MENTAL HEALTH AND RESILIENCY IN LONG-TERM CARE PROJECT

Evaluation of The Art of Resilience – Leaning into the Hard

FINAL REPORT

A component of the Agreement between Nursing Homes of Nova Scotia Association and Mount Saint Vincent University's Nova Scotia Centre on Aging

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Executive Summary

Purpose:

This report provides the results of an evaluation of *The Art of Resilience – Leaning into the Hard* mental health support program that was delivered by two facilitators from Dallas Mercer Consulting (DMC) and was implemented in 46 Nova Scotian LTC homes from January 2022 to March 2022.

Background:

The Art of Resilience – Leaning into the Hard is a program aimed at supporting the mental health and well-being of staff working in LTC. The program addresses change on three levels: individual, organizational, and sector. The *individual level* consisted of five self-care education sessions online comprised of a presentation and discussion aimed at all staff. This was evaluated through online surveys before the education (T1), immediately after the education (T2), and six weeks after the education (T3). In addition, at the mid-point of the sessions, evaluators held a group discussion with participants. The *organizational level* consisted of five webinars and workshops and a one-on-one site consultation with a facilitator. This was evaluated through interviews, the first immediately after the site consultation and a second follow-up interview about six weeks after the site consultation. The *sector level* consisted of 10 weekly Community of Practice (CoP) meetings for leaders to come together and share practices on psychological well-being with the goal of transitioning to a peer-led space that could be sustained post-project. This was evaluated through four group discussions, weekly questionnaires from DMC facilitators, and a final online survey for all registrants (minimum one session attended).

Key Findings:

Individual – Self-Care Education

The self-care education was rated highly among participants both in terms of benefit and impact on mental health. Majority (80%) of participants reported the program was beneficial, relevant to their individual needs, and relevant to their work in LTC. Specifically, the self-care education series provided validation to their feelings and work, offered new skills, and the ability to reflect on their experiences working during COVID-19. The skills and strategies learned from the education series (i.e., taking a minute to breath, reframing of behaviours, understanding of experiences, and general self-care skills) were beneficial to participants evidenced by the majority (80%) having used the skills learned or planning to use them in the future. Over half of the participants reported the education series contributed to positive change in their mental health and over time, there are trends indicating improved mental health (self-rated by participants on a five-point scale from poor to excellent). Using validated measures, there was a significant decrease in stress and a significant increase in resilience six weeks after the self-care education compared to before the program. While the self-care series provides evidence of high satisfaction and improvements in mental health, almost half of participants found it difficult to make time to participate due to other work demands and the length of the education sessions. Support from management, ability to attend on unpaid time, and flexible work schedules all facilitated participants' ability to partake. Over 90% of participants said they would recommend this self-care education to their co-workers.

Organization – Site-Based Team Support

The site-based team support, including both webinars and consultations, were highly regarded among participants, some indicating that it had the highest value in the whole program. The webinars provided conceptual understanding of common issues and site consultations allowed for one-on-one meetings whereby sites could identify issues pertinent to their organization. All five sites were able to identify their needs and have the beginning stages of an implementation action plan to meet their specific goals. Most of the sites were driven by the desire to create a psychologically safe workplace for all employees. The site-based support provided most participating sites with the internal capacity by providing a common language base, knowledge, and tools to support leaders and direct care staff, and a shift in management style to be more open and empathetic. While most sites reported increased capacity, others identified and received funding to obtain additional external support. At the one-month follow up, all sites reported minimal or no progress with their action plans. The main barrier to implementing the action plans was the community spread of COVID-19 that coincided with the time frame of the program. Most LTC homes were in an outbreak, causing decreases in staffing and the need for managers to shift their role to hands-on care. This inhibited their ability to focus on the mental health initiative at that time.

Sector – Community of Practice

The development of the CoP was gradual as planned. The initial approach transitioned from a facilitator-led to a peer-led space over the 10-week period. As the CoP progressed, the number of participants gradually declined (from around 120 to 25) but engagement among remaining leaders improved as participants became more comfortable. The beginning required a lot of preparation work and facilitation from DMC, but around the eighth session, participation became more diverse and peer-led and by the tenth session two people emerged as leaders to continue the CoP post-project. Majority of participants (85%-100%) reported the CoP was a good use of their time and the content was relevant. Participants were highly satisfied (~70%) with the online format, approach taken by facilitators, and being with leaders from across the province, but were less satisfied (~50%) with the length of sessions, group size, and level of participation. For participants who regularly attended, almost two thirds (65%) reported it helped them as leaders to better support staff's mental health as well as to build capacity within their organization to address staff's mental health concerns. Among participants who had intermittent or decided to discontinue their participation, they indicated that their absence was mainly because their other work demands took priority, or they did not understand the purpose of the CoP citing that it was not for them.

Challenges:

There were many challenges associated with the evaluation of this program. Foremost was that the program was delivered during the COVID-19 Omicron wave. LTC homes across Nova Scotia experienced the highest number of COVID cases during January – March 2022 and active outbreaks often lasted one month or longer. The outcome of this COVID-19 wave, resulted in unprecedented staff shortages. This situation, in turn, increased the workload and other demands on staff and management. Not only did this affect their ability to participate in the program, but also their capacity to participate in the evaluation. This program was also implemented in a very short time frame (three months) where there were often two or more activities each week. The short time frame may have impacted organization's ability to participate given the context, but it also impacted our ability to evaluate the program,

especially to understand what the longer-term impacts of the program are. Therefore, this evaluation is limited to immediate and short-term impacts and outcomes. The evaluation does not benefit from a control group given the short time frame and the desire to involve all staff in an intervention considered needed in the sector. Evaluators did not have access to a group of staff who did not participate as participation was anonymous and we did not want to place an increased burden on administrators to identify a control group. The multi-level program was evaluated as independent components (individual, organizational, sector) and has limited ability to examine impacts across the components and draw conclusions to the outcomes of the program as a whole. This is due to limited and varied participation in all three components. The strength of the *Leaning into the Hard* program is the model that prioritizes the needs across all three levels. Among the few participants who could speak to the program as a whole, having participated in all three levels, they reported benefits to all components and identified links and connections among the three levels.

Conclusion:

The *Leaning into the Hard* program provides a unique approach to mental health that is highly relevant to the LTC sector and experiences of working in LTC. For those who participated, there was high satisfaction among all components whereby participants reported benefit, improved mental health, and increased internal capacity to address mental health and well-being as evaluated in the short-term. The activities within this program aim to create a psychologically safe workplace. This program provided a first step to driving change, but it should not be a “one and done” training. There is need for ongoing support and education for the sector, especially given the constant changes in staffing and evolving challenges in the LTC sector. The program has elements of sustainability; specifically, an innovative approach to site-based team support where LTC homes have a specific action plan as well as a framework and buy-in from select leaders across different LTC homes for a CoP. In order to assess longer term change in how workplaces view mental health, there needs to be greater participation from all staff in self-care education and increased buy-in from leaders into a CoP regarding psychological safety. Overall, the multi-level approach to address changes at the individual, organization, and sector level has merit and is valuable to driving change within the culture of LTC. This approach recognizes support is essential at all levels, for individual direct care staff and leaders. With increasing and ongoing engagement, workplaces will become more psychologically safe and have increased organizational capacity to support staff mental health and well-being.

Introduction

This report presents the results of the evaluation of a program intervention aimed at supporting the mental health and well-being of staff working in long-term care (LTC). Staff from 46 LTC homes across Nova Scotia participated in the intervention between January 2022 and March 2022. The program was delivered by Dallas Mercer Consulting (DMC) and promoted as *The Art of Resilience – Leaning into the Hard.* DMC's approach was to implement 'bio-psycho-social-spiritual' awareness at the individual, organizational, and sector level. By creating a multi-level approach whereby three separate initiatives were provided, each part of the system could have their needs independently prioritized, providing a foundation to support a potential cultural shift. The program was made possible through the Nursing Homes of Nova Scotia Association by funding from Healthcare Excellence Canada. Evaluation of the program occurred between January and May 2022.

Program Delivery

The *Leaning into the Hard* program took a multi-level approach targeting – the individual (micro), the organization (meso), and the sector (macro) (see Figure 1). Each targeted level (or component) of the intervention had its own independent activities and time frame in which the activities were implemented (see Figure 2 below). Due to challenges being faced by participating homes arising from COVID-19 outbreaks, DMC practitioners adjusted the scope of activities and time frame of the activities from their original proposal.

Figure 1

Multi-level approach to the program delivery

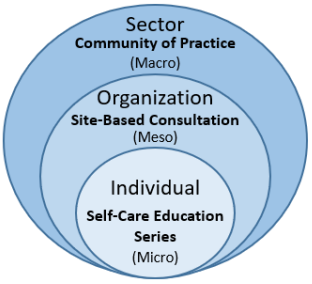
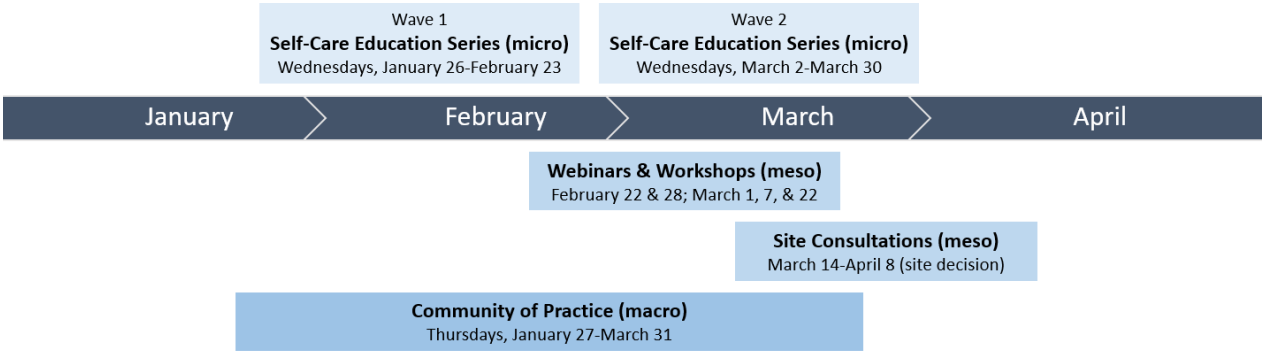


Figure 2

Leaning in the Hard program delivery timeline



Organization of Report

This report presents information on the activities undertaken to evaluate *The Art of Resilience - Leaning into the Hard* mental health program. The report is organized into three main sections, by the component of the program – self-care education series (micro), site-based team support (meso), and community of practice (macro). Each section begins with a description of the component's activities and our approach to the evaluation of the activities. We then present information on the sample who participated in the evaluation activities. Findings for the measures used to assess the respective intervention component are then presented followed by information on the delivery on the

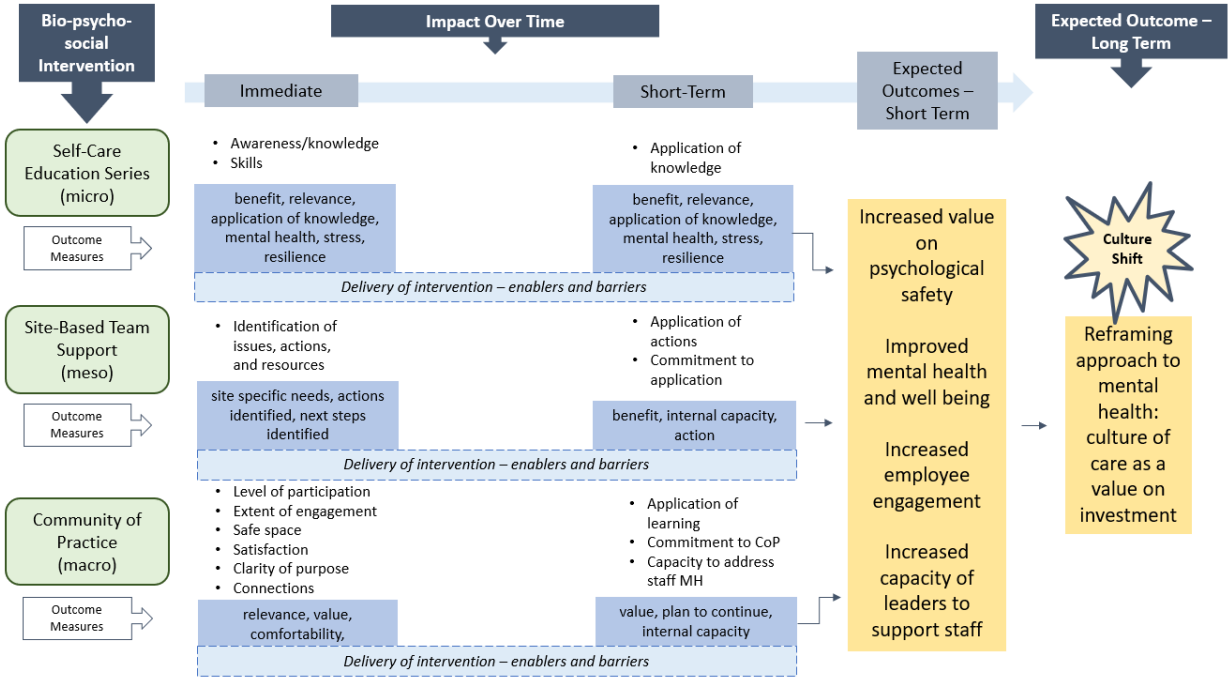
component's activities. Each section concludes with a summary of insights. After the three main sections, we discuss overall learnings from the evaluation work and general observations and challenges to our work.

Approach to Evaluation

The aim of the *Leaning into the Hard* program was to reframe the sector's approach to supporting mental health. To this end, the evaluation was to understand whether, and to what extent, the program achieved this goal and made a difference for participants. The evaluation was outcomes-based guided by key areas where change was expected: (1) value on psychological safety, (2) mental health and well-being, (3) employee engagement, and (4) capacity for leaders to support staff. The self-care education (micro) roughly followed a quasi-experimental pretest-posttest design while the site-based team support (meso) and community of practice (macro) were posttest only, though all three intervention components had multiple posttest evaluations to follow the process of change instilled by the interventions. The design did not include a control group for any of the activities. Attention to factors related to delivery of the program was also given to understand how they may impact expected outcomes, and to offer insights to inform subsequent delivery of this and other programs in the LTC setting. Because of the multi-level approach to the program, evaluation methods varied. The evaluation framework which guided the work provides an overview of the program intervention, its expected outcomes and the measures used to assess the outcomes (see Figure 3).

Figure 3

Evaluation framework

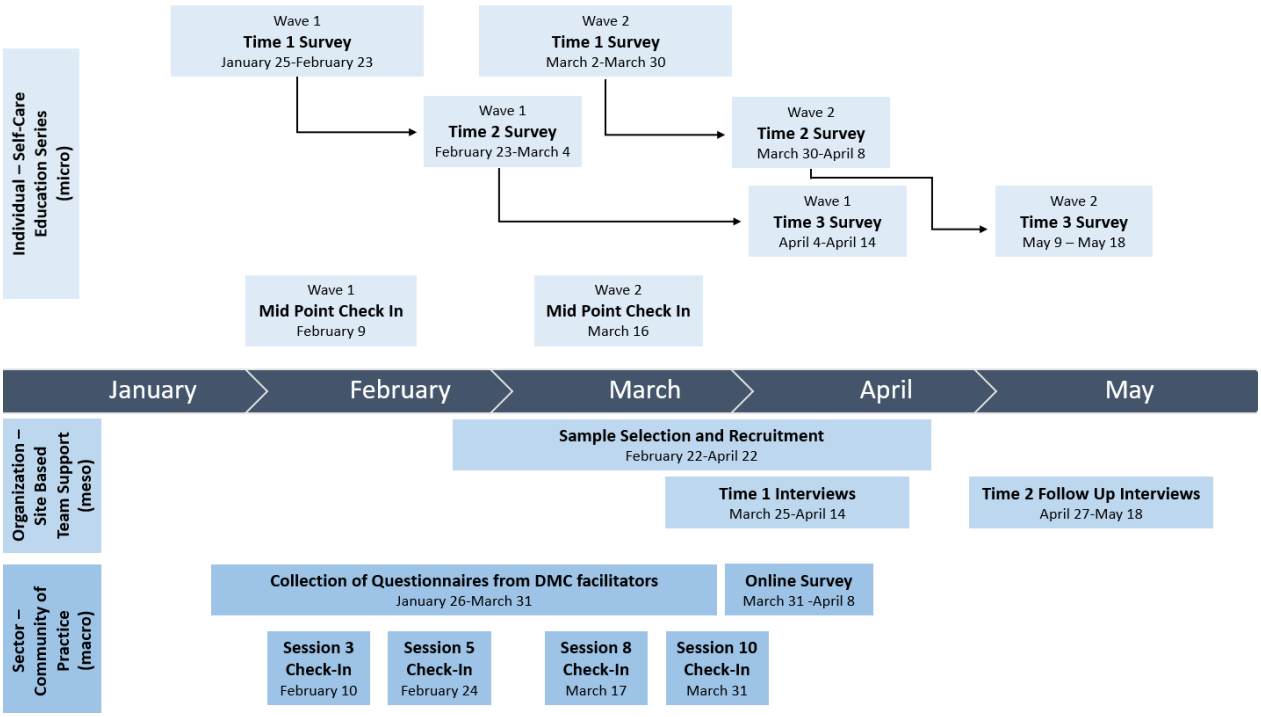


Due to the complexity of the intervention attributed to the independent activities with their own objectives and time frame, the evaluation employed a variety of methods (e.g., questionnaires, semi-

structured interviews, focus groups). Data collected is cross-sectional and at different points of time (see figure 4 for data collection timeline).

Figure 4

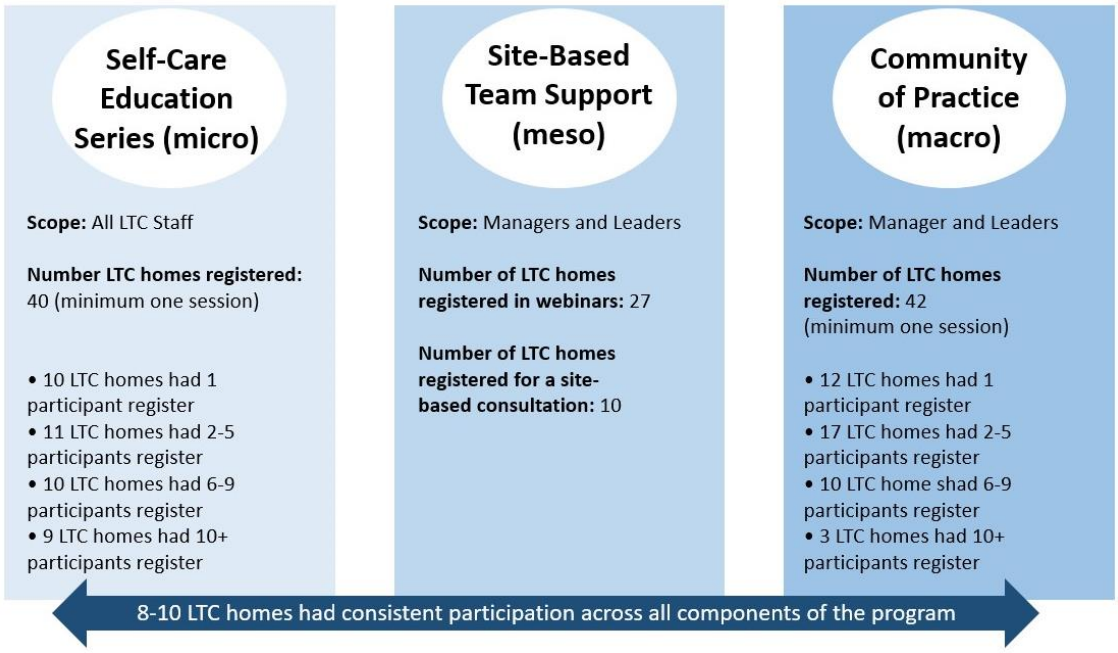
Timeline of the data collection for the evaluation



While some participants (i.e., management level) could have participated within each level, and we understand that to be case in a few instances, there are generally different participants from the care homes throughout the activities and the extent of participation across the levels varies as well (see Figure 5). The *Leaning in the Hard* program was open to the 50-member homes of the Association that originally expressed interest in fall of 2021, and they all received communication about the program and the respective activities in early January 2022. The site-based team support (meso) and Community of Practice (macro) activities were geared towards senior management, while the self-care education series (micro) was open to any staff member within the home. Based on available information, participation from 46 care homes was recorded (i.e., minimum of one person from the home participation in any one of the activities).

Figure 5

Participation across the three levels of the program



Note: consistent participation refers to LTC homes that had 10 or more individuals register for the self-care education, LTC homes who had representation at the webinars and a site-consultation, and had consistent registration in all 10 Community of Practice sessions.

Note: information presented above is for registration and participation in the program, it is not exclusively participation in the evaluation. Information on the number of participants in the evaluation activities is provided in each section of this report.

Having provided background on the set up of the *Leaning into the Hard* program and our approach to the evaluation, we now present information specific to the evaluation approach and our findings for each component of the intervention.

Individual – Self-Care Education Series (micro)

Description

The self-care education series was offered to any staff in LTC and delivered as five-week online education sessions, each session exploring a different concept of self-care (i.e., self-awareness, self-compassion, self-growth, etc.).

All sessions were offered through Zoom videoconferencing. The first part of each session (approx. 45 minutes) focused on content delivery, while the second part of each session was a facilitated group discussion actualizing the concepts in the lives of the participants in attendance. The first part of each session (content delivery) was recorded and made available for all registrants for separate viewing. All sessions were offered in the morning (9:30am to 11:30am) and repeated in the afternoon (1:30pm to 3:30pm). The series was offered from January 26th to February 23rd (*Wave 1*) and then repeated March 2nd to March 30th (*Wave 2*). Throughout the self-care education series, the facilitator was consistent to participants whereby one facilitator was responsible for the Eastern zone and Northern zone and the other facilitator was responsible for the Central zone and Western zone. The schedule for the self-care education sessions can be viewed in Appendix A (Table 1).

Objective and Measures

The objective of the education series was to help staff be better equipped to identify, discuss and manage emotional and mental distress in their caring profession. We assessed to what extent this was achieved through measures including:

- **Immediate Impact** – create awareness and knowledge and gain self-care tips, skills, and coping strategies.
- **Short-term Impact** – application of knowledge, benefit over time, and changes in mental health.

Our Approach

Two methods of data collection were used – self-administrated online survey and facilitated focus groups. Participants were invited to complete an online survey at three points in time: baseline-immediately prior to their participation in Session 1 of the education series (Time 1), immediately following completion of Session 5 of the education series (Time 2), and six weeks following completion of Session 5 of the education series (Time 3). In addition, to get a gauge of how the sessions were going, we met with participants as a group at the conclusion of the 3rd session to obtain their input. See Appendix A subheading "Methods" for additional information on method.

Sample

Online Survey Sample

From the 46 LTC homes participating in the program, 289 staff registered for the education series (both Wave 1 and Wave 2). Out of all registrants, 234 (80%) agreed to be contacted for the evaluation and were sent the surveys. Response rate to each survey varied – Time 1 (N=115 or 49%), Time 2 (N=42 or 19%) Time 3 (N=41 or 17%) (see Table 2 in Appendix A).

Below is an overview of the sample of participants who completed the online survey at each point in time (see Table 3). Participants in the sample were predominantly female who represented a range of job roles (most common were direct care staff, management, and recreation) and had been working in

their role and respective LTC home on average 12 years (with a wide range from one month to 40+ years) (see Table 3). Participants, on average, reported a moderate level of perceived stress and a medium level of resilience. Approximately half reported their mental health as poor or fair. At baseline, over half reported that their mental health had worsened since a year ago (see Table 4).

Table 3

Demographic information of the online survey sample at three points in time

	T1 Baseline Pre-Education Series		**T2 Immediate Post-Education Series**		**T3 Six Weeks Post-Education Series**	
Surveys Completed	N = 115		N = 42		N = 41	
Average Age	50.0 years (23-75)		48.0 years (25-70)		48.0 years (23-64)	
Gender	Female	94%	Female	100%	Female	98%
	Male	4%			Male	2%
	Prefer not to say	1%				
	No response	1%				
Job Role	Direct care	25%	Direct care	24%	Direct care	22%
	Nursing	22%	Management	17%	Recreation	17%
	Management	17%	Recreation	17%	Other	15%
	Recreation	10%	Nursing	12%	Management	15%
	Allied health	9%	Administration	10%	Allied health	12%
	Other	8%	Allied health	10%	Administration	10%
	Administration	6%	Other	10%	Nursing	10%
	Support services	3%	No answer	2%		
Average Years Working in LTC Home	10.6 years (1 month-44.0 years)		14.5 years (2 months-44.5 years)		13.0 years (3 months-38.5 years)	
Average Years Working in Job Role	11.8 years (1 month-44.0 years)		12.6 years (2 months-44.5 years)		11.8 years (6 months-38.5 years)	
LTC Homes Represented	31 (78%)		23 (58%)		21 (53%)	

As observed, there are significantly more participants who completed the Time 1 survey. However, as seen in Table 3 above, the sample is quite similar in terms of age, gender, job role, and years of service.

The number of people registered for the education sessions exceeded the number of participants who attended the sessions ‘live’ at the scheduled time. It is unclear who registered in anticipation of watching the recording at a later time or who registered and did not follow through. There was consistent attendance across all given sessions (25-30 participants) and majority attended ‘live’ meaning they participated in both the content delivery and discussion. Slightly more attended on paid time, but many attended on unpaid time. Most participants attended alone, while some attended the session with

others. On average, participants attended three sessions live (Median = 3, Mode = 4, Range 0-5) and watched on average one recorded session (Median = 0, Mode = 0, Range 0-5).

Table 4

Mental health and well-being profile for online survey sample at three points in time

	T1 Baseline Pre-Education Series	**T2 Immediate Post-Education Series**	**T3 Six Weeks Post-Education Series**
Surveys completed	115	42	41
Perceived stress Low = 0.00-1.30 Moderate = 1.40-2.70 High = 2.80-4.00	Moderate stress (M = 2.03, R = 0.20-3.50)	Moderate stress (M = 1.87, R = 0.70-3.10)	Moderate stress (M = 1.59, R = 0.50-3.20)
Resilience Very low = 1.00-2.00 Low = 2.17-2.83 Medium = 3.00-3.83 High = 4.00-4.50 Very high = 4.67-5.00	Medium resilience (M = 3.34, R = 1.50-5.00)	Medium resilience (M = 3.23, R = 1.83-4.83)	Medium resilience (M = 3.60, R = 1.83-5.00)
Mental health rating	Poor = 8% Fair = 46% Good = 28% Very good = 15% Excellent = 3%	Poor = 5% Fair = 41% Good = 37% Very good = 15% Excellent = 2%	Poor = 0% Fair = 20% Good = 53% Very good = 25% Excellent = 3%
Change in mental health	In the past year: Worsened = 57% No change = 24% Improved = 19%	In the past year: Worsened = 39% No change = 22% Improved = 39%	In the past month: Worsened = 13% No change = 55% Improved = 33%

Note: due to missing data for some of the variables in the table above, the number of surveys completed may fluctuate from one to eight

The most common factor impacting staff's mental health was workplace challenges such as feeling overworked, burnt out, and being denied time off. The next most common factor reported was personal life challenges which included financial strain, family illness, and lack of social fulfillment. Some others reported COVID-19 specific challenges such as dealing with restrictions and strict safety measures as well as increased anxiety about the virus. A few other challenges mentioned were in regard to specific mental health attributes such as depression or clinical anxiety.

Mid-Point Check-In Sample

A group discussion was held at the mid-point (Session 3) of the education series. A total of 56 attendees (six different sessions combined) participated in the discussion. Half (50%) of the participants in the mid-point check-in were in a management role.

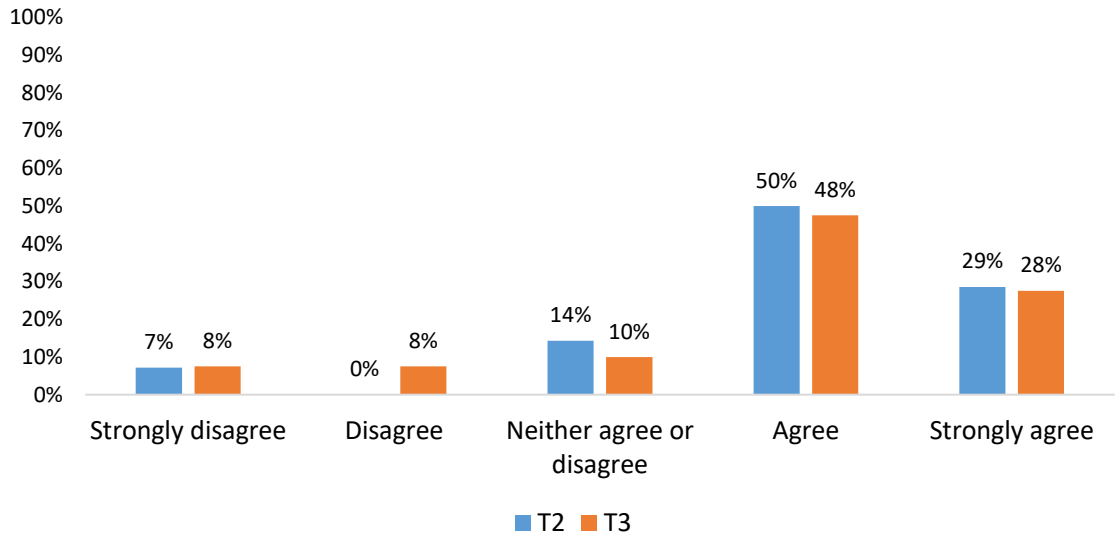
Outcome Measures

Benefit of Self-Care Education Series

Majority (~77%) of participants were in agreement that the self-care education was beneficial, a few (10%-14%) were neutral, and very few (7%-16%) did not find the self-care education beneficial (see Figure 6).

Figure 6

Participants' agreement level that the self-care education series was beneficial immediately after (T2) and six weeks after the self-care education (T3)

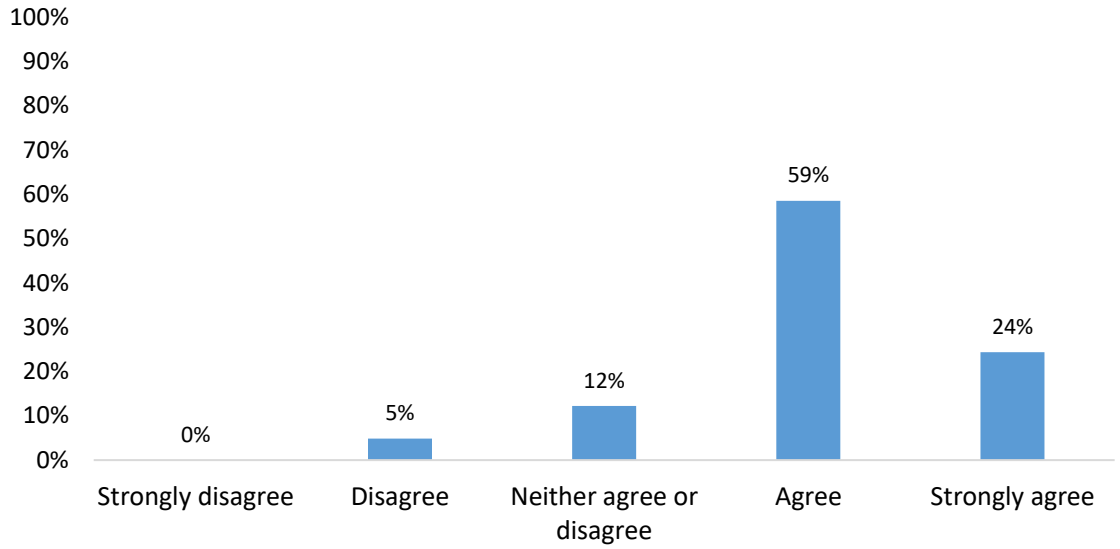


- **Of the participants who found the self-care education sessions beneficial** most indicated that it provided validation through hearing others experiences and uninterrupted time to reflect. As well, many participants reported the coping mechanisms they learned were beneficial for themselves and the workplace.
- **Of the participants who did not find the self-care education sessions beneficial** one common reason offered for their assessment was that they could not attend all five sessions. For example, unable to attend the live sessions meant they were unable to participate in the discussion component and they had trouble accessing the recording of the sessions they missed.

Majority (83%) of participants agreed or strongly agreed that the self-care education series has long-term benefits fo their mental health and well-being (see Figure 7).

Figure 7

Participants' agreement level that the self-care education has a long-term benefit for their mental health and well-being six weeks after participation in the self-care education (T3)

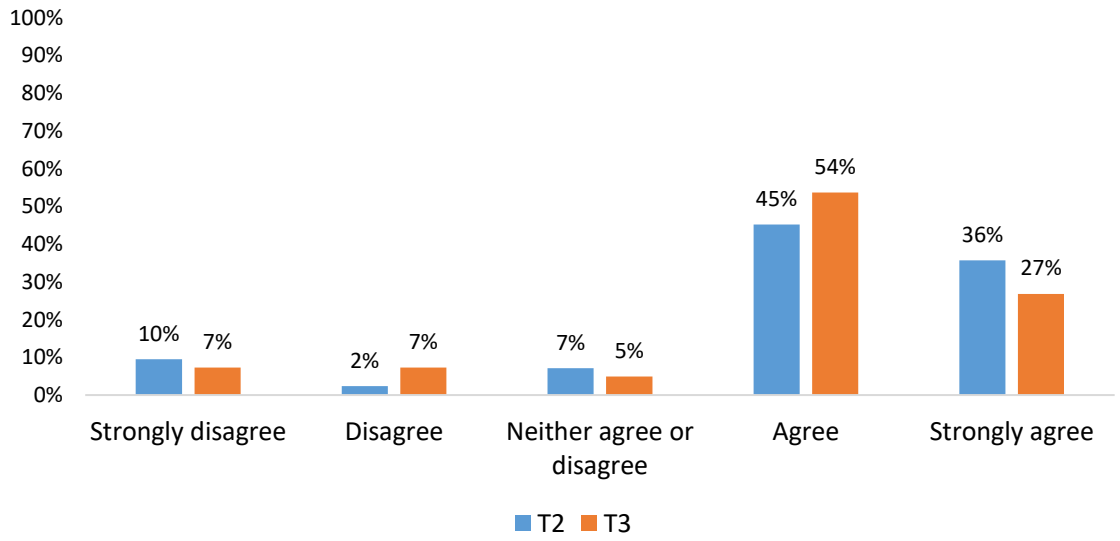


Relevance of Self-Care Education Series to Self

Participants reported that the education series' content was highly relevant to their individual mental health needs (see Figure 8). Around 80% of participants were in agreement that the self-care education was relevant to themselves both immediately after and then again six weeks following participation in the self-care education series.

Figure 8

Participants' agreement level that the self-care education series was *relevant to their needs immediately after (T2) and six weeks after participation in the self-care education (T3)*



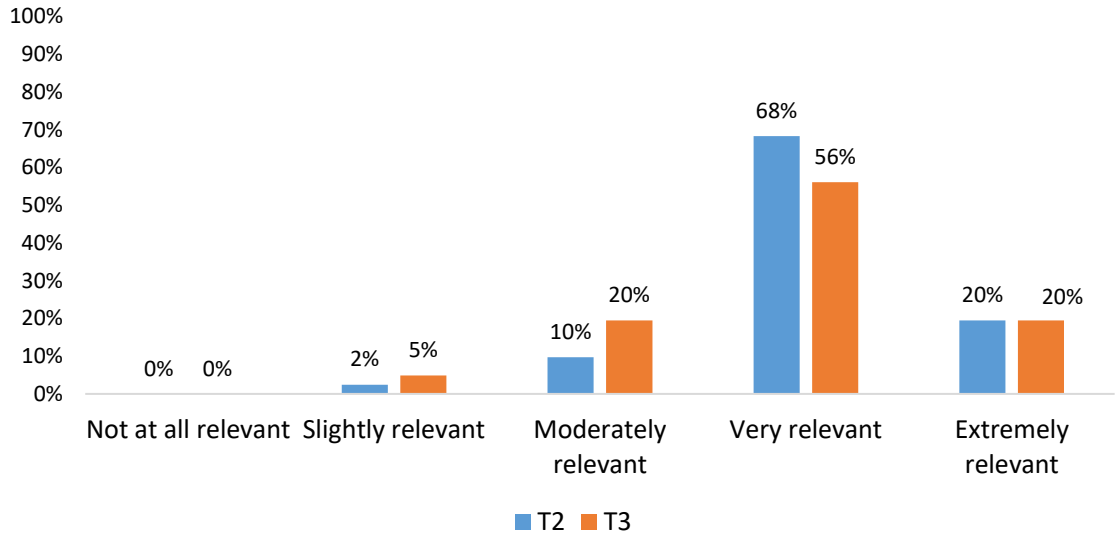
- Of those participants who indicated it was **relevant** to their individual needs many commented that it created self-awareness and validated they are not alone in how they are feeling. As well, many shared that it helped them to recognize the importance of taking the time and processing what they have gone through and how to apply strategies to help cope. Several participants noted that it helped them reflect on how they've been impacted by the pandemic.
- Of the few participants who reported it was **not relevant** to their needs, reasons offered include existing familiarity with the content and feeling they had better mental health. These participants suggested the self-care education series may be aimed at people who were struggling more.

Relevance of Self-Care Education Series to LTC

One of the aims of the *Leaning in the Hard* program intervention was to provide a program specifically relevant to LTC. Participants reported that the education series was highly relevant to working in LTC wherein around 80% reported the self-care education series being very or extremely relevant (see Figure 9).

Figure 9

Participants' perception of the self-care series' relevance to working in LTC immediately after (T2) and six weeks after participation in the self-care education (T3)



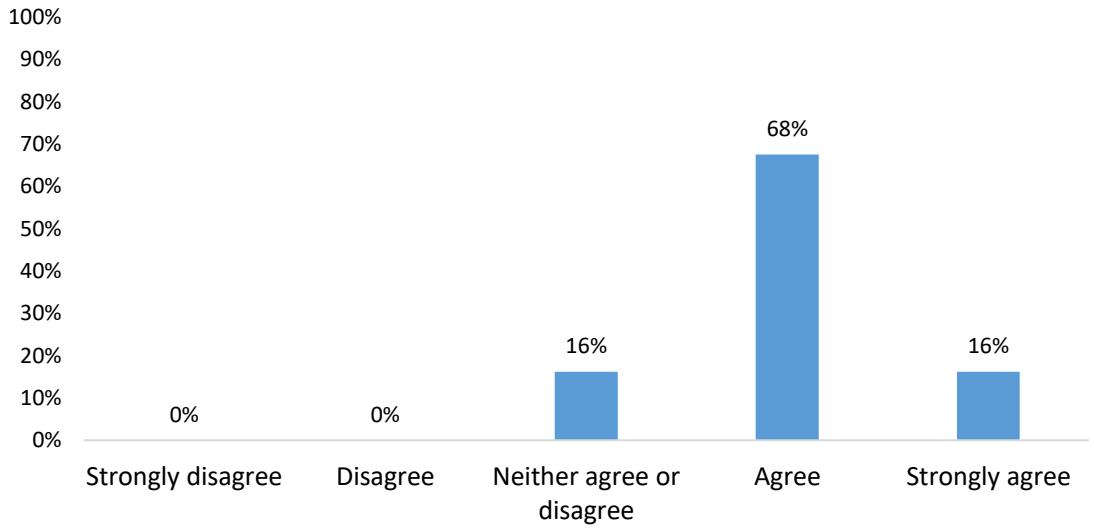
- Participants who reported the self-care series as **very/extremely relevant** to LTC mostly indicated that the self-care content and applicability of skills and tools was relevant to their work. Most noting that it addressed challenges specific to their role as direct care provider and their experience dealing with COVID-19 in their workplace. Some also added that the self-care series provided validation to the work they do.
- Of the few participants who indicated it was **moderately relevant** to LTC commented that the content was less relevant for staff who do not have direct contact with residents. One participant commented that there was more focus placed on the individual rather than the workplace.

Application of Strategies

Overwhelmingly, participants were in agreement that the strategies they learned from the self-care education series were of benefit to them (see Figure 10). Of the strategies discussed, the one commonly identified as beneficial was the reminder to take a minute to themselves and breathe. Some described that the sessions allowed them to reframe their behaviours and the language around their issues gave them a better understanding of their experiences. Some others indicated that there were general self-care and self-compassion strategies shared that they found beneficial.

Figure 10

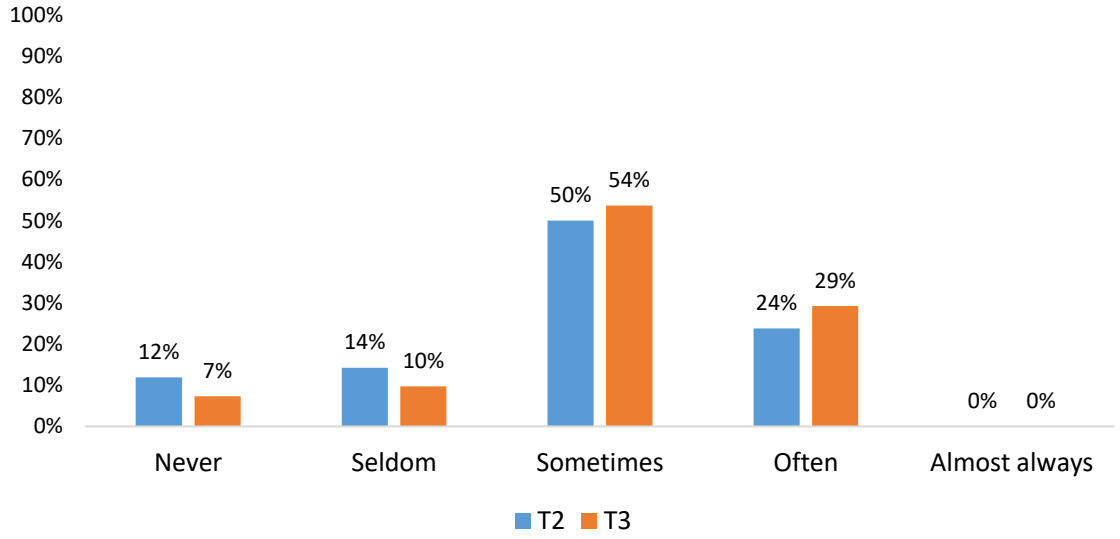
Participants' agreement level that the strategies learned in the self-care education series were of benefit



Close to three quarters of participants reported they have used the strategies discussed during the sessions. Participants were slightly more likely to use the skills learned six weeks following the self-care series compared to immediately after (see Figure 11).

Figure 11

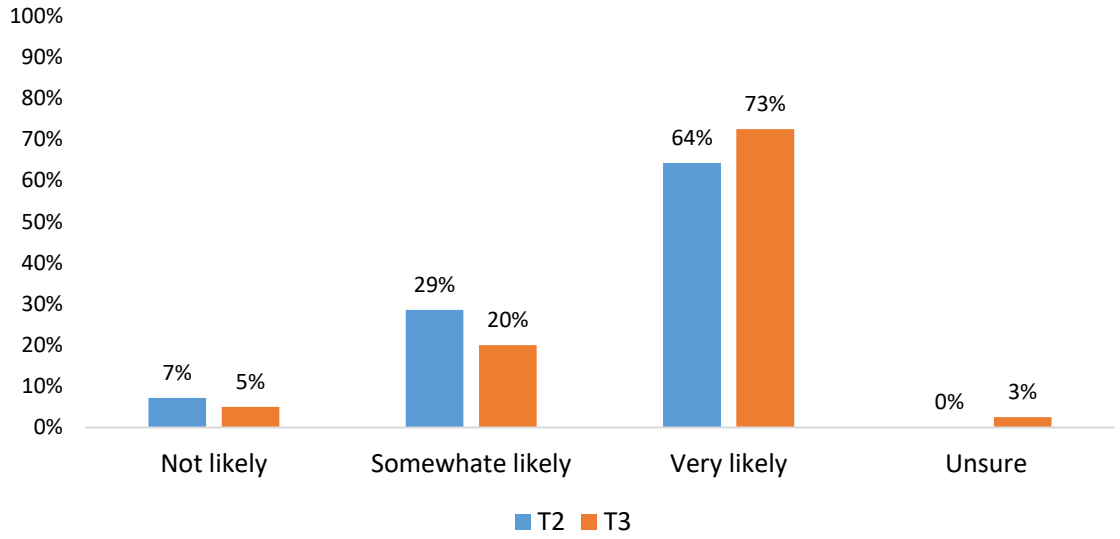
How often participants use strategies from the self-care education series immediately after (T2) and six weeks after participation in the self-care education (T3)



Some participants may not have had the opportunity to use any strategies during the short time period of the evaluation, however majority indicated that they were very likely to use them in the future (see Figure 12).

Figure 12

How likely participants are to use the strategies from the self-care education series in the future immediately after (T2) and six weeks after participation in the self-care education (T3)



Mental Health and Well-Being

Participants were asked to self-rate their current mental health status at baseline (T1), immediately after (T2), and six weeks after (T3) participating in the self-care education series. As depicted in Figure 13, there are positive trends whereas the "poor" and "fair" mental health rating has decreased, while "good" and "very good" mental health rating has increased over time. Furthermore, participants described changes in their mental health over the past year and month more positively after participation in the self-care education series, specifically that it has improved rather than worsened (see Figure 14).

Figure 13

Change in mental health rating at baseline (T1), immediately after (T2), and six weeks after (T3) participation in the self-care education series

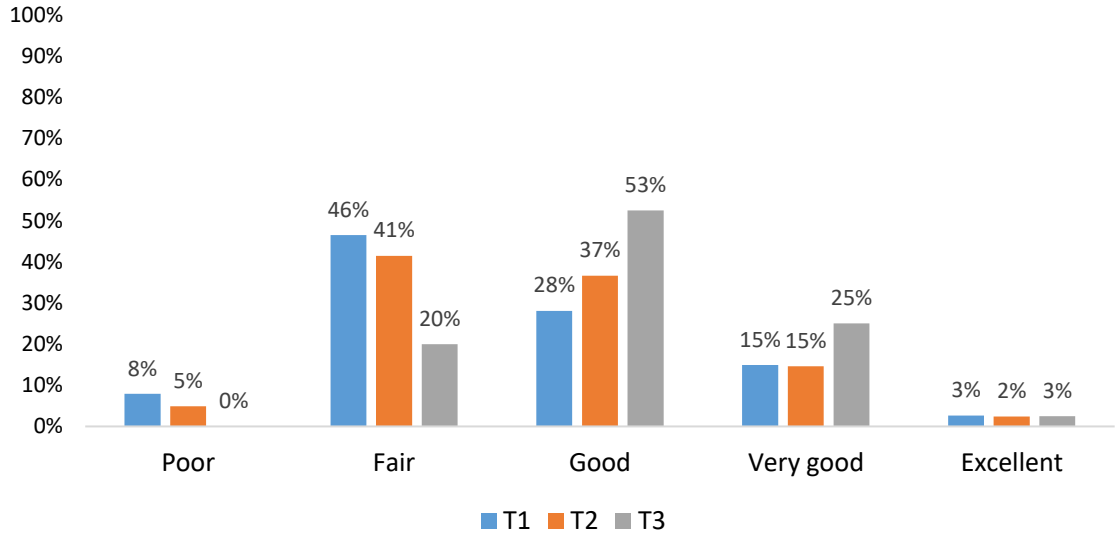
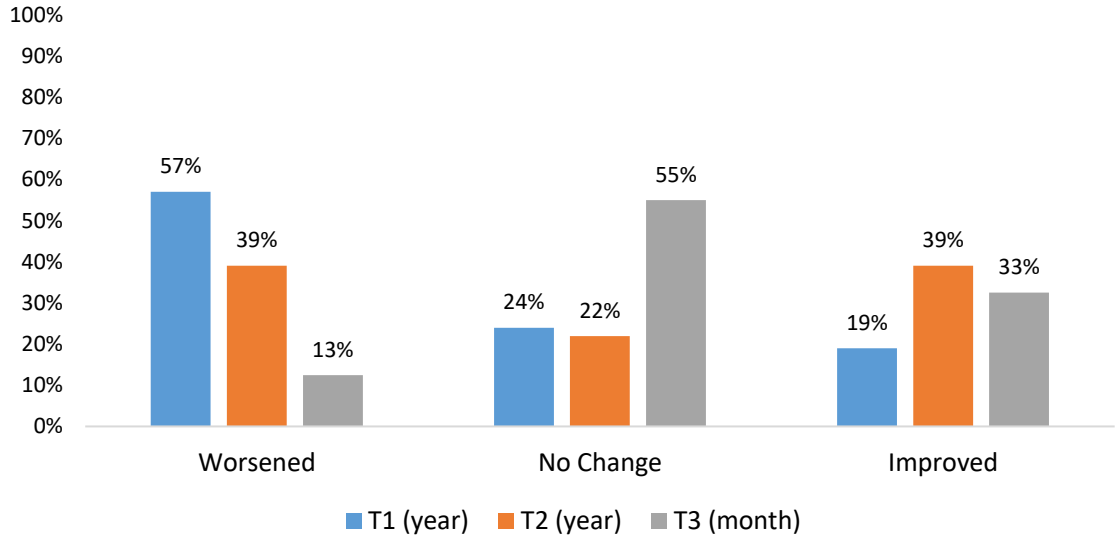


Figure 14

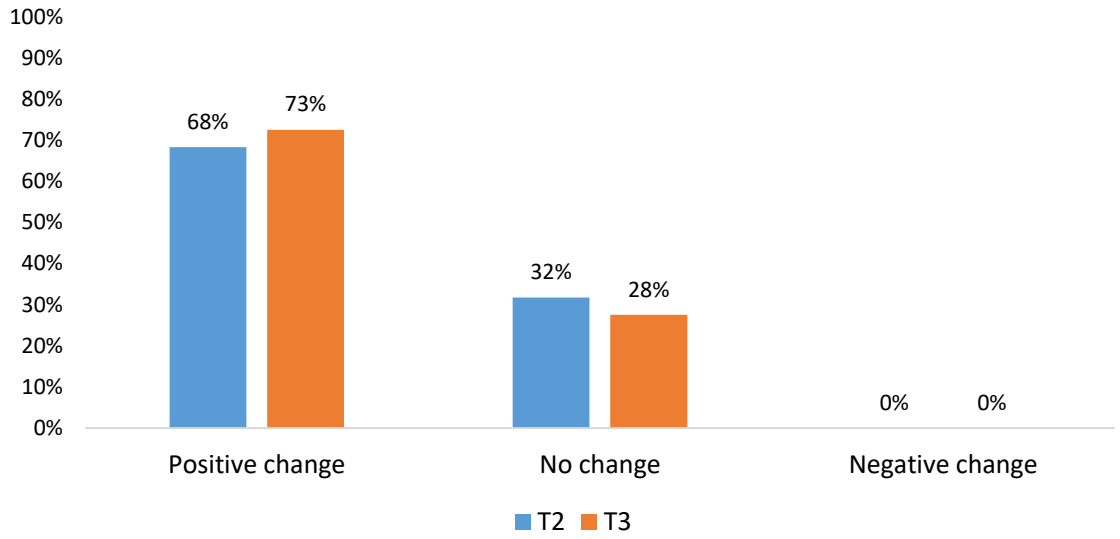
Change in mental health at baseline (T1), immediately after (T2), and six weeks after (T3) attending the self-care education series



Participants were **asked whether the self-care education series contributed to any change** in their mental health both immediately after (T2) and six weeks after (T3) attending the self-care education series. Over half of participants reported positive change because of the education series while some indicated no change (see Figure 15).

Figure 15

Self-care education series' contribution to change in mental health immediately after (T2) and six weeks after (T3) participation in the self-care education



- Of those who provided comment as to why the **education series contributed to a positive change**, the majority shared reasons such as validation of shared experiences, increased comradery with co-workers, and the feeling of not being alone with their struggles and experiences. As well, the majority commented that they benefited from new skills they learned, new ways of re-framing their experience, and the ability to look at their issues through a new perspective.
- Of those who provided comment as to why the **education series did not contribute to any change** in their mental health reasons shared include too busy to process and apply the information, the series did not provide any new insights, and unable to attend enough sessions to report any change.

Perceived Stress

To understand if participants' level of perceived stress changed over time, their level of stress was measured at baseline (T1), immediately after (T2), and six weeks after the self-care series (T3) using the perceived stress scale (PSS)[1]. Our data enabled analysis of change for two different groups.

i) Change in perceived stress for all participants across three points in time

On average, participants reported ***moderate stress at three points in time*** (baseline, immediately after, and six weeks after the self-care education series) (see Figure 16 in Appendix A for the average PSS scores and range at all three points in time). Although participants' stress levels remained moderate, an independent sample t-test revealed a ***significant decrease in perceived stress six weeks after attending the self-care education series*** compared to baseline prior to attending. There was no significant difference between baseline and immediately after (T1 and T2) or immediately after and six weeks after (T2 and T3) attending the self-care education series. Results and statistical significance are presented in Table 5.

Table 5

Independent sample t-test analysis of average PSS score at three points in time

Comparison	Average PSS Score	Interpretation	P Value
Baseline (T1) and Immediately After (T2)	2.02 (T1), 1.87 (T2)	No significant difference in perceived stress	0.21
Baseline (T1) and Six Weeks After (T3)	2.02 (T1), 1.59 (T3)	Significant decrease in perceived stress	**<0.001***
Immediately After (T2) and Six Weeks After (T3)	1.87 (T2), 1.59 (T3)	No significant difference in perceived stress	0.051

*Significant

[1] Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24,* 386-396.
The PSS measures stress on a scale of 0 to 40 (using average = 0.00-4.00) indicating if an individual is experiencing low stress (0.00-1.30), moderate stress (1.40-2.70), or high stress (2.80-4.00).

ii) Change in perceived stress for same participants across three points in time

The above information presents stress for the entire sample and at different data points sample will be comprised of different people. At participant's discretion, tracking numbers were applied so individual participants perceived stress scores could be tracked over time, allowing for testing of paired samples. When following the same individuals over time, a paired samples t-test revealed a ***significant decrease in perceived stress immediately after (T2) and six weeks after (T3) the self-care education series*** compared to participants stress level prior to attending (T1). Table 6 presents statistical significance and average PSS scores among the paired sample.

Table 6

Paired sample analysis of average PSS score at three points in time

Comparison	Number of Participants	Average PSS score	Interpretation	P Value
Baseline (T1) and Immediately After (T2)	19	2.06 (T1), 1.77 (T2)	Significant decrease in perceived stress	**0.011***
Baseline (T1) and Six Weeks After (T3)	18	1.96 (T1), 1.53 (T3)	Significant decrease in perceived stress	**<0.001***
Immediately After (T2) and Six Weeks After (T3)	18	1.77 (T2), 1.60 (T3)	No significant difference in perceived stress	0.052

*significant

Resilience

To understand if participants' level of resilience changed over time, participants' level of resilience was measured at baseline (T1), immediately after (T2), and six weeks after the self-care education series (T3) using the brief resilience scale (BRS)[2]. Our data enabled analysis of change for two different groups.

i) Change in resilience for all participants across three points in time

On average, participant's reported *medium resilience* at three points in time (baseline, immediately after, and six weeks after the self-care education series) (see Figure 17 in Appendix A for the average BRS scores and range at all three points in time). Although resilience levels were consistently medium an independent sample t-test revealed a ***significant increase in resilience six weeks after attending the self-care education series (T3)*** compared to baseline (T1). There was no significant difference between

[2] Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International journal of behavioral medicine*, *15*(3), 194-200.

The BRS measures resilience on a scale of 6 to 30 (or using average 1.00-5.00) indicating an individual's resilience on a five-point scale of very low resilience (1.00-2.00), low resilience (2.17-2.83), medium resilience (3.00-3.83), high resilience (4.00-4.50), and very high resilience (4.67-5.00).

baseline (T1) and immediately after (T2) or six weeks after attending the self-care education series (T3). Results and statistical significance are presented in Table 7.

Table 7

Independent sample t-test analysis of average BRS score at three points in time

Comparison	Average PSS Score	Interpretation	P Value
Baseline (T1) and Immediately After (T2)	3.35 (T1), 3.32 (T2)	No significant difference in resilience	0.389
Baseline (T1) and Six Weeks After (T3)	3.35 (T1), 3.60 (T3)	No significant difference in resilience	0.058
Immediately After (T2) and Six Weeks After (T3)	3.32 (T2), 3.60 (T3)	Significant increase in resilience	**0.023***

*significant

ii) Change in resilience for same participants across three points in time

The above information presents resilience for the entire sample and at different data points sample will be comprised of different people. At participants' discretion, tracking numbers were applied so individual participants' brief resilience scores could be tracked over time, allowing for testing of paired samples.

When following the same individuals over time, results from the paired sample t-test indicated a ***significant increase in resilience six weeks after the self-care education series (T3) compared to baseline (T1) and a significant increase in resilience six weeks after (T3) compared to immediately after the self-care education series (T2)***. Table 8 presents statistical significance and average BRS scores among the paired sample.

Table 8

Paired sample analysis of average BRS score at three points in time

Comparison	Number of Participants	Average BRS score	Interpretation	P Value
Baseline (T1) and Immediately After (T2)	19	3.44 (T1), 3.42 (T2)	No significant difference in resilience	0.882
Baseline (T1) and Six Weeks After (T3)	17	3.49 (T1), 3.88 (T3)	Significant increase in resilience	**0.012***
Immediately After (T2) and Six Weeks After (T3)	17	3.27 (T2), 3.66 (T3)	Significant increase in resilience	**0.001***

*Significant

While there is a smaller sample size for the paired samples (both PSS and BRS) the demographics (age, gender, job role, years of service) are similar to the general population sample. See Table 9 in Appendix A for a table of demographic information for the paired sample.

Program Delivery Considerations – Enablers and Barriers

The way in which the education series was delivered may impact participants' experience and therefore expected outcomes. Participants indicated there were various aspects in which the education series was delivered were beneficial including using Zoom (facilitated comfortability when using the chat function), choice to attend in the morning or afternoon, smaller group sizes, skill of facilitators to create a safe and welcoming space, and the combination of content delivery and discussion.

Ease to Participate

While this component of the intervention was aimed at all individual staff (direct care, allied health providers, management), not all found it easy to participate.

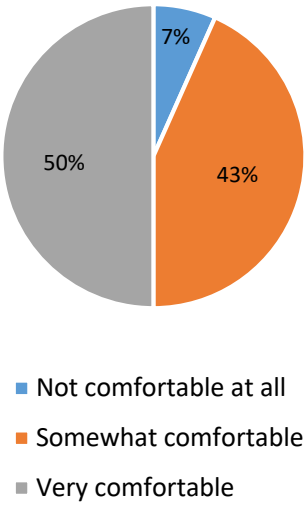
For those who attended the education series, almost half (46%) found it difficult to make time to participate because of other work demands, the time of the self-care sessions conflicted with their schedule, or the length of the session made it difficult to attend. Participants who found it easy to attend had the support from management, attended on their own time, or their type of work had flexible schedules.

Comfortability

The format of the self-care education series included a discussion portion for those attending 'live', therefore participant's comfortability to engage in discussion could have an impact on their own and others experience. Immediately following participation in the education series, half (50%) of all participants who attended the live sessions reported being comfortable sharing and discussing among the group, while 43% were only somewhat comfortable, and seven percent were not comfortable at all participating in the group discussion (see Figure 18).

Figure 18

Comfortability sharing in the discussion portion



- Of the participants who were ***very comfortable*** and offered comments for their rating, a few indicated the feeling of not being alone and validation of others with similar experiences supported their comfortability. A few others commented that DMC facilitators were welcoming and they created a confidential and safe space with no judgement where participants felt comfortable. Three participants reported comfortability through the ability to leave cameras off and to contribute to sessions through the chat.
- Of the participants who were ***somewhat comfortable*** and commented on the reason a few noted personal reasons such as being shy or nervous, concern having their name on the screen with a group of strangers. A couple of participants reported becoming more comfortable towards the end of the series.
- Of the few participants who were ***not at all comfortable*** isolated reasons offered include large group size including the group dynamics (worried about coworkers seeing response and not knowing who else was participating. As well, one reported discomfort due to uncertainty about the recording and who it would be shared with.

Suggestions

Overall, very few participants (four) suggested changes to the self-care education sessions and their suggestions were often contradictory (one participant suggested no discussion portion while another suggested more discussion; one participant suggested more sessions while another suggested less sessions; one participant wanted larger groups, two said that smaller groups would be better) thus potentially indicating a personal preference. Two participants suggested sessions be offered at a different time of day but did not provide a preferred time.

In sum, **majority (90%) of participants did not have any suggested changes to the self-care education sessions and almost all (98% at T2 and 92% at T3) would recommend it to their co-workers**.

Summary

The self-care education series had a positive impact on participants. Most agreed that the tools and strategies learned from this education series were relevant to their work and personal experience, with the majority stating they employ these strategies and benefit from them, or otherwise plan to use these strategies in the future. Higher proportions of respondents reported better levels of mental health following the education series and fewer reported seeing their mental health worsen. This is reinforced by a significant decrease in perceived stress and significant increase in resilience between the initial baseline survey and the six-week follow-up. While some staff found it challenging to participate either through attendance or discussion, just over half were able to do so without issue, and the self-care sessions appeared moderately accessible. Though half of participants reported being comfortable, reasons for reduced comfort for some included being shy, lack of anonymity, or challenges with the size of the group and who may be able to view their responses. Besides learning tools and strategies, in discussions staff often found the validation of shared experiences to positively impact their wellbeing. Some participants noted a shift in their ability to reframe their challenges and look at their issues with new perspectives. While our evaluation results cannot conclusively confirm that change in our measures of mental health was due to the self-care education series as the design did not include a control group, there is evidence from participants as to the program's relevance to their needs and direct benefit to them thereby corroborating results.

Organization – Site-Based Team Support (meso)

Description

The site-based team support included two webinars on separate topics Grief and Trauma Informed Leadership and Psychological Safety and Wellbeing in the Workplace- each followed up with a workshop session where participants could discuss the topics and applicability, and thirdly a webinar/discussion session on the topic of Transformational Leadership. In addition, all homes were given the opportunity to meet individually with DMC facilitators. These individual consultation meetings were an opportunity for sites to further discuss grief and trauma and a psychologically safe workplace and to identify actions that are relevant and tailored to their site's needs and context. The site-based team support was aimed at leaders within the organization. Leaders could choose whether they attended one topic or both, and whether they wanted to proceed with a site consultation or not.

The webinars and workshops took place online. LTC homes had the option to have their consultation online or in-person but due to rising COVID-19 cases and outbreaks, all consultations were held with site leaders online. See Table 10 in Appendix B for the delivery schedule of webinars and consultations as part of the site-based team support.

Objectives

The overall objective was to generate short-term change targeted at the organization (meso) level.

- **Immediate Impact** – identification of issues, actions, and resources that are specific to the LTC site's needs.
- **Short-term Impact** – application of actions or commitment to application.

Our Approach

One method of data collection was used. One-on-one semi-structured interviews at two points in time with participants who were leaders at their respective site. Time 1 interviews were conducted within one week following the site consultation and Time 2 follow-up interviews were conducted 5-6 weeks after the site consultation (one month following the first interview). While the site-based team support component had multiple activities, we did not evaluate the webinars or workshops specifically but gathered feedback about these activities during the interviews. See Appendix B subheading "Methods" for additional information on method.

Sample

Recruitment

All 50 LTC homes were offered opportunity to participate in this component. Around 27 LTC homes had representation in the webinars. Ten LTC homes participated in a site consultation meeting with DMC facilitators. Of these 10 sites, five participated in the evaluation.

A two-stage recruitment process was used: recruiting sites and recruiting participants within selected sites. Once DMC facilitators confirmed a site had signed up for site consultation meeting and it was scheduled, the main contact at the site was contacted to discuss staff participation in the evaluation. We did this with all 10 sites as that was the original target for inclusion in the evaluation of this component. If the main contact agreed to have their site participate, they were asked to identify two to three people who were a part of the site consultation and permission to have their contact information forwarded to

us to discuss involvement in an interview. Within the sites there were two main ways in which participants were identified: (1) the site contact identified a few individuals for us to follow up with or (2) the site contact copied a larger group of individuals on the email whereby individuals could reply if interested and we would determine if they were eligible. Participants identified within the sites were contacted by email. They were given information about the purpose of the interview and informed consent document to review their rights and safeguards. Participation was voluntary and if agreed an interview was scheduled via telephone or videoconference to be completed at a time convenient for the participant.

Out of the 10 homes contacted, five agreed to participate, four did not confirm or were unable to participate within the time frame, and one did not respond.

Sample

Interviews at Time 1 included a total of nine participants who represented five LTC homes from two zones. Follow-up interviews at Time 2 included seven of the same participants, still having representation of the five homes (one denied a second interview, and one did not reply). See Table 11 for the overview of LTC homes in the consultation. Table 12 in Appendix B provides a detailed overview of the sample and interview context for the site consultation evaluation.

Table 11

Overview of LTC homes included in the site consultation evaluation

	LTC homes in sample
Total number of LTC homes	5
Average number of residents at each LTC home	96
Average number of staff working at each LTC home	167
Location of LTC homes (zone)	Western zone Central zone

All participants who were interviewed as part of the site consultation were CEOs, administrators, managers, or leaders within their organization (i.e. food services manager, recreation director, etc.). Participants had varying involvement in the webinars and discussions, but all were involved in the site consultation (see Table 13 in Appendix B). Reasons for their participation in the site consultation varied by site. Most recognized poor mental health among staff (exacerbated by COVID-19 and related issues) and wanted to build a psychologically safe work environment. Much of their reason for participation informed topics of discussion at the consultation and an action plan moving forward.

Outcomes Measures

Experience with Site Consultation

The site consultation was met with a positive reception from most. One home stated that it was the most valuable component of the entire *Leaning into the Hard* program for their organization, while others stated it provided “aha moments” and was “mind-blowing”. Site consultations were beneficial in

that organizations could address issues that were specific to their site. This was evident as each site had varying reasons for attending, topics discussed, and different actions to address the issues identified – consultations provided a customizable approach based on the sites needs and resources. The site-based team support provided a unique approach to supporting mental health initiatives at an organizational level as described by one participant:

> It was so different from anything we've done in the past, I think in healthcare there has really been a push to keep your personal feelings down, you're here to do a job, you're not to share much of your personal information, then to have that vulnerability offered on work time in the work space was a big learning curve, once you got into it, it was a lot more relatable and you could see the benefits of it, but at first it was hard to see why we were doing it.

Participants specified that consultations were more beneficial for sites that were able to have open and honest conversations during the meeting. Sites that had more difficulty with open dialogue described less benefit as they were unable to move forward with any strategies, "we're very much in a state where the psychological safety doesn't exist, and we're all terrified to talk about it". Nevertheless, the ability to have these discussions was beneficial, "I'm not sure if we're at a point where we can implement anything here but at least we're all on the same page on how to discuss it because we all have the same vocabulary now... we never would have talked about something like this before".

Participants viewed the consultations as a first step to recognize where they were as a leadership team and an organization and how to get to where they wanted to be with respect to a psychologically safe work environment. The experience with the site-based team support seemed to be different from anything in the past as described by one participant, "I felt like it was very validating and I wasn't the only one having this experience, it gave us the opportunity and platform to have those conversations that have never really been welcomed in the workplace before". This approach allowed for individual reflection, understanding that there will be continual impacts on staff mental health exacerbated by the pandemic, and a need to provide actions and support for a path forward.

Connection to Grief and Trauma and Psychological Safety

The two webinar topics were rated satisfactory by all interviewees and described as informative, relevant, and validating. For some, the webinars reinforced their knowledge and others it provided a new lens that allowed them to have novel conversations about. Three of the five sites specifically mentioned "Grief and Trauma" as especially beneficial, broadening their understanding of this concept. For example, webinars provided understanding of the different types of grief that could be experienced such as grieving pre-pandemic job roles and socialization with co-workers.

Themes from the webinars were discussed at the consultations whereby participants indicated it provided a baseline understanding and vocabulary for many of the participants at the five sites. One of the sites specifically focused on grief and trauma and creating a pre-emptive program to address the grief and trauma from the pandemic that staff were either already facing or would eventually need further support. Three of the sites were specifically focused on creating a psychological safe work environment through improving safety within the leadership team, between management and direct care staff, and implementing the psychological health and safety standards. Another site did not participate in the webinars and therefore had different goals.

Participants understood how the various components of the overall program were connected and seemed to complement each other. A couple of participants felt the other components (self-care education, webinars, and community of practice) were beneficial to build their understanding and could go into the consultation further ahead than prior to the program.

Action Plan Identified

The strategies and action plans set forth from the consultations were influenced by the reasons each site participated in the program. One common reason to participate was to learn strategies and acquire tools and methods to support staff mental health. All five homes had some form of action or goal on this theme such as:

- Increasing discussion about mental health,
- Listening to staff responses about support needs,
- Shifting workplace culture to encourage self-reflection, or
- Removing disparity in understanding and recognition of mental health needs.

As a result of the consultation, all five homes had a plan to move forward, each varying in the extent of work required. Action plans included:

- Sharing information more broadly throughout the organization,
- Engaging leadership teams and direct care staff through activities, and
- Implementing a benchmarking survey on psychological health and safety needs and use these results to create plans and programs addressing any gaps found.

Interviewees commonly talked about organizational readiness as a factor that would either facilitate or impede moving forward with their action plan. Several identified buy-in from leadership and support from upper management as necessary. There was also recognition that COVID-19 outbreaks and the impact on staffing resources, such as creating higher work demands, would be a barrier in immediately moving forward with the action plans.

Capacity for Leaders

Activities provided with the site-based team support component helped leaders better understand how to support others (i.e., build capacity within organization). The webinars provided a new lens and understanding of relevant issues. The site consultation allowed leaders to reflect and discuss specific issues to their site wherein those issues were turned into action plans which they could implement. The expertise needed to create an action plan was available with discussion about implementation. Four of the five sites felt that the site-based support provided them with the knowledge and tools to move forward. The majority of the leaders reported feeling ready and confident to move forward with their action plans and apply the concepts learned from the webinars. Some participants indicated a change in their management style wherein they were more empathetic and understanding to staff, wanting to create a more positive and safe space for staff to feel encouraged and continue to build relationships between direct care staff and management. Some participants' capacity came from their ability to share insights with staff through newsletters and incorporating mental health check-ins at employee meetings. The consultation helped to solidify the next steps to creating a psychologically safe and grief-informed environment for three of the sites. Participation in the site-based team support provided a clear path forward, wherein one site reported that without participating, the path forward may not have been as clear. For one site, a participant felt that the consultation meeting did not yield expected

outcomes and expressed the need for more external support to work through their workplace dynamics which were viewed as a barrier to moving forward.

Action Plan Realized

At the one-month check-in, all five homes reported no progress or minimal progress in achieving their goals. In all cases, this was due to a current or recent outbreak of COVID-19 and the resulting staff shortages placing higher work demands on leadership teams. One of the homes was able to administer the psychological health and safety survey, while the other home had to postpone for when they expected staffing levels to stabilize. Some homes indicated that they have discussed the topic, but there have been no actions. Another two homes had recently received funding to continue involvement with DMC but had not formalized any meetings at time of check-in. In view of the current context of COVID-19 outbreaks impacting staffing shortages and increased work demands, leadership teams feel like they have no time right now. While progress was stalled by the pandemic, the desire to move toward the goals they established was still there.

Program Delivery Considerations – Enablers and Barriers

Delivery

All interviewees from the five homes had positive things to say on the delivery of the site-based team support. For the site consultation, some participants mentioned that the online format was not a good fit and would have preferred to see more in-person programming (which was the original model proposed by DMC), suggesting there would have been higher engagement, deeper understanding of issues, and would have gotten more out of this component. A participant from one site suggested a mix between one-on-one conversations rather than just group oriented.

The webinars and discussions included leaders from across the province. This was mentioned both as an enabler and barrier by participants. Some felt that hearing the experience of others was validating, while others had difficulty engaging, finding the discussions to be silent and awkward. “You don’t quite say what you want to say because the whole province is watching”, which inhibited a productive discussion.

The time frame in which the site-based support (webinars, site consultation) was delivered was rapid, spanning around two months. The short time period was beneficial for some as it provided a focused time and momentum toward making progress. Others felt the rapid pace did not fit with their organization, they needed more time to process the information and that it “only scratched the surface”. There was a lot of information to process in a very short period of time, particularly for this component which required participants to reflect at an organization level.

Summary

The site-based team support (both webinars and site consultation) were positively received by participating sites. Building upon and complementing the other two components of the *Leaning in the Hard* program, this component targeting the organization level was a unique approach that aligned with the specific needs and contexts of each site. All five sites involved only management and leaders in the consultation meeting, however some mentioned wanting to see more diverse participation (i.e. informal direct care leaders) but lacked capacity to do so. The webinars provided conceptual understanding and a framework for the issues discussed in the consultation and majority of participants in the site consultation participated in the webinar providing that continuity of concepts and ideas. From the consultation, action plans were formed whereby sites were in the beginning stages of identifying needs

and actions to meet their goals. Site consultations were largely driven by a desire to create psychologically safe workplace that support all employees. All sites, but one, indicated that the site-based support, specifically the consultation, provided them with the language, knowledge and tools to support a psychologically safe work environment. Increased capacity was realized through implementing the information more broadly, changes in management style, and having a clear path forward. For one site, while not the same outcome as others, the consultation was important as it helped to identify at what stage they are, the potential barriers to moving forward and the need for more internal work. At the one-month follow-up, the majority of sites were unable to make progress as expected or desired largely due to COVID-19 outbreaks and associated staff shortages and work demands. Many were still highly motivated and committed to this work, seeing it as necessary for their organization. The consultations were viewed as a first step, with a couple of the sites applying for additional funding to further support their endeavors.

Sector – Community of Practice (macro)

Description

A Community of Practice (CoP) was developed to create a space for informal sharing of experiences and practices to navigate a path forward in creating psychologically safe workplaces. The CoP was facilitated by DMC practitioners using a guided process with the goal to transition into a peer-led group by end of 10 sessions. All LTC leaders (administrators, directors, managers) in the 50 participating LTC homes were invited to participate, thus the intent was to be province wide.

The CoP meetings took place on a weekly basis over a 10-week period (January 27 – March 31). All CoP sessions were on Thursdays from 1:30pm – 3:30pm. The CoP was offered online through Zoom videoconferencing. Individuals joining the meeting were required to pre-register.

Objective and Measures

The objective was to create a province-wide CoP for long term care that would be sustainable post project funding to better equip leaders in supporting staff with mental health concerns. We assessed to what extent this was achieved through measures including:

- **Immediate Impact** – level of participation and extent of engagement, safe space that supports connections, clarity of purpose and satisfaction with the CoP.
- **Short-Term Impact** – application of learning, commitment to continue the CoP, increased capacity to address staff mental health.

Our Approach

Three methods of data collection were used – focus groups, online survey, questionnaire. Throughout the 10 weeks, we met with participants to ask questions about their experience with the CoP (open-ended and use of poll feature) and participants were asked to complete an online survey at the completion of the 10 weeks. This participant data was supplemented with information collected through a questionnaire from the DMC facilitators for each of the 10 sessions. See “Methods” Appendix C for additional information on method.

Sample

All participants in the CoP were senior leaders in LTC homes. Of the 50 LTC homes who were communicated information about the CoP, registration for this component indicated that eight LTC homes had zero involvement (no registrants), 22 LTC homes had less registration (one to four participants registered), and 20 LTC homes had higher registration (five to 12 participants registered). While registration was moderate to high and consistent for over half of the LTC homes involved, it is unclear how many followed through in their participation. Personal demographic information of participants in the evaluation for this component was not collected.

Focus Groups

The number of people who registered for the weekly sessions fluctuated. At the outset there were 160 registrants compared to the last session which saw 72 registrants. Similarly, the number of participants in the evaluation activities varied over the weekly sessions. For example, our initial focus group with participants during Session 3 involved 66 participants at the start of the discussion and reduced to 45 by

the end of our discussion (see Table 14 in Appendix C for information on number of focus group participants).

Online Survey Sample

The link to the survey was sent to 199 participants who had registered (minimum one session) for the CoP. We received 55 completed surveys, a response rate of 28%. Demographic questions were not asked to online survey participants.

Of the 55 surveys completed, respondents were from 22 different LTC homes (of the 42 represented in the CoP, representing 52% of LTC homes). Eleven participants did not respond or provided an invalid response.

On average, participants attended five, out of the ten, CoP meetings (Standard Deviation = 2.72, Mode = 6, Median = 6). (See Figure 19 in Appendix C for the number of CoP meetings attended by online survey participants).

More than one-third (37%) attended most if not all meetings while one quarter (25%) reported attending intermittently over the 10 weeks. Thirty-eight percent started to attend but discontinued participation (n=21). See Table 15 and Figure 20 in Appendix C.

Outcome Measures

Level of Participation and Engagement

Engagement from participants in the first half of the CoP (sessions 1 through 5) was a challenge. DMC facilitators were highly involved in preparing for the sessions and were primarily leading the group. Participants were silent, had cameras turned off, and the preferred method of communication was through the chat function on Zoom.

One of the contributing factors to the low level of engagement can be attributed to the large group size. This was a challenge for both DMC facilitators and participants. Participants shared that the group dynamics (i.e., co-workers and high-level management) impacted their willingness to open up and share within the group. Some also indicated that this format of sharing and discussing was not something they were used to as previous learning has been more of a didactic approach.

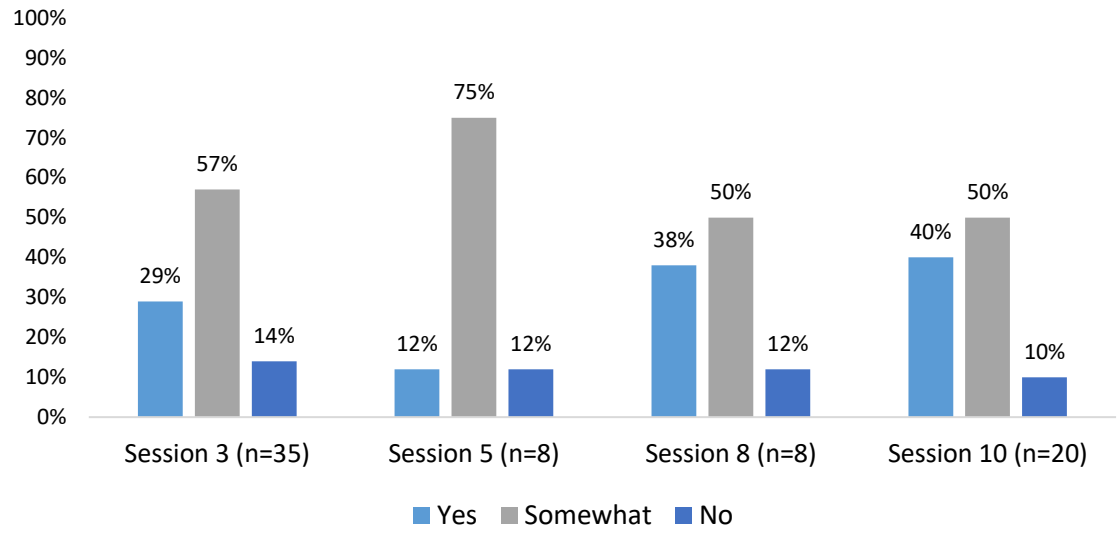
As the CoP progressed, DMC facilitators noted the number of participants gradually declined and level of engagement from participants improved each week. As reported by participants in the online survey, reasons for intermittent or discontinued participation were largely (~66%) due to other work demands (such as staffing shortages and COVID-19 outbreaks) and scheduling constraints. Almost half (43%) of participants who started attending and discontinued their participation (n=21) indicated it was because the CoP did not meet their expectations based on the content, format, and purpose. As well, other work demands, and time constraints often associated with the impact of COVID-19 contributed to their discontinuation. Some other reasons for limited participation included personal circumstances (e.g., vacations and personal problems), communication, and technology issues.

At the 8th session, DMC facilitators described a turning point in terms of leadership transitioned to a peer-led space wherein participants carried the discussion, and less preparation work was required by DMC facilitators.

Over time, participant's level of comfortability participating in the discussion shifted. Participants who were somewhat comfortable sharing became more comfortable sharing, while those who were uncomfortable sharing stayed consistent (see Figure 21). Participants felt more comfortable participating in the discussion after hearing others' experiences and when cameras were turned on. For those who are still uncomfortable indicated that they felt their contributions were insignificant, they were unable to relate, they want to listen and learn from others, or were preoccupied with other work demands.

Figure 21

Comfortability participating in the discussion over time



In the final three sessions of the CoP, there was a smaller and more consistent group of leaders attending and engagement became more equal and inclusive. However, it was noted by DMC facilitators that there were still more dominant voices and a few who remained silent with their camera off.

Relevance and Value

Throughout the 10-week period in which the CoP was delivered by DMC facilitators, majority of participants at the group discussions reported the CoP being a good use of their time (see Figure 22) and that the areas of discussion were relevant (see Figure 23). Participants shared that the CoP topics were relevant to the self, the workplace, and the LTC sector however, most felt the relevance of topics were primarily due to challenges that are pandemic related.

Figure 22

Participants in agreement that the CoP was a good use of time

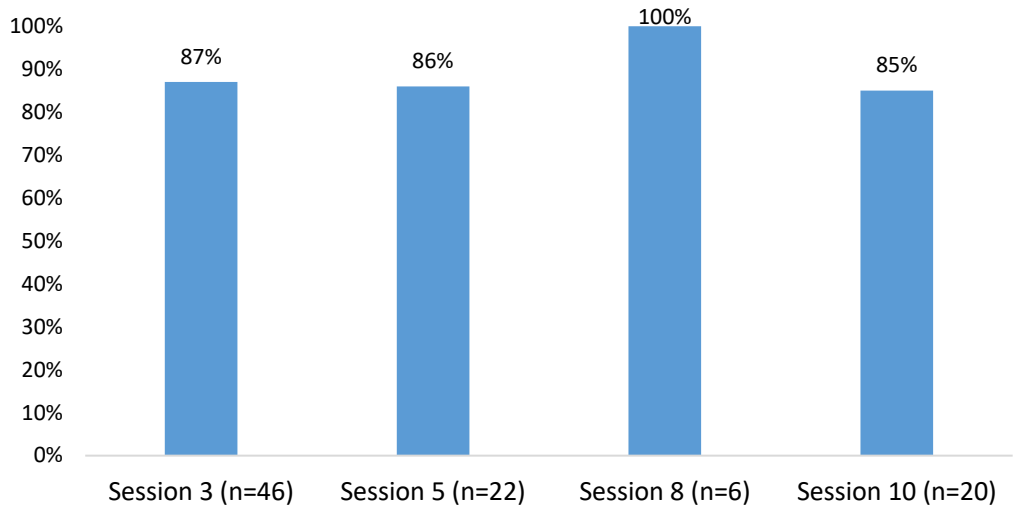
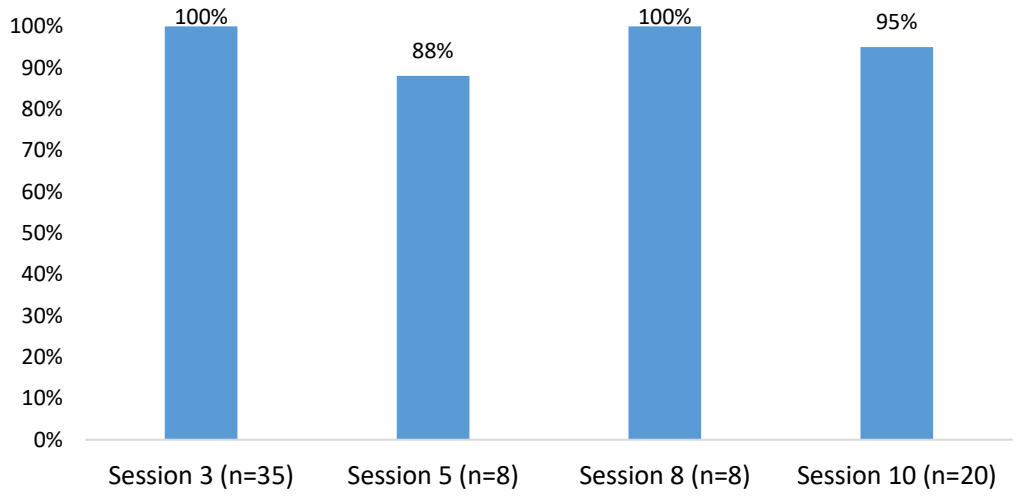


Figure 23

Participants in agreement that the topics of discussion were relevant



Clarity of the Purpose of the CoP

Participants (in the focus group) expected a more didactic learning approach rather than something that was participant-driven and interactive. For some this caused confusion regarding purpose of the CoP. At the beginning for most the purpose of the CoP was clear however, as the CoP progressed the purpose became less clear, and by the 10th session almost three quarters of participants (72%) indicated the purpose of the CoP was clear (see Figure 24). Of note, many who reported uncertainty of the purpose of the CoP discontinued their participation (as reported in the online survey). Those who discontinued due

to uncertainty, reported a need for focused topics with tools available to increase leadership capacity (see Figure 25).

Figure 24

Participants who reported purpose of the CoP was clear by evaluation points

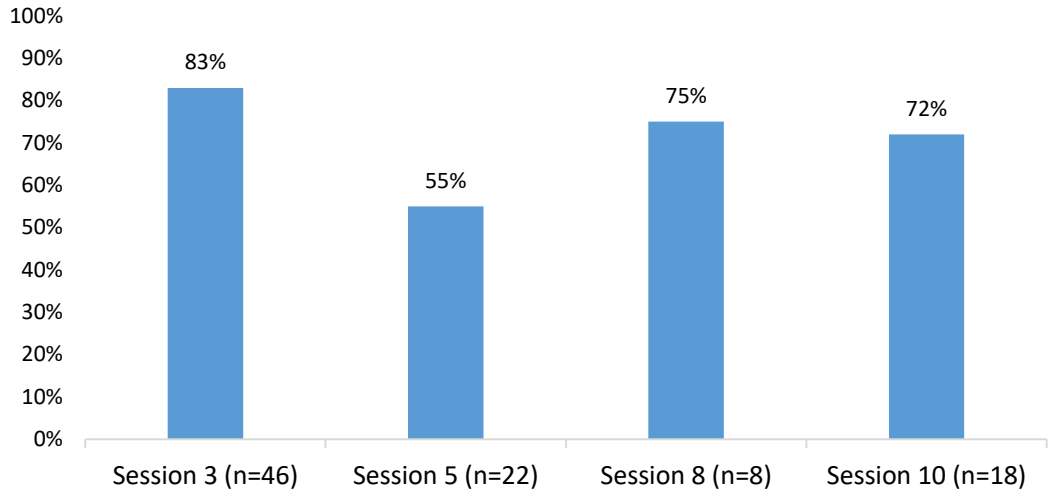
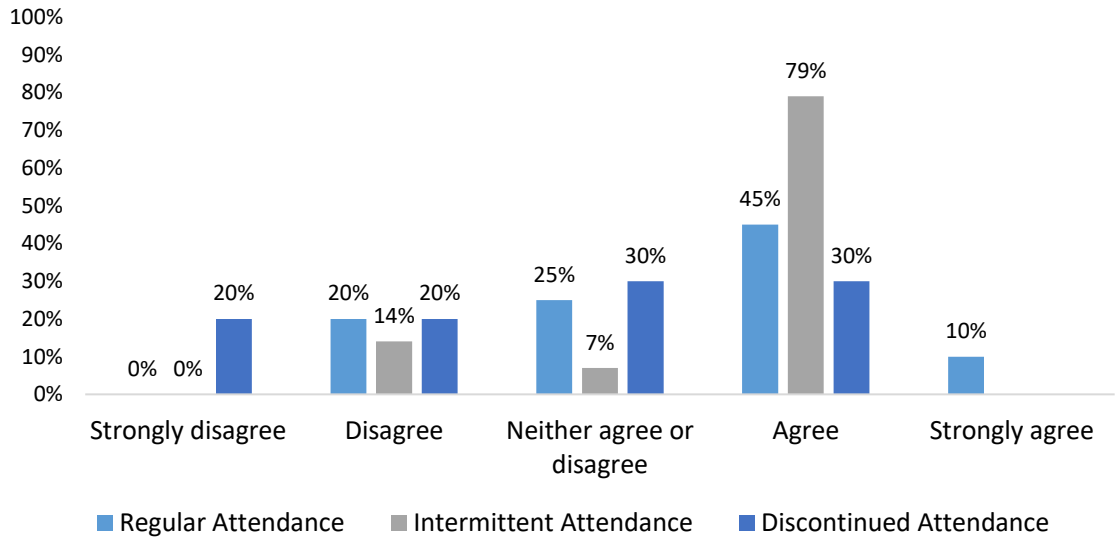


Figure 25

Participants' level of agreement that purpose of the CoP was clear by attendance (online survey, n=55)



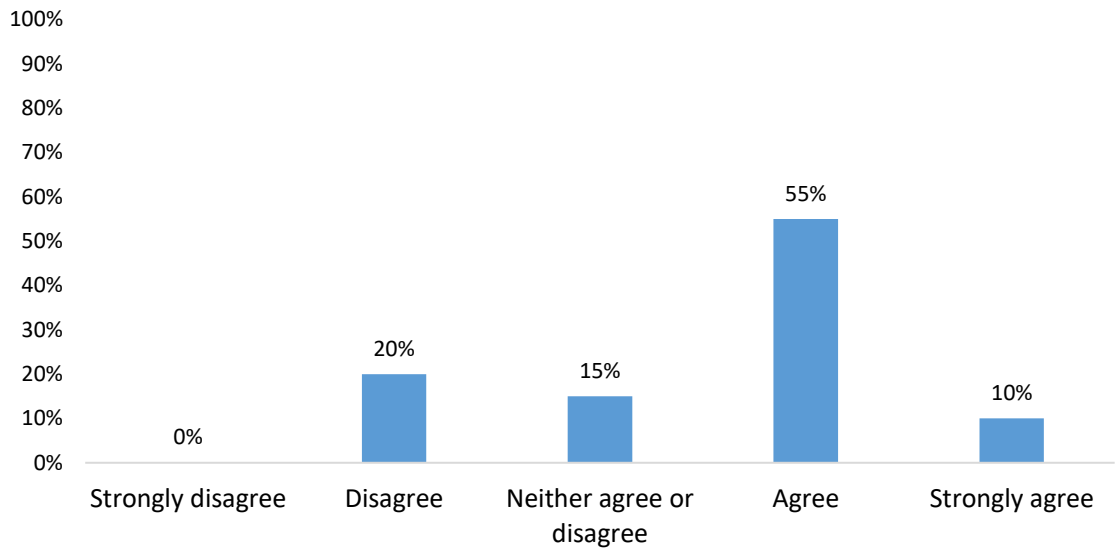
Building Capacity and Apply Practices

One of the objectives of the CoP was to help build capacity for leaders to address staff mental health concerns and navigate a path forward.

At the mid-point, many participants did not yet see how the CoP would help to build capacity within their organization. After the 10th and final CoP meeting, almost two thirds (65%) of regular attendee participants reported that the CoP helped them as leaders to support staff's mental health concerns (see Figure 26) and to build capacity within their organization.

Figure 26

Regular attendee participants' level of agreement that the CoP helped them as leaders to better support staff's mental health (online survey, n=20)



- For those who indicated the CoP *helped build capacity* reported that it allowed them to first reflect on themselves and their own mental health. The CoP provided a space to share experiences and build awareness and have a better understanding of psychological well-being.
- For those who indicated the CoP *did not help build capacity* reported uncertainty among leadership buy-in and not enough time to understand the full impacts and needing further support from facilitators to help build capacity.

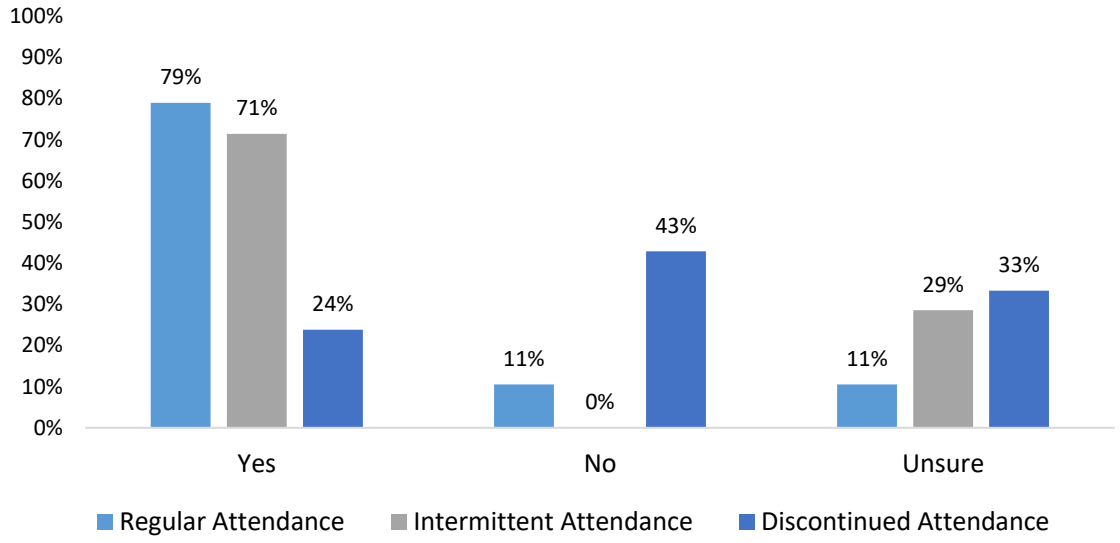
Commitment to the CoP Post Project

At the 10th and final CoP session, two participants emerged as leaders committed to continue the CoP. This was a shift from the 7th session wherein participants vocalized not feeling equipped to lead the CoP.

Participants who attended the CoP on a regular basis were more likely to continue their participation whereas participants who had started and then discontinued attending the COP were more likely not to participate in the CoP if it continued. Figure 27 illustrates participants' responses to whether they would consider continuing their participation in the CoP, with 79% of the regular attendee group and 71% of the intermittent attendee group indicating "yes".

Figure 27

Participants who would consider attending the CoP if it continued by attendance (online survey, n=55)



There were two main areas that participants identified as needing modifications in order for them to continue their participation:

- *Delivery format* – less frequent meetings (monthly or bi-weekly), alternate time of day, shorter length of meeting (maximum 60 minutes), and the option for a hybrid of in-person and virtual meetings.
- *Framework of the CoP* – more structured topics and discussion, defined outcomes, clearer topics and language used, and smaller more defined (i.e. by role) groups to help build trust and increase dialogue.

Program Delivery Considerations – Enablers and Barriers

Satisfaction with the CoP

Participants were asked to rate their satisfaction with various components of the CoP to understand how the delivery format facilitated or hindered their experience and thus sustainability of the CoP.

Various components of the CoP were rated as *satisfactory* among all participants. All participants were highly satisfied with the online format used, the approach taken by facilitators, and coming together with leaders from across the province (70%-72% rated as satisfied). Components of the CoP that were rated as *less satisfactory* include the length of each session, frequency of meeting, group size, and level of participation/discussion (45%-58% rated as satisfied, 24%-35% rated as neither satisfied or dissatisfied, 16%-31% rated as dissatisfied). **The components that were less satisfactory coincide with the suggestions by participants in order for their participation to continue**. See Figure 28 for an overview of all participants' satisfaction with various components related to the delivery of the CoP and Figure 29 for participants' satisfaction with various components related to the content and approach to the CoP.

Figure 28

Satisfaction with various components related to the delivery of the CoP among all participants (online survey, N=55)

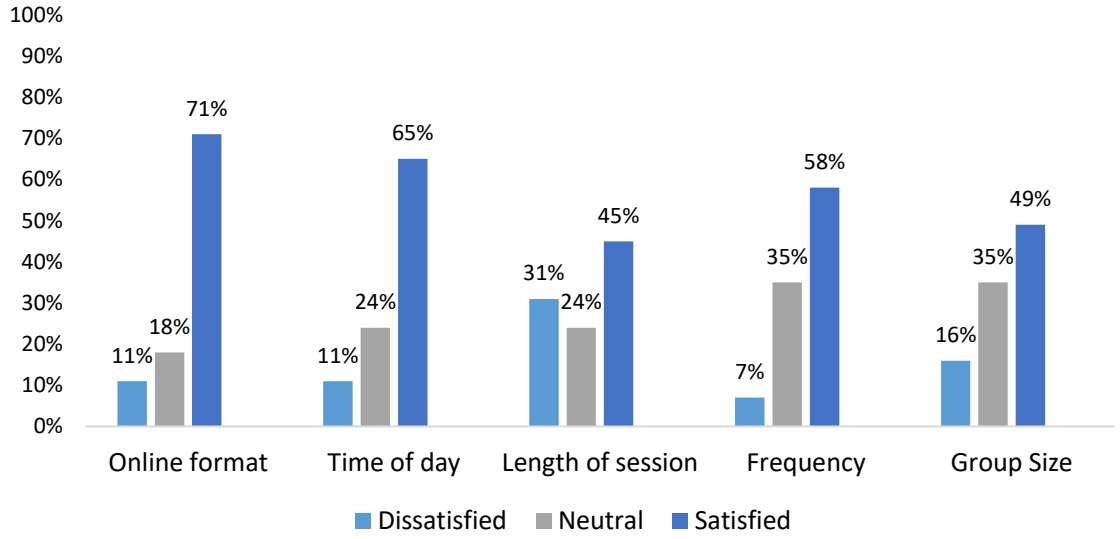
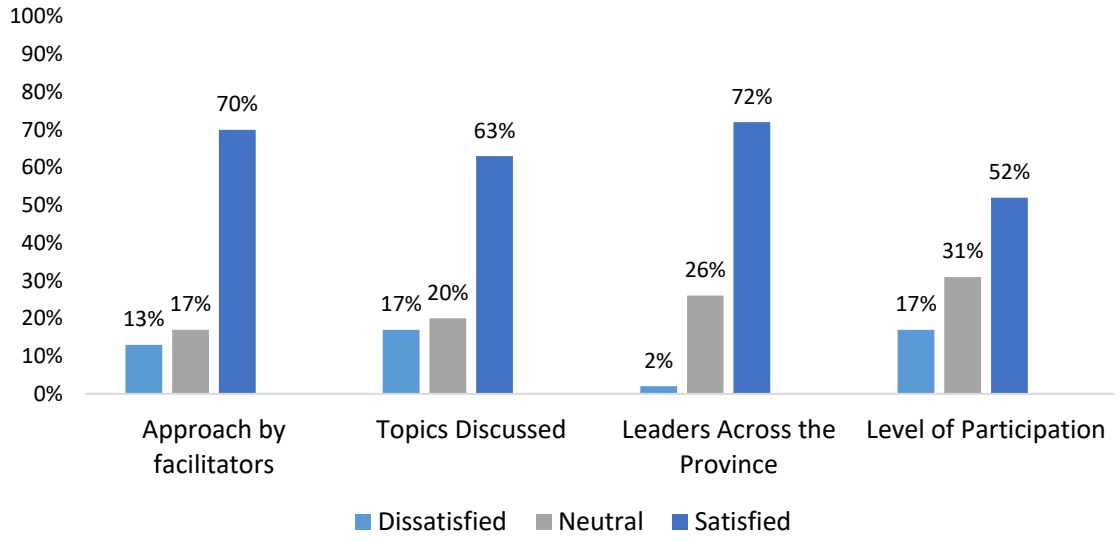


Figure 29

Satisfaction with various components related to the content and approach of the CoP among all participants (online survey, N=55)



Summary

The CoP seemed to build in strength over time. As sessions went on, overall attendance dropped but participation among remaining leaders increased. Some of this can be attributed to increased comfort of participating due to validation from hearing others share similar experiences and feelings. Participants generally felt like it was a good use of their time, particularly those with regular attendance and those

who discontinued attendance commonly raised this point as well as factors related to how the activity was delivered. Recognition of the CoP as improving leader capacity to support staff mental health improved over time, with some participants noting that this was able to develop when they started to build the same capacity to understand their own mental health and needs. At the end of the facilitated CoP sessions, two participants volunteered to continue the CoP work under their leadership. Thus, with the CoP looking to continue and most participants benefitting from its existence, the objective of the CoP work seems to be met.

Key Insights and Observations

The Art of Resilience – Leaning into the Hard program was offered to LTC homes across Nova Scotia in the winter of 2022 (January-March). The multi-faceted intervention included a variety of activities (education series, webinars, consultation, community of practice meetings) aimed at the individual level, organizational level, and sector level. In view of the escalated stress and anxiety staff are experiencing through the pandemic, attention to enhanced understanding of grief and trauma and its implications in the workplace were critical to staff mental health and well-being. Collectively, the activities were intended to support a psychologically safe workplace culture. Individuals were to be more aware and gain self-care skills, organizations were to work on issues specific to the needs of their site, and sector leaders were to come together to learn/share to be better equipped as leaders to address mental health and well-being in their organization. Across all components of the intervention, a recognition of grief and trauma in the workplace and attention to the value of a psychologically safe workplace was emphasized.

For the varied activities across the components, evaluation results indicate benefits, improved mental health, and increased capacity for leaders in the short-term across all components. Our results, however, are limited in terms of time frame and capacity to understand longer term impact of the program on the individuals and organizations involved. A summary of the key insights from the individual components follows.

Self-Care Education Series

Individuals found the education sessions to be beneficial, relevant to their individual needs, and relevant to the LTC sector. Over 90% of participants said they would recommend this self-care education to their co-workers. Majority had gained new skills that they have already incorporated into their daily lives, and many intend to incorporate the skills in the future. Several participants noted the value of the sessions going beyond delivery of information and many reported the most benefit to them was the time taken to reflect and feel validated with their feelings through sharing and listening to peers' experiences. New ways of framing their experience and the ability to look at their situation differently were reported and are the foundation of shift in viewing mental health and well-being. Despite the ongoing realities workplaces were facing with the ongoing pandemic (Omicron Variant during program implementation), there was a significant reduction in participants' stress level and a significant increase in participants' resilience. Several noted challenges (more so non-management), however, with being able to participate in the sessions due to scheduling and length of the session.

Site Consultation

Despite strong expression of interest in this component and the evaluation, a few sites engaged in the site consultation component. For those that did, the opportunity for the focused attention on the needs and realities of their organization was generally viewed as valuable. The organizations which participated in the site consultation indicated that many of them required the individualized help from DMC, their challenges with advancing work on psychologically safe workplaces could not be addressed internally. While many of their goals differed, each were given a next step to work towards that was based on their needs, thereby unique to their organization. The timing of this component (i.e., March-April) impacted organization's capacity to advance the work that was identified in the site consultation. Workplaces were affected on an ongoing basis during this time frame with outbreaks in the sites and

staff shortages due to wider spread in the community. However, the individuals who participated in this component are highly driven and motivated to see this through and plan to continue post-project through additional funding. Most participants noted that meetings on site would have been richer and with individual meetings with senior leads before the group meeting.

Community of Practice

The CoP received varying reviews during the implementation. Participants commonly noted that the purpose was not always clear, the large group size was a barrier to engagement, and lack of structure (perhaps connected to unclear purpose) impeded participation. However, the understanding and how a community of practice develops/evolves, particularly one in which is intended to be peer/participant led, may have been lacking amongst some participants. The course of the CoP's development was as expected given its short time frame. As the CoP progressed, the group became smaller in number (presumably those with a mutual goal), with increased engagement and sessions morphed to being more participant-led. Those who were regular attendees reported high satisfaction with various components and just over half indicated it helped them to develop capacity as leaders to undertake work within their organization (evidence of shift from external to internal). However, there were concerns throughout the sessions about comfortability of sharing which may have impacted engagement and participation level in the early stage. There are plans for the CoP to continue on a less frequent basis with two leaders in the sector seeing it through.

Next, we offer some further insights about the program overall.

Affect Across the Program

The overall program had three separate and distinct components targeting different levels and different staff within LTC, yet it was the intention of the three components collectively to make change. Measuring the effect of the program overall was challenging due to the low number and inconsistent participation across all three components. However, we heard from a few of the participants who were interviewed as part of the site-based team support component (individuals who had participated in multiple activities) of the connections and linkages across the activities. They noted the value of the common themes and use of language and recognized the importance of having staff on the same page with the same vocabulary and understanding in order to move forward with putting the learnings into practice. This finding suggests that for organizations who can commit on a wider scale within their organization to all components of the *Leaning into the Hard* program, greater success in shifting the culture is likely.

Program's Relevance to LTC

In background work completed to understand existing mental health initiatives, we found a major gap in programs designed specifically for LTC. There were general mental health programs, programs for health care workers, and generic self-help websites and phone lines and all with more or less a "training" approach. Working in a LTC setting is unique compared to other healthcare settings and concerns about work conditions, grief, and compassion fatigue, etc. are paramount to staff mental health and well-being, being further exacerbated by the pandemic. Therefore, one of the key reasons for selecting this program was that it was designed for the LTC sector in mind.

Our findings indicate that the program was met with success in being relevant to LTC. Participants in the self-care education series described high relevance to their work in LTC. Specifically, it provided new skills applicable to work in LTC. Hearing experiences from others helped to provide validation to the care they provide, the stress they experience, and grief and loss they feel is real. The self-care series provided understanding of the experiences in LTC, relevant coping mechanisms, and increased confidence. A few felt validated to have a program focused on LTC and a facilitator with experience in LTC as the sector is not often prioritized compared to other healthcare settings.

The site-based team support component was relevant to LTC mainly due to the unique approach that allowed sites to discuss issues that were specific to their organization. The webinars and workshops drew on two main topics that were regarded as relevant to LTC and provided a new lens or reinforced existing knowledge. The site consultations allowed leadership teams and organizations to discuss the challenges related to LTC (especially during the pandemic), come to a common understanding to where they are at as an organization, identify needs, and create an action plan specific to their LTC site moving forward.

The CoP was relevant to LTC in terms of the topics discussed and participants setting the agenda. Some participants described that reflecting on shared experiences and learning strategies from others, specifically around grief related practices, was relevant. Moreover, some felt the CoP was relevant because of pandemic related challenges that were specific to LTC settings, while others recognized these challenges existed before the pandemic.

In sum, on the three levels this program aimed to address, participants reported it being highly relevant to their work and experiences in LTC. Across the three components, the content was relevant and the ability to be vulnerable, hear others' experiences, and gain practical tools was all relevant (and considered necessary) to validate or increase capacity to address mental health in the LTC sector.

Discussion and Disclosure as an Enabler and Barrier

One of the underpinnings to each component of the *Leaning into the Hard* program was the sharing and discussion component. The self-care education series, webinars and workshops, site consultations, and CoP all incorporated a group discussion focused on the content and sharing experiences or practices. Across all components, this was regarded positively for some and as a barrier or point of hesitancy for others. Participants who regarded the discussion positively reported feeling they had a safe space to share how they were feeling, learned from others' experiences, and felt a sense of not being alone after understanding others have similar feelings and experiences. Others were hesitant to share during the discussion portion, understandably due to the sensitive nature of the topics being discussed. For many, this would have a first time even being asked to reflect and share on such topics and there were concerns about disclosure and privacy. Moreover, the group dynamics played a role wherein there were supervisors and senior management participating or participants felt uncomfortable disclosing/sharing with peers from across the province. Although there was comfortability for some surrounding the group discussion component, we saw that over time once a safe space was established, participants became more comfortable (in the self-care education series and CoP). Speaking in front of a group and sharing experiences on a vulnerable topic is difficult, but when moving forward to create a culture change, being able to talk about mental health is critical. It is important that in future programs there continues to be a space that builds trust and understanding that it is ok to talk about mental health.

Challenges

The implementation of the program and our work to evaluate the program was not without its challenges given the timing of the program (January-March 2022) and short timeframe for implementation. The main challenge being the impact experienced in Nova Scotia's LTC sector by the COVID-19 Omicron variant, which resulted in many homes having active outbreaks often lasting a month or longer. The outbreaks meant that much of the staff were unable to work, which placed higher demand on existing staff and impacted managers traditional roles wherein they were consumed with providing care themselves. This impacted staff's ability to participate in the program and additionally in the evaluation work.

Level of Participation

While staffing shortages and high work demand were barriers to participation, the outbreaks increased this barrier leaving various levels of staff minimal or no capacity to participate in the program, as well as the evaluation activities. For some sites, the proportion of staff who completed the education series was low, so while maybe beneficial on the individual level, a larger number of employees from the workplace, or even from a particular department within the organization, would presumably increase potential for change within the organization. Further, there was a discrepancy in the number of participants registered for the self-care education compared to the number of people participating at the scheduled time. It is unclear whether participants registered in anticipation of receiving a recording of the session (presentation portion only) or whether they were unable to attend for other reasons. Level of participation was also a factor in the site-consultation phase where 10 of the possible 50 homes participated. Reasons for lack of engagement in this specific component is not known but with our repeated follow ups to potential sites to discuss evaluation activities, we were met with the site's inability to participate in the evaluation due to challenges with outbreaks.

Program Implementation Changes

Given the context in which this program was delivered, it was an evolving process whereby changes to the delivery and timeframe of activities were made throughout. Changes were made to reflect the challenges in the LTC sector and in hopes to improve accessibility and increase individual capacity to participate. Prior to starting the program, LTC homes provided mixed feedback on the best time to start with some needing a program immediately and others having no capacity and needing time. The self-care education was then delayed until the end of January and it was decided that the program would be repeated again in March. The second time the education sessions were offered there was a much smaller group and therefore the responses were pooled together with the first group. This created additional evaluation work in terms of developing and sending additional surveys, moderating mid-point group discussions, and managing and analyzing the data.

The community of practice was originally intended to be five sessions for leaders and five sessions for direct care staff (alternating bi-weekly for 10 weeks). However, this was changed due to leaders indicating they need more than five sessions. Furthermore, the online survey was not originally part of the evaluation but given the group dynamics and wanting to understand why some participants discontinued, a survey was developed and sent to all registrants (minimum one session) to get a more diverse perspective. This placed additional work and increased the timeline for analysis of this piece of the program.

The site-based team support component was initially to be implemented beginning of February, but after communication with LTC sites who indicated they were experiencing virtual fatigue, the webinars were pushed to the end of February and consultations were done from mid-March to mid-April. This component was very fluid wherein originally there were to be webinars, then it was decided no webinars (due to virtual fatigue) and then ultimately decided to do the webinars. Moreover, the site consultations were originally planned to be half day or full day meetings in-person, but with the context of COVID-19 and other factors, all consultations were around one hour and online. The uncertainty of the activities offered made it difficult to plan the evaluation activities and the delayed timeline impacted our understanding of any longer-term outcomes from this component.

Communications

This was a multi-level program that encompassed various activities across the three components targeting similar but also different people within the homes. This created some confusion for participants. In the context of LTC leaders receiving copious emails a day and balancing a high workload, it is understandable that what is required of their participation would be confusing. In addition to participants receiving communication from the Association or DMC facilitators about the program, they would also receive communication from us at the Nova Scotia Centre on Aging asking for their participation in various components of the evaluation (i.e., online surveys and interviews). This inundation of information may have impacted their full participation in both the intervention and evaluation component.

Communication to direct care staff for the self-care education relied upon administrators and managers. It is unclear to us how individual staff received information and what information they were receiving from management about the sessions. For example, whether they were told that this education was not a lecture based didactic education and that there was a discussion component for those attending at the scheduled time. There may have been variation between LTC homes and whether it was supported by management and how it was communicated.

Evaluation Method

This evaluation work does not benefit from a control group. The evaluation is comprised of individuals who participated in the program, there is not a group of individuals who did not participate that can be used as a comparison. Therefore, there is possibility for improvements in mental health of other staff working in LTC who did not participate in the program. The multi-level program that involved different participants across activities did not allow for us to understand who was participating and who was not, and the fluidity allowed for participation at any point in during the program. Further, since the program was offered to all staff and participation could be anonymous, it was unknown who was not participating. We did not have ready access to staff who were not in the program, and we did not want to place an increased burden on management to recruit this group[3].

Given the sensitive subject matter and goal to create a safe space for participants, there was no observation of any activities (self-care sessions, community of practice, webinars and workshops, or site consultations). As previously mentioned, there was a change in approach to the evaluation of the

[3] However, it should be noted that there was an attempt to interview a site that did not participate in the site-based team support. However, there was no response from that site.

community of practice whereby an online survey was added for participants to complete after the final session. This was added after feedback from participants who indicated those with less dominant voices were not expressing their opinion during the group discussions. While the survey was additional work for the evaluation, this is seen as a strong point whereby participants could provide anonymous feedback and we could get more diverse feedback such as the perspective of those who discontinued their participation or were uncomfortable speaking in the group discussions.

The *Leaning into the Hard* program was a multi-level intervention designed with three independent components and activities. The strength in the model is that when put together, there is potential to produce long-term change shifting the culture on psychological safety in the workplace. Given the limited number of participants from the same organization in the self-care and varied participation across the three levels, it limited our capacity to evaluate the program as a whole in a meaningful way. Many participants were only involved in one or two of the different components and had varied participation (i.e., attended some of the community of practice or some of the self-care education). Therefore, interviews as part of the site-based support provide some understanding of the program as a whole, but it is difficult to draw conclusions with a small and varied sample.

Timing

Despite planning and coordinated effort between the Association, DMC facilitators, and evaluation team, the implementation of this complex intervention, and its evaluation, in Nova Scotia's LTC sector in a 10-week period was problematic. The intensity of the initiative may have led to better outcomes if spread over a longer period of time. It was noted by many that because of the content, having time to process and reflect would have beneficial. Moreover, because of the context of the LTC sector during this time frame, changes to the original program's implementation plan were made during implementation. For example, the positioning of the site-based team support may have led to different outcomes if following the completion of the CoP meetings. Regardless, the delivery of activities were compressed and decisions were made resulting in adjustments to the evaluation workplan. Further, while information on some outcomes were able to be captured in this time frame, more time to allow for subsequent follow up of participants across the components (e.g., 3-6 months) would have strengthened the evaluation work.

Conclusion

Our evaluation of the *Leaning into the Hard* mental health program for staff working in LTC provides evidence that in the short-term it was beneficial, had a positive impact on mental health, and it helped to build internal organizational capacity. The format in which the program was delivered was generally positive and the approach taken by facilitators and their ability to create a safe space was commended by many. The online format worked well for most who indicated it provided flexibility, but others felt there would have been stronger impacts and greater participation if some of the program was to be in-person. For individuals, leaders, and organizations who *leaned into* the program, meaning they were open, vulnerable, and committed, reported positive outcomes. The program provided an increased understanding and value on psychological safety and increased capacity for leaders to support staff. The LTC sites involved described a commitment to the work to improve their working environment to support staff mental health and move toward a culture of care and well-being. However, there was recognition that this program was just the first step for many and recognition that there needs to be continued opportunities and support for creating a psychologically safe workplace.

The multi-level approach that addresses needs on three independent levels (individual, organization, and sector) has merit and should be considered in future programs. When aiming to reframe/shift the culture around mental health, there needs to be support and change targeted at the individual and organization. The program model's strength is in its ground-up approach while also recognizing the role of leaders in effecting change. However, this program should not be regarded as a "one-and-done" initiative but rather as ongoing work particularly if long term sustained change is the goal. As well, the program should not be considered "training" but rather framed as a foundational support to transition how the sector views and approaches mental health, providing the tools and resources necessary to support organizations and their leaders to do the necessary work rather than relying on external sources. There is evidence that the program is relevant for the LTC sector, it made a difference in individuals lives and organizational capacity and that parts of this program can be sustained if offered on an ongoing basis, more broadly, and with the proper resources.

While the programs at the three levels appear to be relevant to creating a psychologically safe workplace, there must be higher levels of participation, continued external support, and additional time to obtain any longer-term goals. We caution that the participation in the individual self-care sessions is only a small proportion of all staff working in LTC, there needs to be more participation within organizations and across the sector to see higher impacts. Similarly, the CoP has established a framework and there are plans and commitment from a smaller dedicated group to move forward. In order to share practice more widely and commit to change on a sector wide level, there needs to be greater participation from more LTC homes across the province. The site-based support provided an innovative approach that provided value to the participating LTC sites. Many have specific actions and plans to move forward, but a few indicated they needed additional external support and some have received additional funding to continue this work.

In conclusion, this program provides a relevant approach to individuals working in LTC and has contributed to change at the individual and organizational level. The implementation of the program was not without its challenges given the current context of LTC - staff turnover and shortages, increased work demand, limited time to participate, and organizational support and readiness – factors which were exacerbated by the COVID-19 Omicron variant spreading through the LTC sector in the winter of

2022. Individual and organizational needs will vary and a multi-level approach that can be adapted to any organizations' needs is a promising model to fostering a culture in which staff's mental health and well-being can be supported in a psychologically safe environment. While short term effects were evident, the program provides a foundation for long term change. Organizations must continue to work towards their goals post-project and the sector should receive external support where needed to ensure that mental health support for staff is seen as a value on investment.

Appendix A

Individual – Self-Care Education Series (micro)

Supplementary Information on the Delivery, Method, Sample, and Findings for the Self-Care Education

Delivery

Table 1

Schedule for the self-care education sessions

	Session 1 **Self-Care**	**Session 2** **Self-Awareness**	**Session 3** **Self-Compassion**	**Session 4** **Self & Others in Action**	**Session 5** **Self-Growth**
Wave 1	January 26 9:30-11:30 (x2) 1:30-3:30 (x2)	February 2 9:30-11:30 (x2) 1:30-3:30 (x2)	February 9 9:30-11:30 (x2) 1:30-3:30 (x2)	February 16 9:30-11:30 (x2) 1:30-3:30 (x2)	February 23 9:30-11:30 (x2) 1:30-3:30 (x2)
Wave 2	March 2 9:30-11:30 (x1) 1:30-3:30 (x1)	March 9 9:30-11:30 (x1) 1:30-3:30 (x1)	March 16 9:30-11:30 (x1) 1:30-3:30 (x1)	March 23 9:30-11:30 (x1) 1:30-3:30 (x1)	March 30 9:30-11:30 (x1) 1:30-3:30 (x1)

Method

Detailed purpose of each method of the evaluation for the self-care education:

- ***T1 survey*** – the goal was to gain a baseline understanding of what participants expected prior to attending the sessions and a self-rating of their current mental health including their perceived stress, resilience, and the biggest factor impacting their mental health.
- ***T2 survey*** – the goal was to understand the immediate impact on participant's mental health and gather feedback on the delivery, content, and value of the education sessions. This goal was assessed by having participants provide insights into how they attended the sessions, whether it met their expectations, feedback on the delivery, relevance, and benefit of the sessions, and completing the same self-rating of their mental health as T1.
- ***T3 survey*** – the goal was to understand the longer-term impacts on participant's mental health and gather feedback on the education sessions as a whole after a longer period of time. Participants had a final opportunity to provide feedback on the delivery and benefit of the education sessions and completed the same self-rated mental health questions as T1 and T2.
- ***Mid-point check-in focus group*** (including both structured questions through polling and open ended questions) – the goal was to gain insight into participant's experience with the education sessions and open dialogue to what has/has not been working well, the greatest value, and suggested changes regarding the education sessions.

By asking the same self-rated mental health questions at three points in time (immediately prior to sessions, immediately after sessions, and one month after sessions) it will provide insight into the impact of the self-care education and if/how participant's mental health has changed.

Lime Survey was used as the platform for the online survey. Participants who registered for the sessions (through NHNSA) were asked whether they wanted to participate in the evaluation component. If they agreed, we emailed them with information about the evaluation and a link to the survey. This practice was done at each point in time and their consent to participate in each survey was asked prior to them advancing in the survey. As a way to increase participation in the evaluation activities, participants were invited to enter their name for a draw of one of five $50 gift cards.

Some participants may have registered at the 2nd, 3rd, 4th, and even 5th session. If so, they were given the opportunity to complete the baseline survey as long as they had not attended any sessions prior. The link to the second survey was sent to all participants who registered for at minimum one or maximum all of the sessions and whether they participated at the scheduled time with the group or watched the video recording of the session at a later time.

Sample

Table 2

Online survey response rate at three points in time

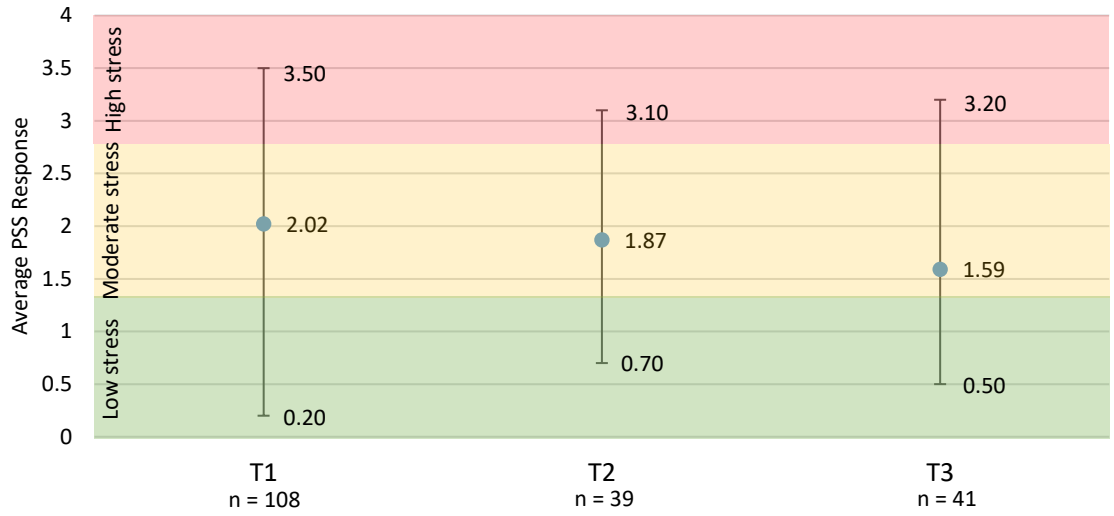
Survey	Number of surveys sent	Number of valid completed surveys
Time 1 (T1) – baseline pre-program	234	115 (49% response rate)
Time 2 (T2) – immediate post-program	234	42 (19% response rate)
Time 3 (T3) – six weeks post-program	234	41 (17% response rate)

Findings

The figure below presents the range and average PSS score among the general population of LTC staff participants at three points in time.

Figure 16

Perceived stress scale (PSS) average rating at baseline (T1), immediately after (T2), and six weeks after (T3) participation in the self-care education series



The figure below presents the range and average BRS score among the general population of LTC staff participants at three points in time.

Figure 17

Brief resilience scale (BRS) average response at baseline (T1), immediately after (T2), and six weeks after (T3) participation in the self-care education

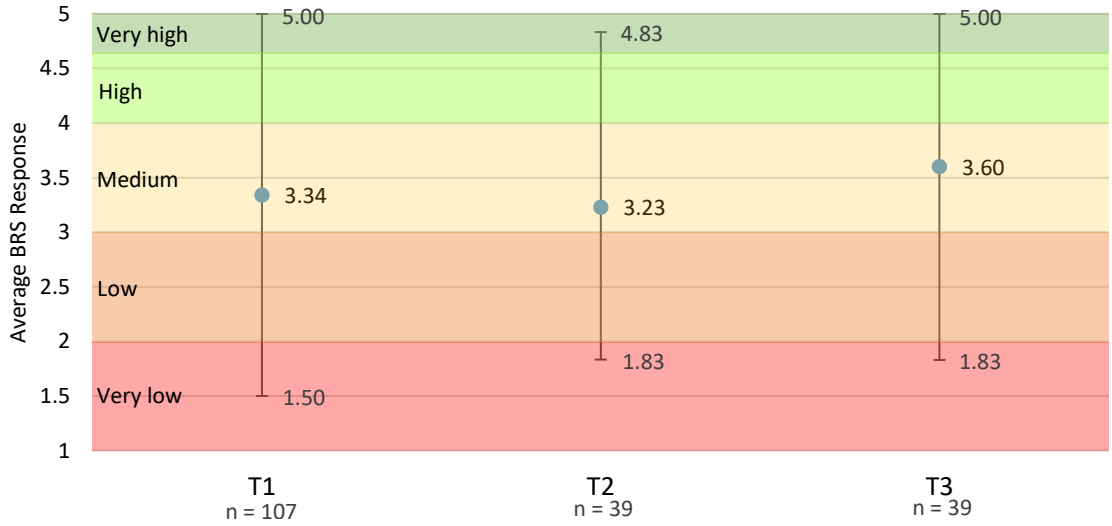


Table 9

Demographic information of the online survey sample at three points in time for paired sample

	T1 Baseline Pre-Education Series		**T2 Immediate Post-Education Series**		**T3 Six Weeks Post-Education Series**	
Surveys Completed	N = 81		N = 29		N = 27	
Average Age	49 years (23-69)		49 years (25-65)		48 years (23-68)	
Gender	Female	94%	Female	100%	Female	96%
	Male	5%			Male	4%
	Prefer not to say	1%				
	No response	0%				
Job Role	Direct care	25%	Direct care	24%	Direct care	30%
	Nursing	20%	Nursing	8%	Nursing	4%
	Management	22%	Management	17%	Management	11%
	Recreation	11%	Recreation	21%	Recreation	18.5%
	Allied health	7.5%	Allied health	10%	Allied health	11%
	Other	5%	Other	10%	Other	18.5%
	Administration	7.5%	Administration	10%	Administration	7%
	Support services	2%				
Average Years Working in LTC Home	10.0 years (0.08-44.41)		15.6 years (0.5-44.5)		12.6 years (0.58-38.5)	
Average Years Working in Job Role	11.3 years (0.08-44.41)		13.6 years (0.41-44.5)		11.4 years (0.5-38.5)	
LTC Homes Represented	32 (80%)		18 (45%)		15 (38%)	

Appendix B

Organization – Site-Based Team Support (meso)

Supplementary Information on the Delivery, Method, and Sample for the Site-Based Team Support

Delivery

Table 10

Delivery of site-based team support

	Date	Time	Location
Webinar – Grief and Trauma	February 22	9:30-11:00	Virtual
Workshop – Grief and Trauma	March 1	9:30-11:00	Virtual
Webinar – Psychological Safety	February 28	2:00-3:30	Virtual
Workshop – Psychological Safety	March 7	2:00-3:30	Virtual
Transformational Leadership	March 22	2:00-3:30	Virtual
Site Consultation	March 14 – April 8 (site decision)	Site specific	Virtual

Methods

Approach to site-based team support evaluation:

The evaluation approach for the site-based team support included semi-structured interviews at two points in time. A semi-structured approach was used so that the specific actions identified by the home could be probed and discussed in the follow-up interview. Given the change in delivery and uniqueness of this approach, an in-depth interview with participants who were involved in the consultation was the method of choice.

Purpose of each interview:

- ***Time 1 Interview*** (within 1-week post-consultation) – understand the motivation to be involved, experience with this component's topics and approach, actions moving forward, and the intervention as a whole.
- ***Time 2 Interview*** (within 5-6 weeks post-consultation) – understand any progress made on the actions identified, the capacity and barriers to making progress, and the impact on psychological health and safety within the organization.

Interviews were conducted one-week post-consultation so that participants could provide timely reflection wherein the topics and actions would be on top of mind. Given the short time frame of the delivery, follow-up interviews were completed one month following the first interview (or 5-6 weeks

following the consultation). Ideally, there would be a larger time span between interviews to understand the progress over time and longer-term impacts.

Sample

Table 12

Overview of participants interviewed for the site consultation at two points in time

	Time 1 Interview – One Week after Site consultation	Time 2 Interview – One Month Follow Up
Total number of sites	5	5
Total number of participants	9 (2 participants each at 4 sites; 1 participant at 1 site)	7 (2 participants at 2 sites; 1 participant at 3 sites)
Date of interview	March 25 - April 14	April 27 - May 18
Average length of interview	51 minutes (32-75 minutes)	24 minutes (17-33 minutes)

Table 13

Participation from interview participants in the various activities as part of the site-based team support

Activities	Attendance
Webinar – Grief & Trauma	7
Discussion – Grief & Trauma	6
Webinar – Psychological Safety	7
Discussion – Psychological Safety	7
Transformational Leadership	2
Site Consultation	9

Appendix C

Sector – Community of Practice (macro)

Supplementary Information on the Method and Sample for the Community of Practice

Methods

1. Focus groups with CoP Participants

The perspective of CoP participants (leaders participating the sessions) was obtained throughout the development process through group discussions. We met with participants over several points in time following the CoP session itself (i.e., sessions #3, #5, #8 and #10). Participants were invited to remain online for a group discussion with us where we gathered information through polling questions as well as open-ended questions. The process we followed for these group discussions was entering the meeting in the final 15 minutes wherein DMC facilitators then left the meeting. We read a consent script and informed participants who we are, what we were doing, and that it is their choice to participate or not. We then launched a series of questions using the Zoom polling function whereby participants submit their answers anonymously. We then asked some open-ended questions where participants responded by going off mute and speaking or typing in the chat. To conclude the group discussion, we had some final questions using the polling function. Points of discussion cover their experience with the CoP and their perceptions on the sustainability of the CoP. Two members of our team were present for each focus group session.

2. Online Survey

Participant perspective was also obtained through an online survey at the completion of the 10 week meetings. Lime Survey was used as the platform for the survey. This was a final opportunity for participants to provide anonymous feedback and for us to gather in-depth information on specific features of the CoP. This additional piece of the evaluation was carried out after it was suggested as a method to facilitate less dominant voices and to get the perspective of those who did not attend the group discussion(s) or were uncomfortable speaking during them. At the 10th and final check-in, rather than a group discussion, we sent a link to the online survey through the chat function in Zoom to participants in attendance. The survey was then sent via email to all participants who registered for minimum one CoP session.

- 17 surveys were completed at the 10th check-in (out of 22 participants at the meeting).
- 38 surveys were completed out of 177 emailed to participants

3. Questionnaires from DMC Facilitators

The perspective of DMC facilitators who delivered the CoP sessions was obtained through a questionnaire submitted at the end of each session. The questionnaire gathered information on the engagement of participants, challenges and barriers, work required by facilitators, and sustainability of the CoP moving forward. Questionnaires provided temporal information about the evolution of the CoP over the 10-week period.

Focus Group Sample

Table 14

Focus group participants by session

	Participants ***prior*** to consent	Participants ***after*** consent	Participants at ***closing*** poll
Session 3	66	57	45
Session 5	35	28	14
Session 8	16	9	6
Session 10	22	22	22

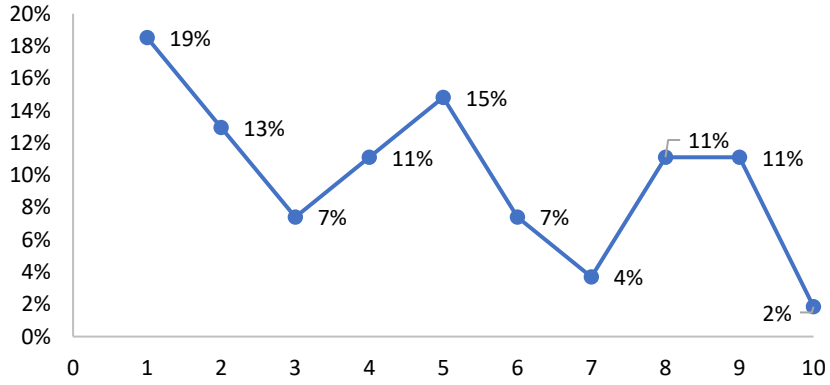
Information about participants across all focus groups:

- Around 70% of participants work in ***Western and Central Zone***
- All participants but one attended on ***paid time***
- Around 80-90% ***participated alone***, while the others participated as part of a group
- Participant's ***attendance varied*** for the sessions, half attending eight or more times, a quarter attending five to seven times, and a quarter attending four times or less.

Online Survey Sample

Figure 19

Number of CoP meetings attended by online survey respondents (n=54)



Participants were asked to self-describe their participation based on the following four options presented in Table 15:

Table 15

Type of participation in the CoP based on attendance among online survey respondents

	Number of participants
Regularly attended, did not miss any meetings	2% (1)
Regularly attended, but missed a few meetings	35% (19)
Attended intermittently	25% (14)
Started to attend but discontinued my participation	38% (21)

Note: For the purpose of the following analysis, we have combined "regularly attended, did not miss any meetings" with "regularly attending, but missed a few meetings". Results will be presented by three types of participation (regular participation, intermittent participation, discontinued participation).

Figure 20

Type of participation in the CoP based on attendance among online survey respondents (n=55)