Yes	❒	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason	❒	Yes	❒	No
Has the issue of confidentiality been explained to you?	❒	Yes	❒	No
Do you understand who will have access to the information you give?	❒	Yes	❒	No
Do you understand that the focus group will be audio-recorded?	❒	Yes	❒	No

Continued page 2.

This study was explained to me by: _____

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness
_____		_____
Printed Name		Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Investigator or Designee	Date

APPENDIX 5 – LITERATURE REVIEW

In psychology, quality of life (QOL) is often called "subjective well-being" (SWB). "Subjective well-being is a broad category of phenomena that includes people's emotional responses, domain satisfactions, and global judgements of life satisfaction" (Diener, Suh, Lucas, & Smith, 1999, p. 277). Each of these components can be further sub-divided into: (a) positive (e.g. happiness) and negative (e.g. depression) affect; (b) satisfaction with one's current life as a whole or distinct areas thereof; and (c) satisfaction with different domains, including recreation (Diener et al., 1999). In part because personality traits are relatively stable, people typically maintain, or eventually return to, the same level of happiness (Lyubomirsky, Sheldon, & Schkade, 2005) and life satisfaction (Cummins, 2013). This so-called "hedonic set point" explains roughly 50 percent of a person's SWB, with another 10 percent or so being explained by "life circumstances" (e.g. age, gender; Lyubomirsky, 2008). The remaining 40 percent is dependent on the degree to which an individual engages in "intentional activities" that are flexible, self-congruent, self-determined, intrinsically-appealing, and socially-supported (Lyubomirsky, 2008).

Spiers and Walker (2009) noted that the intentional activity characteristics identified by Lyubomirsky (2008) were very similar to the attributes often ascribed to leisure (cf. Kleiber, Walker, & Mannell, 2011). Similarly, after conducting a comprehensive review of the pertinent literature, Newman, Tay, and Diener (2014) proposed that leisure could "trigger" five core psychological mechanisms—detachment-recovery, autonomy, mastery, meaning, and affiliation (or DRAMMA)—that, in turn, could lead to increased SWB. Many of these mechanisms correspond with what Beard and Ragheb (1980) called recreation satisfaction, that is: "the positive perceptions or feelings which an individual forms, elicits, or gains as a result of engaging in leisure activities and choices. It is the degree to which one is presently content or pleased with his/her general leisure experiences and situations" (p. 22). Beard and Ragheb identified six recreation satisfaction sub-dimensions, five (i.e. social, psychological, physiological, educational, and relaxation) of which are congruent with SWB as described above, while the sixth (i.e. aesthetic) is better construed as leisure satisfaction facilitator.

To date, the majority of empirical research on the above has focused on how frequency of leisure participation, and overall leisure satisfaction, influence SWB. Of these two, leisure satisfaction is the better predictor (Kleiber et al., 2011), likely because leisure participation is antecedent to leisure satisfaction (Walker, Halpenny, Spiers, & Deng, 2011). A recent meta-analysis (Kuykendall, Tay, & Ng, 2015) supports the above, with these researchers reporting intercorrelations of: .26 between leisure participation and SWB, .38 between leisure satisfaction and SWB, and .42 between leisure participation and leisure satisfaction.

Although Kuykendall and colleagues (2015) also examined the relationships between leisure participation, leisure satisfaction, and SWB separately for workers and retirees—and discovered, for example, that the latter group generally exhibited stronger correlations—none of these retirees, as far as we could ascertain, resided in CC facilities. (Somewhat similarly, in the aging area, Adams, Leibbrandt, and Moon, 2011, reviewed over 40 studies on social and leisure activity and wellbeing in later life, but did not identify whether participants were community- or site-based.) In fact, a review of the literature by our research team suggested this type of research is relatively rare. Among the few exceptions are: (a) Horowitz and Vanner's (2010) study of seniors aged 65 and older residing in assisted living facilities, which "found significant low to moderate correlations between retained engagement in life activities (leisure, social, and instrumental activities of daily living and life satisfaction, and several QOL domains, including physical functioning, mental health, general health, and vitality" (p. 130). And (b) McGuinn and Mosher-Ashley's (2000) study of older adults residing in LTC facilities, that found that although the

overall number of recreation activities participated in did not affect residents' life satisfaction, those who reported engaging in self-generated recreation activities had a higher level of life satisfaction than those that did not. Worth noting here is that neither of these investigations measured recreation satisfaction, which has been found to be an intervening variable between recreation participation and life satisfaction (Kuykendall et al., 2015; Walker et al., 2011).

Also noteworthy is that it may not only be whether recreation activities are or aren't self-generated that is important, but also the amount of direct care provided by activity staff. For instance, in a longitudinal study of nursing homes from 2007 to 2010, Shippee and associates (2014) found that, while age, gender, marital status, and functional health were consistent predictors across a number of QOL domains, "[t]he positive association between increases in QOL and activity staff hours suggests the importance of providing residents with participation in social or goal-directed activities. Interventions to improve QOL among this group of facilities may include increasing the number of hours per day of activity staff" (p. 574). Bergland and Kirkevold's (2006) study of Norwegian nursing home residents seems to support both approaches, as their participants reported both organized (e.g. musical events) and self-initiated (e.g. reading) recreation activities were described as pleasant and meaningful, and contributed to a sense of thriving.

Solely self-organized recreation, and entirely externally-organized recreation, can be viewed as the opposite poles on a recreation service continuum (Rossman & Schlatter, 2008). Various permutations (or "modes") exist between these two extremes; and this is true for each external recreation provider. Thus, in order to understand a CC resident's overall recreation satisfaction, it would seem necessary to know both his or her overall recreation participation frequency *and* not only how frequently each mode is employed by him or her (e.g. self-organized, self-organized but externally facilitated; externally organized), but also across all major external recreation providers (e.g. facility staff; non-facility staff, such as family and friends).

APPENDIX 6 – DETAILED STATISTICAL INFORMATION FOR ON-LINE SURVEY RESULTS

Hierarchical Regression Results Predicting Overall Recreation Satisfaction

Regression Variable Predicting Overall Recreation Satisfaction	Block 1: Sociodemographic Characteristics and Type of Facility	Block 2: Block 1 Plus Overall Recreation Participation Frequency	Block 3: Blocks 1 and 2 Plus Recreation Service Modes	Key Findings
Intercept	3.60	1.02	0.50	-----
Gender	-0.13**	-0.09**	-0.11***	Higher for females than males
Year of Birth	0.00	0.00	0.00	-----
Physical Mobility	0.08	0.05	0.05	-----
Type of Facility	-0.04	0.00	0.04	-----
Overall Recreation Participation Frequency	-----	0.73****	0.63****	Variable having the largest positive effect
Independent Mode (Resident organizes recreation activities on his/her own)	-----	-----	0.10***	-----
Dependent - Staff Mode (Resident staff organize recreation activities)	-----	-----	0.06*	-----
Dependent - Non-Staff Mode (Non-staff —e.g. family, friends—organize recreation activities)	-----	-----	0.00	-----
Interdependent – Staff Mode (Resident organizes but resident staff facilitate recreation activities)	-----	-----	0.16****	Mode that has the largest positive effect
Interdependent – Non-Staff Mode (Resident organizes but non-staff—e.g. family, friends— facilitate recreation activities)	-----	-----	-0.09*	Only Mode that has a negative effect
Explained Variance	**.04**	**.31**	**.37**	-----
***Note*. 1**=Never. **2**=Seldom. **3**=Sometimes. **4**=Often. **5**=Very Often. * $p < .05$. ** $p < .01$. *** $p < .001$. **** $p < .0001$.				

Hierarchical Regression Results Predicting Quality of Life – Positive Affect

Regression Variable Predicting Positive Affect	Block 1: Sociodemographic Characteristics and Type of Facility	Block 2: Block 1 Plus Overall Recreation Participation Frequency	Key Findings
Intercept	3.52	2.27	-----
Gender	-0.05	-0.01	-----
Year of Birth	0.00	0.00	-----
Physical Mobility	0.15**	0.11*	Higher for those who could walk independently
Type of Facility	0.00	0.01	-----
Overall Recreation Satisfaction	-----	0.34****	Variable having the largest positive effect
Explained Variance	**.02**	**.13**	-----
***Note*. 1**=Never. **2**=Seldom. **3**=Sometimes. **4**=Often. **5**=Very Often. ***** $p < .05$. ****** $p < .01$. ******* $p < .001$. ******** $p < .0001$.			

Hierarchical Regression Results Predicting Quality of Life – Life Satisfaction

Regression Variable Predicting Life Satisfaction	Block 1: Sociodemographic Characteristics and Type of Facility	Block 2: Block 1 Plus Overall Recreation Participation Frequency	Key Findings
Intercept	4.19	2.55	-----
Gender	-0.08	-0.02	-----
Year of Birth	-0.01	0.00	-----
Physical Mobility	0.19**	0.15**	Higher for those who could walk independently
Type of Facility	-0.02	0.00	-----
Overall Recreation Satisfaction	-----	0.46****	Variable having the largest positive effect
Explained Variance	**.04**	**.16**	-----
***Note*. 1**=Strongly Disagree. **2**=Disagree. **3**=Neutral. **4**=Slightly Agree. **5**=Strongly Agree. ***** $p < .05$. ****** $p < .01$. ******* $p < .001$. ******** $p < .0001$.			

APPENDIX 7 – REFERENCES FOR THE REPORT

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