"Here for the Residents": A Case Study of Cultural Competence of Personal Support Workers in a Long-Term Care Home

Aysha Tayab and Miya Narushima

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Aysha Tayab, MA[1], and Miya Narushima, PhD[2]

Abstract

Purpose: This study explores the perception of cultural competence of personal support workers (PSWs) in a long-term care (LTC) home in Ontario. As Canada's demography becomes older and more diverse, LTC homes will increasingly accommodate residents from various cultural backgrounds. However, few studies have examined cultural competence among PSWs in the LTC home setting. **Design:** The study employed a qualitative case study approach. Data collection and analysis were conducted in three phases: document analysis of organizational policies, a key informant interview with the Director of Care, and two focus groups with PSWs. **Results:** Our findings illuminated the PSWs' broad definition of culture, the process of developing cultural competence and its strong connections to person-centered care, and the organizational factors that facilitate or hinder PSWs' cultural competence. **Implications:** The ambiguous perception of cultural competence reported by PSWs suggests the need for more education and further research on this topic.

Keywords

gerontology, long-term care homes, personal support workers, cultural competence, qualitative research

Introduction

Canada is simultaneously getting older and more diverse. The ratio of "senior citizens" (65 years and older) currently constitutes 14.8% of the total population, a figure that is projected to almost double by 2036 (Statistics Canada, 2007, 2012). The majority of immigrant seniors today are from countries in Western and Northern Europe and the United States. Over the last two decades, however, the source countries of immigration have dramatically changed. According to the 2006 Census, 75% of immigrants are from Asia, the Middle East, Central and South America, the Caribbean, and Africa (Statistics Canada, 2008). The aging of the increasingly diverse Canadian mosaic will pose some new challenges for health care providers, families, and communities that serve older people in the coming years (Conference Board of Canada, 2011; Novak & Campbell, 2006).

One such challenge is how to incorporate culturally competent care delivery in long-term care (LTC) facilities, especially through personal support workers (PSWs) who provide direct care to residents by assisting them in their daily activities (Parker & Geron, 2007). A large number of PSWs themselves are from diverse ethnocultural backgrounds (Armstrong, Armstrong, & Scott-Dixon, 2008; Lilly, 2008; Parker & Geron, 2007; Stone, 2005). According to the Ministry of Training, Colleges, and Universities in Ontario (2004), PSWs are required to learn cultural sensitivity as part of their training. Nevertheless, there is limited research on PSWs' cultural competence in LTC settings. How do PSWs perceive cultural competence in their LTC practice? How does culturally competent care function in an LTC home? What strategies are suitable to enhance culturally competent practices among PSWs? To answer these questions, this qualitative case study explored PSWs' perceptions and practices of cultural competence within the work environment of an Ontario LTC home.

Literature Review

Personal Support Workers

PSWs are a growing body of unregulated health care workers in Ontario, who provide direct personal support services to vulnerable populations, such as the elderly and people with disabilities, by assisting with personal hygiene, dressing, toileting, feeding, transferring and escorting, and providing social support (Kontos, Miller, & Mitchell, 2010; Ministry of Health and Long Term Care, 2011). Although their work differs from homemaking (e.g., cooking, meal preparation, and cleaning and laundry), PSWs may carry out these functions

[1]Independent Practice, Kingston, Ontario, Canada
[2]Brock University, St. Catharines, Ontario, Canada

Corresponding Author:
Aysha Tayab, 103-95 Notchill Rd., Kingston, Ontario, Canada K7M5Y6.
Email: aysha.tayab@gmail.com

depending on their workplace needs (Lilly, 2008). Although "PSW" is often used as job title in Canada, the international classification of health workers by the World Health Organization (2010) defines their job as similar to that of a "health care assistant" (e.g., nursing aid, patient care assistant), classified under "personal care workers in health services." According to a study of ancillary health care workers in Canada, PSWs are "invisible and undervalued" (p. 4) workers who are disproportionately women, immigrants and people from racialized groups, and part-time staff paid a minimum wage, who often work at multiple sites to amass full-time hours (Armstrong et al., 2008). While PSWs work in all types of health care facilities, they are most commonly employed in LTC homes and home care. There are approximately 57,000 PSWs working in Ontario LTC homes (Lilly, 2008).

Although Ontario's Long-Term Care Act in 2010 outlined a minimum standard of education for PSWs working in LTC facilities, there is still huge variation across training programs that PSWs receive at community colleges, continuing education programs, and private career colleges, since there is no standardized curriculum and the length of training varies across the programs. PSWs working in LTC homes are required to work under the supervision of a registered nurse or registered practical nurse (Health Professions Regulatory Advisory Council, 2006).

Parker and Geron's (2007) study on cultural competence in LTC homes suggested that ethnoculturally diverse PSWs experience language barriers with their coworkers, the residents, and the residents' family members. The study also found that when residents directed racially discriminatory remarks at PSWs, they were usually ignored or reported to other staff departments. The study concluded that cultural competence is not necessarily a given attribute among PSWs who come from diverse cultural and religious backgrounds and that PSWs need appropriate training to increase their level of understanding of the residents and minimize the impact that language barriers and discriminatory attitudes can pose (Parker & Geron, 2007). Previous research also indicates a number of structural factors in PSWs' work conditions that cause inconsistency of care, which in turn influences their capacity to provide culturally competent care. Such factors include heavy reliance on casual workers (Gnaedinger, 2003), high turnover rates (Barry, Brannon, & Mor, 2005; Gnaedinger, 2003; Kontos et al., 2010), and limited decision-making power (Barry et al., 2005; Gnaedinger, 2003; Janes, 2008; Kontos et al., 2010; Parker & Geron, 2007).

Cultural Competence

Cultural competence in health care is defined as the implementation of behaviors, attitudes, and policies that enable staff and the organization to work effectively in cross-cultural situations (Burchum, 2002; Campinha-Bacote, 1999; Kleinman, 1995; Leininger, 1995; Pacquiao, 2003; Shen, 2004; Suh, 2004). Among the many models, we chose Suh's (2004) as our analytical framework for its comprehensive harmonization of many existing models of cultural competence. Suh (2004) views cultural competence as a social construct in specific contexts, the acquisition of which can be understood using three components: *antecedents, attributes*, and *outcomes*. The antecedents are elements of cultural competence such as "awareness," "knowledge," "sensitivity," "skills," and "encounters." The blend of these antecedents is then developed into cultural competence by optimizing three personal *attributes*—"ability," "openness," and "flexibility." The mastery of cultural competence leads to *outcomes* for patients (e.g., "holistic nursing care," "health care satisfaction," "adherence to treatment"), health care providers (e.g., "personal and professional development"), and health care organizations (e.g., "improved quality of nurse performance," "improved treatment and cost effectiveness"). In this way, Suh's model (2004) helps us understand the constituents, processes, and outcomes of developing culturally competent care. However, since this model was created for nurses working in acute care settings, we wanted to find out whether it could be applied to PSWs in LTC homes. One factor distinguishing acute care settings and LTC homes is that a LTC home is not a mere health care facility; it is a residence for many older adults in their last stage of life.

Person-Centered Care

Person-centered care emphasizes the integration of the social model of care (Gnaedinger, 2003; Jones, 2011; Kitwood, 1997; Kontos et al., 2010). This approach encourages LTC home staff to understand the resident from a holistic perspective and, furthermore, to customize their care delivery based on each resident's needs and lifestyle (Gnaedinger, 2003). Various models have been developed (Barry et al., 2005; Canadian Healthcare Association, 2009; Gnaedinger, 2003; Jones, 2011; Kitwood, 1997; Rahman & Schnelle, 2008; Robinson & Gallagher, 2008; Stolee et al., 2005). These models commonly highlight the reciprocal benefits of person-centered care for the residents and care providers. When LTC staff understand and prioritize the residents' needs, the residents' quality of life is improved and the PSWs' job becomes more rewarding (Jones, 2011; Robinson & Gallagher, 2008). However, the literature on person-centered care has not explicitly identified cultural competence as a contributing factor. Since cultural competence is a relatively new concept in LTC research (Parker & Geron, 2007), it has not been fully studied in relation to person-centered care.

Methodology

Research Design

This study employed a qualitative case study approach to understand PSWs' perceptions and practice of cultural

competence in the context of an Ontario LTC home. Merriam's (2009) case study approach enabled us to scrutinize a "bounded system" from multiple angles. In this study, the bounded system of an Ontario LTC home was described and analyzed. We used multiple data sources to uncover the bounded nature of the selected home, thereby allowing us to draw on multiple sources for evidence of culturally competent care in the PSWs' daily practice. We argued that qualitative research methods were best for collecting rich information in collaboration with PSWs in their work environment. We investigated PSWs' perceptions and practice of cultural competence through documentary analysis, a key informant interview with the Director of Care (DOC), and focus groups with PSWs. Ethics clearances were obtained from the Research Ethics Boards of the LTC home and the researchers' university.

The Case

The case is a nonprofit charitable LTC home located in a metropolitan area with a population of 520,000 in Ontario (called the LTC Home henceforth). Among the eight organizations contacted, the LTC Home was the only one that voluntarily responded to our recruitment flyers. The LTC Home is composed of 370 beds and 550 staff members, approximately 200 of whom work as PSWs. While the LTC Home is faith based, multidenominational services are available to residents. The LTC Home has a good reputation in the area and has received awards from the local community.

Participants

Six employees of this LTC Home voluntarily participated in this study. Their identities were protected through the use of pseudonyms in this article. The DOC participated in a key informant interview, while five PSWs were recruited for two focus groups. The DOC had joined the LTC Home as a registered practical nurse 20 years earlier and had held her current position for 6 years. As head of the nursing department, she was responsible for residents and nursing staff, supervising five registered nurse managers, and overseeing the PSWs working in each of the five units of the LTC Home. Recruiting the PSW participants was the most challenging part of the study. Whether it was due to a lack of time or incentives or for personal reasons, many PSWs seemed reluctant to participate in the study. After our persistent efforts over several weeks, sending invitation letters, providing flyers, and attending staff meetings, five PSWs agreed to participate. They were female between 40 and 50 years old, who had worked at the LTC Home for an average of 20.5 years. All were full-time staff who worked in the same home unit. Two identified themselves as Canadian, while three were immigrants from England, Jamaica, and the Philippines. English was the common language spoken among these participants. The PSW participant from the Philippines speaks Tagalog as well.

Data Collection

Following a pilot test of the interview guides, the data were collected in the fall of 2010 in three phases: a document analysis, a key informant interview, and two focus groups. The documents used for analysis were the Resident's Bill of Rights (a part of the Ontario Government Long-Term Care Homes Act, 2007), the LTC Homes' Mission Statement, Vision Statement, Values Statement, the Philosophy of Care, Hiring Policy, and the PSW Job Description. Following the analysis of documents, the first author conducted a 60-minute semistructured key informant interview with the DOC in her office. The three main areas explored in this interview were (a) organizational policies and practices related to PSWs, (b) her perception of culture and cultural competence, and (c) future prospects for culturally competent care in the LTC Home. It was audio-recorded and was transcribed by the first author immediately after the interview. The last phase involved two focus groups with the five PSWs. Despite our original plan to have four or five participants in each of the two focus groups, the first focus group turned out to have only one participant (we had expected four) due to sudden changes in work shifts and urgent family obligations. The second group had four participants as we had planned. This unforeseen difficulty in the recruitment and data collection process gave us a window into the hectic working life of PSWs in the LTC Home. Although only one PSW participated in the first group, we still considered it a focus group. According to Casey and Kreuger (2009, p. 2), the focus group method involves conducting more than one focus group session as a means to "identify trends and patterns in perceptions." The first focus group provided the researcher with themes to follow-up in the second focus group (Casey & Krueger, 2009). We could also observe some differences in tone when PSWs spoke singly or in a group.

At the beginning of each focus group the participants completed a demographic survey that contained questions about their immigrant status, ethnic and religious background, years of employment, and previous training. The focus groups were semi-structured with open-ended questions in three main areas: the PSWs' perceptions and experiences of culturally competent care delivery, their work conditions in the LTC Home, and their suggestions for training in cultural competence. Each focus group lasted approximately 30 to 45 minutes, was moderated by the first author in the LTC Home during work hours, and was audio-recorded and transcribed. The focus groups were conducted in English. To protect participants' privacy, each focus group participant was asked to sign an informed consent form to pledge that they would keep the discussion confidential.

Data Analysis

Both authors analyzed the data concurrently in three phases. This process allowed them to compare, test, and validate

findings from the previous data set with data collected in the next phase (Creswell, 2013; Merriam, 2009). For the documentary analysis phase, we used Suh's (2004) model as sensitizing concepts. For example, any information that provided an indication of "cultural awareness" in the policy documents was highlighted and the nature of its contents analyzed. Unexpected themes that emerged from documentary analysis and the key informant interview were incorporated into the focus group guide. The data from the key informant interview and focus groups were analyzed following Merriam's (2009) three steps of qualitative data analysis: finding themes and categories through open coding, interpreting the relationships among categories, and using visualization to conceptualize the whole case. Although the key concepts of Suh's (2004) model of cultural competence were also used in the analysis as a guide for comparison and identifying the distinctive nature of culturally competent care in LTC home settings, we were open to any unexpected themes emerging from the participants' stories. These emergent themes revealed unique features of PSWs' perceptions of cultural competence inherent in their work environment. Both researchers regularly met and discussed the results of the analysis. Although we agreed with each other most of the time, when disagreements were identified, we reexamined the original data together.

In order to enhance the reliability of the study, we used multiple strategies to ensure rigor: triangulation through multiple data sources and investigators, member checking by asking participants to check transcript accuracy, and peer review by periodically consulting with two colleagues to get feedback throughout the research process (Creswell & Miller, 2000; Merriam, 2009). The first author kept a detailed reflexive journal to monitor her subjective reactions during the study.

Findings

Through the comparison of major categories and subcategories across the three data sources, we developed the following five overarching themes: (a) culture and cultural competence in the LTC Home, (b) building a relationship with the residents through consistency of care, (c) provision of a homelike environment, (d) the collaborative team approach to care, and (e) in-services for maintaining staff morale. The following section describes the contents of these overarching themes and their subthemes, marked here in italics.

Culture and Cultural Competence in the LTC Home

The DOC and the PSWs had limited familiarity with the term *cultural competence* due to the fact that it was seldom used in their daily practice. However, when asked to describe what it might mean, the DOC described cultural competence with an emphasis on "competence" rather than "culture," pointing to key elements such as "*ability*," "*knowledge*," "*skills*," and "*judgment*." In contrast, the PSW participants described the residents' culture in broader terms in relation to *the residents' daily needs and preferences*: "lots of colours, languages, ways of doing things, thinking about things" (Angela), "beliefs, food, where they were born, how they dress" (Catharine). Concepts such as *age, sexual orientation*, and *mental health status* were also identified as part of the PSWs' *encounters with residents' cultures*: "We deal with different people, like schizophrenia as well as a lot of ethnic [people]" (Catharine), "We have a male resident who puts on his stockings and high heels before going to bed" (Angela). It is clear that both the PSWs and the DOC perceived *culture as a multidimensional and inclusive* concept in this LTC Home; consequently, cultural competence meant *being knowledgeable about each resident's diverse and complex needs* and having the *abilities and skills to accommodate them.*

Building a Relationship With the Residents Through Consistency of Care

Consistency of care emerged as the second overarching theme. The analysis of all three data sources lead us to find that there is a mutual benefit for both the PSW and resident in fostering a positive relationship. The PSW participants' full-time status placed them at an advantage in providing culturally competent care. Aspects of their *daily routine* with the same residents, such as meal times and bath times, provided opportunities for PSWs to learn about not only *residents' present conditions* but also their *past*, and to *build relationships with those residents*. While they appreciated such opportunities, PSWs also described some barriers that limited them from providing consistent care. *Insufficient staffing* limited the amount of time spent with the residents. "Two PSWs to 25 residents is not enough. We need the chance to get to know them" (Angela). Another factor hindering PSW participants was the increasing number of casual and part-time PSWs who "don't know the floor" and who therefore often feel "frustrated" (Catharine and Abigail).

Provision of a Homelike Environment

The third overarching theme that emerged was the PSWs' effort to create a "homelike environment" for the residents. PSW participants often used phrases like, "*This is the resident's home*" and "*We are here for the residents*." Both the DOC and the PSWs indicated that the privacy of the residents was essential to this process. The DOC emphasized, Often we have to remember that *we're working in their home*, they're not living in our workplace."

The residents' autonomy is another important factor in creating a *homelike environment*. Residents are provided with the freedom to make choices regarding their religious, dietary, and clothing preferences. The Home's Philosophy of

Care states: "All residents will live a life that has *spontaneity and variety as well as structure*." Consequently, PSWs are asked to develop *leadership skills* to maintain a balance between "spontaneity" and "structure" in their care delivery, while ensuring the residents' autonomy. Yet this requires extra caution and sensitivity. One PSW described her experience this way:

> I had a gentleman who said "I was in Africa for a while and we had to layer. I know it makes you hot but this is what my body is used to." And he was in his room sweating. We wanted to put an air conditioner in his room. But he put his foot down, no way was he [going to have one]. But he was sweating to the point where he was actually quite ill . . . that's something we had to monitor quite close, because he would get dehydrated. (Catharine)

In this incident, "spontaneity" was balanced with "structure": the PSW *respected the resident's preference* for a homelike environment, while also careful monitoring his condition.

Collaborative Team Approach to Care

The collaborative team approach was the fourth overarching theme that defined culturally competent care for PSWs. The Home's Philosophy of Care *encourages staff to take the initiative* in improving their work environment. One PSW participant mentioned a problem involving a resident who would not allow a visible minority PSW into her room. "In such a case, whoever her [the PSW's] partner is, they just switch" (Mary). This anecdote suggests that PSWs have a certain degree of flexibility to delegate tasks to teams when necessary to solve problems collectively. *Teamwork among multicultural staff* also helps PSWs' efforts to mitigate potential "*cultural clashes*" *between PSWs and residents*. However, PSW participants indicated that there was a lack of collaboration between the PSWs and the LTC Home's Social Worker. PSW participants mentioned that they were once briefed by the Social Worker about every new resident. The PSWs were unsure why this procedure was eliminated. The DOC pointed to funding insufficiencies as the root cause for increasing workloads for all staff.

In-Services for Maintaining Staff Morale

The last overarching theme was "in-services for maintaining staff morale." Based on the policy documents and the key informant interview, it appeared that the LTC Home takes a proactive approach to maintaining staff morale, providing the staff with *ongoing in-service training and education*. According to the Vision Statement, staff build on "a tradition of *excellence in care* [through] research and education." When asked if there were any in-services available to increase cultural competence, both the DOC and the PSWs mentioned the "Gentle Persuasive Approaches" provided by the Alzheimer's Society. PSWs appreciated that the training "really teaches us how to interact" (Christine) and "teaches *compassion*" (Catharine), helping increase *their morale, empathy, and confidence in care delivery*. These comments also suggest that the PSWs perceived "*interactions*" and "*compassion*" as essentials of culturally competent care. Another educational opportunity mentioned by the DOC was the "Spiritual Care Week" offered by the Home's chaplains, who also invited guest speakers to provide information on particular religions.

While the PSW participants generally appreciated the benefits of in-services, they also mentioned significant challenges facing their daily work. One PSW participant said that *increasing paperwork* prevented many staff from attending these opportunities for professional development. The DOC also admitted that *limited staff* often meant the PSWs *could not learn or execute new skills in their hectic daily routine.* The DOC said that in-services, which offered hands-on learning, were successful, as they were relevant to PSWs' everyday practice. PSWs also saw the potential benefit of in-services and suggested they be integrated into their practice.

These five overarching themes and subthemes are all intertwined, and together they provide a full picture of the perceptions and practice of culturally competent care in the environment of the LTC home. Since one objective of this study was to compare cultural competence among PSWs at an LTC setting with Suh's (2004) model for nursing practice in acute care settings, our model was developed using the basic concepts of Suh's model. We reorganized our above-mentioned overarching themes and subthemes by comparing them with the key components of Suh's model. Figure 1 presents an overall picture of the concept and practice of cultural competence perceived by the PSWs, the work conditions creating culturally competent care, and the goals of cultural competence for the residents, PSW staff, and LTC home environment. In addition, the facilitating and hindering factors for culturally competent care are presented in this diagram.

Discussion

Comparison of the PSW Model of Cultural Competence With Suh's (2004) Model

Overall, the findings of this study suggest that PSWs' cultural competence at this LTC Home, which incorporated sensitivity and respect for each resident's unique needs and preferences, is at the core of the quality of care. As Figure 1 shows, the process of PSWs becoming culturally competent is not linear but rather an ongoing daily practice. This process is also closely related to the PSWs' work environment at the LTC Home including its organizational policy, management practice, and resources. In addition, the comparison between our PSWs' model and Suh's model (2004) suggest that culturally competent care is delivered differently in LTC

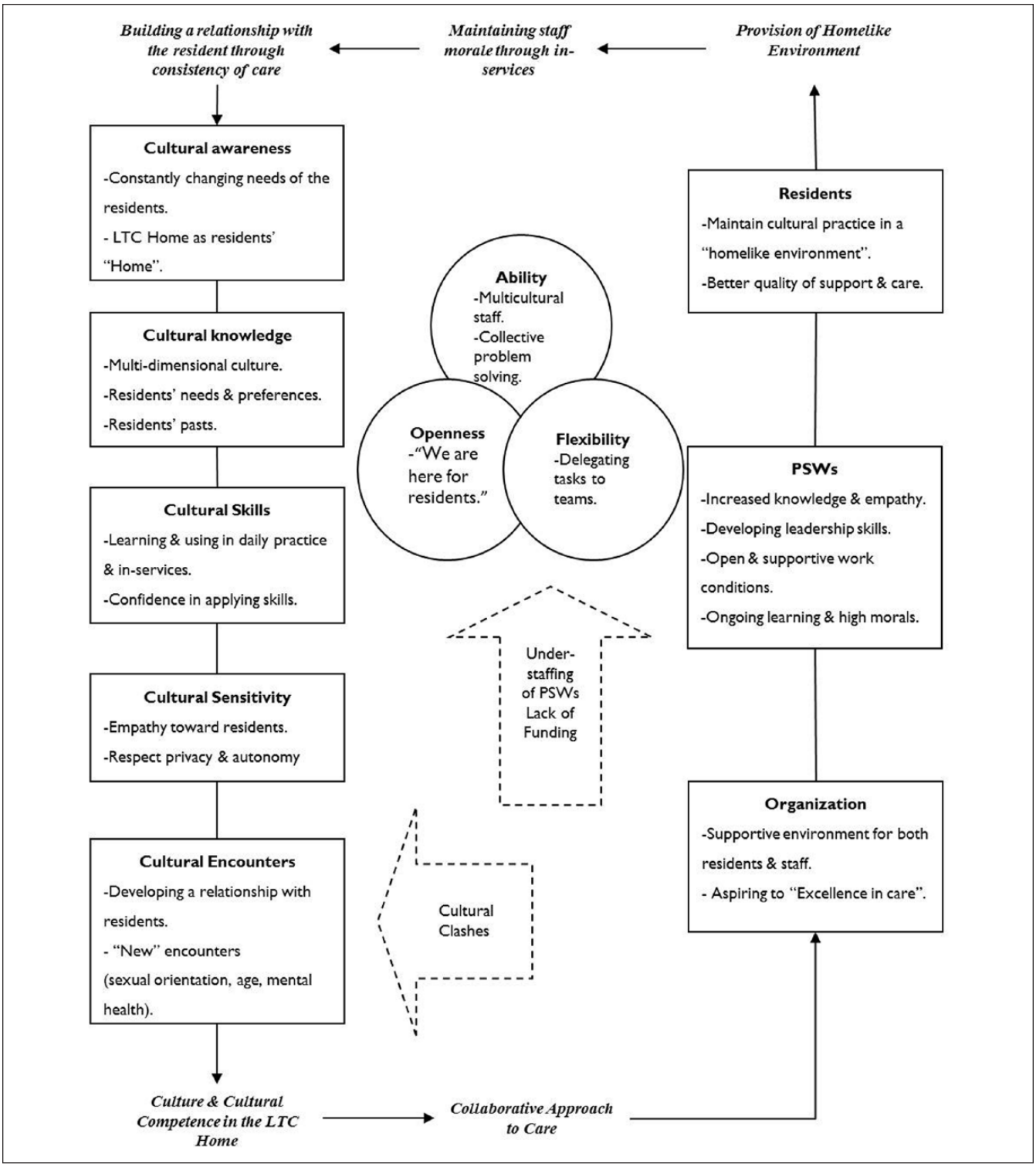

Figure 1. PSWs' cultural competence in the LTC Home.
Note. Five overarching themes in ***Bold and Italic font.*** Original concepts in Suh's (2004) model in **Bold** font.

Home settings and acute care settings. Table 1 offers further details on this comparison looking at each key component of cultural competence.

Three major points were revealed as a result of this comparison. First, in Suh's (2004) model, *culture* is defined in relation to concepts such as "customs," "practices," and

Table 1. Comparison of Suh's (2004) Model of Cultural Competence With the LTC Home Model of Cultural Competence.

Comparison of antecedents of cultural competence (CC)			
	Suh's (2004) model	PSW model	Meanings of CC perceived by PSWs
Cultural Awareness	Awareness of the need for cultural competence Awareness of own culture and cultural biases Understanding diverse cultures and world views Learning historical, economic, social, and political factors that influence culture	Constantly changing needs of the residents[a] LTC home as the residents' "home"[a]	The residents' changing needs are recognized by the PSWs over time due to their long stay at the LTC home (such as reverting back to their native language). Throughout the process of providing assistance with residents' activities of daily living, PSWs' constant and frequent contact with the residents helps them become aware of the fact that this LTC home may be their final home. Thus, the PSWs would like to provide a homelike environment that suits the residents' individual needs. PSWs perceive cultural knowledge in relation to the residents' individual preferences based on their understanding of the residents' lives before moving to the LTC home.
Cultural Sensitivity	Respect for cultural differences Acceptance of diverse cultures	Empathy toward residents[a] Respect privacy and autonomy[a]	Mindfulness of these three factors of empathy, respect, and privacy foster sensitivity toward the residents' dignity.
Cultural Skills	Cultural data assessment Cultural physical assessment Intercultural communication	Learning and using in daily practice and in-services[a] Confidence in applying skills	PSW participants described that the content of these in-services allows them to learn skills to provide care for residents in an empathetic and compassionate manner. The added element that the present research study incorporates is the process involved in implementing the skills required for cultural competence.
Cultural Encounters	"Cultural immersion" Nurses interactions with patients from differing cultural backgrounds	Developing a relationship with residents "New" encounters (sexual orientation, age, mental health)	PSW participants acknowledged the current and future "new" encounters between younger residents and transgendered residents. Awareness of these "new" encounters transforms and broadens the concept of culture that goes beyond ethnic and language differences. Cultural encounters are not solely between the residents and staff. The need for residents to make friendships highlights the importance of social interaction in a home environment. Cultural encounters are also related to PSWs' encounters with residents' family members. These interactions help PSWs to learn about the residents' diverse needs.
Comparison of attributes of cultural competence			
	Suh's (2004) model	LTC home model	Meanings of CC perceived by PSWs
Openness	Being open minded Acceptance and respect	"We are here for the residents"[b]	Openness at this LTC home is practiced through the PSWs' mindset of being "here for the residents." PSWs are open to delegate tasks with each other by switching the role to provide care depending on the resident's comfort level if it is necessary. This openness allows PSWs to be involved in decision making, and exercise their autonomy.
Ability	Solving cultural disparities between patients and health care providers	Multi-cultural Staff[b] Collective problem solving[b]	"Cultural disparities" are resolved through the LTC home's resources of multi-cultural staff and the collective problem-solving approach. In addition, PSWs are offered in-services that teach them how to complete tasks in a compassionate and empathetic manner, skills that are useful toward the delivery of cultural competence.

(continued)

Table 1. (continued)

Comparison of attributes of cultural competence			
	Suh's (2004) model	LTC home model	Meanings of CC perceived by PSWs
Flexibility	Adapting to different situations Appreciation of other cultures	Delegating tasks to teams[b]	PSWs are encouraged to be flexible in their tasks in order to accommodate to residents' schedule and needs (such as allowing them to pray during a communal meal time, or letting them to watch a television show after the scheduled bedtime). PSWs are required to be flexible in their work routine in order to work collaboratively as a team with other PSWs and other staff departments.
Comparison of outcomes of cultural competence			
	Suh's (2004) model	LTC home model	Meanings of CC perceived by PSWs
Provider Based Outcomes	Personal and professional growth Cognitive growth	Increased knowledge and empathy Developing leadership skills Open and supportive work conditions Ongoing learning and high morals	PSWs gain passion for their work through attending in-services because they feel that ongoing education updates their skills to meet the residents' evolving needs. The hiring managers aim to hire PSWs who express this desire to learn more in order to maintain the morale of the home. PSWs are able use their leadership skills in their daily practice. Culturally competent care helps to build better relationships between PSWs and residents, creating a supportive work environment for the PSWs.
Receiver-Based Outcomes	Holistic nursing care	Maintain cultural practices in a "homelike environment"	In the process of receiving culturally competent care, residents have the opportunity to maintain their cultural practices. By maintaining these cultural practices, the residents can continue living their life with dignity in a homelike environment.
	Increased quality of life Increased health care satisfaction Adherence to treatment	Better quality of support and care	
Organizational Outcomes	Increased quality of nursing performance Treatment effectiveness Cost-effectiveness	Supportive environment for both residents and staff Aspiring to "Excellence in Care"	A culturally competent LTC home environment is one in which residents and staff are equally valued. The organizational goal "excellence in care" (such as continuous research and education) is akin to increasing cultural competence among its staff members. Enhancing "excellence in care" not only creates a supportive LTC home environment but also leads to "treatment effectiveness" as well as "cost effectiveness."

Note. LTC = long-term care; PSW = personal support worker.
[a]Content related to a home environment. [b]Collective practice of cultural competence.

"beliefs" (Registered Nurses' Association of Ontario [RNAO], 2007) in line with "race" (James, 1996), "ethnicity" (Maville & Huerta, 2002), or "immigration status" (Boyd & Vickers, 2000). In contrast, *culture* perceived by PSWs in the LTC Home emphasizes diverse individual differences and needs (RNAO, 2007)—including beliefs, lifestyle preferences, age, sexual orientation, and mental health status. PSWs believe that their knowledge of these aspects facilitates their practice of culturally competent care for the residents.

Second, our findings provide additional evidence about the various "cultural clashes" that occur in LTC facilities due to differences between PSWs and the residents in race, age, sexual orientation, and so on (Brandler, 2000; Chan & Kayser-Jones, 2005; Gnaedinger, 2003). Suh's (2004) model did not include such clashes in the work environment. As with previous studies (Armstrong et al., 2008; Parker & Geron, 2007; Lilly 2008), our PSW participants were from various ethnocultural backgrounds. Unlike Geron and Parker's (2007) study, however, PSWs in our study did not see language and

cultural differences as major obstacles. While they mentioned discriminatory comments toward some visible minority PSWs (Parker & Geron, 2007), these were often solved when PSWs collaborated with their team members. Unlike Suh's (2004) model, which views "ability," "flexibility," and "openness" as individual attributes to enhance cultural competence, our model shows that organizational attributes can help create a supportive environment. In other words, ethnoculturally diverse PSWs can serve as a cultural resource to enhance culturally competent care when the organization creates open, flexible, and collaborative work conditions.

Third, akin to Suh (2004) and other major theorists' models of cultural competence (Burchum, 2002; Campinha-Bacote, 1999; Pacquiao, 2003; Shen, 2004), the PSW model confirms that cultural competence involves a cyclical process. Suh's (2004) model conceptualizes this process as linear, with certain outcomes to be achieved. In contrast, PSWs' stories suggested that cultural competence is nurtured and developed through close interaction with residents in ongoing daily practice. Since residents' conditions evolve during their long stay at the home, culturally competent care delivery must evolve as the residents' needs change. Taken as a whole, these distinctions between Suh's model (2004) and our findings may reflect the differing nature of nurses' work in acute care settings and PSWs' work in an LTC home.

Linking Culturally Competent Care and Person-Centered Care

The results of this study also suggest that the PSWs' perceptions of culturally competent care in the LTC Home setting share some features with person-centered care. The approach in culturally competent care described by PSWs in this study is similar to the *cultural generic approach* (Shapiro, Hollingshead, & Morrison, 2005) and *cultural general approach* (Taylor, 2005) often used in LTC homes. These approaches teach the type of knowledge, skills, and attitudes that can be applied to any cultural group without stereotyping the residents. In effect, person-centered care engenders a nonstereotypical approach as well. The results of this study underscore the need to expand the concept of cultural competence in LTC home settings, encouraging care providers to be sensitive to various personal needs and lifestyle preferences that exceed narrowly defined and stereotypical ethnocultural differences.

The PSWs' perceptions of culturally competent care in this study share core principles with person-centered care. Those include preserving the residents' autonomy, understanding the residents' unique needs and preferences, and emphasizing staff empowerment and leadership skills (Crandall, White, Shuldheis, & Talerico, 2007; Jones, 2011; Kontos et al., 2010; Robinson & Gallagher, 2008). PSWs' continuous interactions with the same residents enable them to notice subtle changes in the residents' conditions. This finding further supports Kontos et al.'s (2010) study findings that PSWs can help remedy the flaws of the standardized assessment tools commonly used in LTC homes in Ontario. Our results also confirm that that promoting leadership development and empowerment, emphasized in person-centered care (Jones, 2011; Robinson & Gallagher, 2008), are important enabling factors for culturally competent care.

Limitations

This study has a number of limitations. First, the number of PSW participants in the focus groups was small despite our persistent efforts in recruitment. This difficulty in recruiting PSWs spoke volumes about the demanding work conditions and vulnerability felt by many PSWs in the LTC Home (Armstrong et al., 2008). Second, the PSWs who participated in our study all worked in the same unit. Although a few shared their work experiences in other units of the same Home, the data would have been enriched had PSWs working in different units been included. Third, the study would have been strengthened by including part-time and casual PSWs whose work conditions potentially have more constraints.

Conclusion

Despite these limitations, this study raises a few important practical and research implications. The qualitative case study approach helped us collect contextualized data that not only denote the constituents, processes, and outcomes of cultural competence but also identify organizational environmental factors that enhance or hinder culturally competent care practices in the LTC Home, a factor often missed in prevailing cultural competence models. Overall, this study stands as a positive example of how an LTC home can create a supportive environment for residents and staff by integrating its policy with PSWs' daily practice. Nevertheless, some PSW participants revealed their concerns about the gaps between organizational policies, administrative enthusiasm, and the reality of the PSWs' work conditions, which need to be addressed if improvement in practice is to be achieved. The fact that the PSWs were not familiar with the term *cultural competence* also calls more attention to this issue in education and training for PSWs.

Regarding future research, it would be important to find out (a) whether cultural competence is perceived similarly by PSWs in other LTC homes, (b) whether the connection between cultural competence and person-centered care can be also found in other LTC homes, and (c) whether the perceptions of cultural competence among PSWs in LTC homes are different from those of PSWs working in acute care hospitals. Since PSWs—"invisible and undervalued ancillary workers" (Armstrong et al., 2008) whose role is vital if culturally competent care in our health care system is to be achieved—are so understudied, it is critical to gather more information about their experiences and conditions using qualitative, quantitative, and mixed methodologies.

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