Factors Influencing the Physical Activity of Older Adults in Long-Term Care: Administrators’ Perspectives

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In 2006, the authors conducted a multisite qualitative study in Ottawa, Ontario, Canada to examine organizational and environmental factors that influence physical activity for long-term-care (LTC) residents. The article describes the results of interviews with 9 administrators from nonprofit and for-profit LTC facilities. A content analysis revealed that despite having positive views about the value of physical activity, the administrators encountered challenges related to funding, human resources, and the built (physical) environment. The intersection of staffing issues and challenges in the built environment created less than optimal conditions for physical activity programs. Findings suggest that until there are adequate human and financial resources, it will be difficult to implement evidence-informed physical activity programs for residents in LTC settings in Ontario. A review of provincial LTC standards for physical activity program requirements and the built environment is warranted.

Keywords: exercise, interviews, nursing homes, barriers, facilitators, physical environment, qualitative

Despite a strong body of evidence demonstrating the potential benefits of exercise for frail seniors living in long-term-care (LTC) facilities, such as fall prevention (Gillespie et al., 2003; Norris, Walton, Patterson, Feightner, & The Canadian Task Force on Preventive Health Care, 2003), improved muscle strength and endurance (Bastone Ade & Jacob Filho, 2004; Fiatarone et al., 1994; Lazowski et al., 1999; Ouslander et al., 2005; Schnelle et al., 1996), less depression (Bastone Ade & Jacob Filho), and less urinary incontinence (Ouslander et al.; Schnelle et al., 2003), research consistently indicates that most LTC residents have low levels of physical activity (Bates-Jensen et al. 2004; Ice, 2002; MacRae, Schnelle, Simmons & Ouslander, 1996; Ruuskanen & Parkatti, 1994; Schnelle et al., 2004). Several authors have described the barriers to physical activity for residents in LTC settings (Chin A Paw, van Poppel, Twisk, & van Mechelen, 2006; Lazowski et al.; Ouslander et al.; Schnelle et al., 2002). Prominent among these barriers are externally controlled factors (e.g., decreased staff-to-patient ratios because of funding constraints), internally controlled factors (e.g., physical barriers imposed because of safety concerns), and changing demographics of patients in LTC (e.g.,

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increasingly older). Most studies that have examined how the built (physical) environment influences seniors’ levels of physical activity are community based (Berke, Koepsell, Moudon, Hoskins, & Larson, 2007; Booth, Owen, Bauman, Clavisi, & Leslie, 2000; Cunningham & Michael, 2004; Li et al., 2005). In nursing homes, design elements such as aesthetics and facility size have had a demonstrated impact on leisure choices, social engagement, and wandering behaviors of residents (Cohen-Mansfield & Werner, 1998; MacDonald, 2006; Rabig, Thomas, Kane, Cutler, & McAlilly, 2006; Schwarz, Chaudhury, & Tofle, 2004). It is reasonable to assume that environmental factors such as the availability and aesthetics of outdoor walking paths and physical features of the indoor environment such as handrails in hallways and on stairs also influence levels of physical activity among institutionalized seniors.

In 2006, we undertook a multisite qualitative study in nine LTC homes in Ottawa to gain a better understanding of the factors that influence residents’ physical activity. In Ontario, LTC facilities are classified as nonprofit (e.g., municipal homes for the aged, charitable homes for the aged) and for-profit (e.g., nursing homes) facilities (Ontario Ministry of Health and Long-Term Care, 2007), with about 62% being for-profit facilities (Berta, Laporte & Valdmanis, 2005). There is some evidence that staffing levels are higher in nonprofit facilities than in for-profit facilities and that spending decisions might be different in the two types of homes (McGrail, McGregor, Cohen, Tate & Ronald, 2007; McGregor et al., 2005). These differences could potentially affect the promotion of physical activity in the LTC setting.

This article presents the results of our walkabout interviews with administrators. These interviews were part of a larger study that also included focus-group discussions with residents, their family members, and care providers. We interviewed the administrators because they play a critical role in establishing the philosophy of care in LTC homes (Smith, 2004). In addition, they are the direct links between the Ontario Ministry of Health and Long-Term Care and their organizations and oversee the operation (e.g., budget, physical environment) of the facility. Administrators could potentially play a pivotal role in advocating for more physical activity opportunities for their residents.

The objectives of these interviews were to examine administrators’ perspectives on the meaning of the terms exercise and physical activity, the value of physical activity, and how physical activity is or is not encouraged in their settings. A secondary objective was to compare responses of administrators from for-profit and nonprofit LTC sectors.

Methods

Sampling and Recruitment

A list of the 28 LTC homes located in Ottawa was provided to the research team by the Ottawa Community Care Access Center (CCAC). CCACs are the local point of access to community-based health care services such as home care.
CCACs are also responsible for assessing clients for LTC placement. A pilot site was purposefully selected based on availability, size (larger), and location (central). The pilot site was used to test our interview schedule and to determine the feasibility of the walkabout interview. The pilot data were included in the final analyses, because no major revisions were made to the study’s protocol after pilot testing.

The remaining 27 LTC facilities were grouped into nonprofit \((n = 14)\) and for-profit \((n = 13)\) categories. Six facilities were randomly selected from each group. Commencing in July 2005, administrators at the 12 LTC facilities were contacted by phone to determine their interest in participating. One facility was unable to participate and a replacement facility was randomly selected. Although 12 LTC facilities showed initial interest, only eight letters confirming support were returned. Our final sample included nine sites (one pilot and eight randomly selected sites). Ethical approval was received from the University of Ottawa Health Sciences and Science Research Ethics Board and other boards affiliated with the study sites.

Administrators were eligible to participate in an interview if they had been employed in the LTC home for at least 3 months and provided written informed consent. Interviews were completed in English by a trained research assistant from March to June 2006. A two-part interview was conducted. The first part began in the administrator’s office, where the interviewer asked the administrator questions about the facility (i.e., number of beds, category of staff hired, and number of volunteers), resident characteristics (i.e., number and gender of residents), and the administrator’s perspectives regarding physical activity and exercise for residents in the facility (see Appendix). A walkabout interview was then conducted. The administrator and interviewer walked around the facility, both indoors and outdoors, with other questions being posed along the way. Both parts of the interviews were audiotaped using a handheld cassette recorder.

**Data Analyses**

Data on facility and resident characteristics were entered into SPSS version 11.0, and descriptive statistics (i.e., frequencies, means, and percentages) were computed. The qualitative data were content analyzed (Miles & Huberman, 1994). The first author developed an initial coding structure. To refine the codes and identify subcategories the transcripts were reread and codes were refined. For example, under the code “barrier,” subcategories were identified and labeled (e.g., physical environment, staffing, funding). Matrices were then used to examine relationships or patterns among the data across the nine sites. For example, a matrix was used to determine whether there was a relationship between challenges and beliefs about physical activity. Matrix displays were also used to compare and contrast nonprofit and for-profit facilities. All authors read the transcripts and met several times during the analysis to arrive at consensus on the coding structure. When there were divergent opinions, the authors went back to the transcripts and reexamined the data to arrive at consensus on the final coding structure.
Establishing Trustworthiness and Rigor

The credibility, transferability, dependability, and confirmability of data are criteria by which to judge the trustworthiness and rigor of qualitative data (Devers, 1999). Several strategies can be used to assess adherence to these criteria (Devers; Patton, 2002). The main strategies used in this study were the creation of a detailed audit trail, a search for deviant (unusual) cases, and having the authors meet on several occasions to arrive at consensus on the coding scheme and interpretation of the results (Devers).

Results

Sample and Facility Characteristics

Six administrators from nonprofit facilities and three from for-profit facilities participated. The average number of beds was considerably higher in nonprofit ($M = 203$ beds) than for-profit facilities ($M = 121$ beds). Most residents were women, with a slightly greater percentage of female residents in nonprofit facilities (77.6%) than for-profit facilities (67.6%). All facilities employed registered nurses, registered practical nurses, and health care aides or personal support workers. Physiotherapy services were provided in all facilities, and occupational services were provided in six. All facilities had one or more staff member assigned to recreational or restorative care services (e.g., recreational therapist, activity coordinator, recreational assistant, restorative care aide). The services of physiotherapists and occupational therapists were most often contracted out, whereas recreational services were provided by in-house staff. All administrators reported that their facilities had volunteers, although the number of volunteers varied considerably, ranging from 15 to 300.

Meaning of the Terms Exercise and Physical Activity

We asked the administrators to tell us what the terms physical activity and exercise meant to them. Exercise was more often described as a formal, structured, supervised, and/or group program that included structured activities such as walking, ball toss, morning stretch program, seated chair exercises, bed exercises, or yoga. In contrast, physical activity was described as activities of daily living and included “everyday activities,” “residents’ ability to be mobile and do things,” or “any type of body movements,” as well as more social activities like gardening and bean-bag toss. Administrators also described formalized programs such as physiotherapy, restorative care, and occupational therapy.

The Value of Physical Activity

Most administrators expressed positive beliefs regarding the value of physical activity for residents, indicating that it was important in promoting and maintaining residents’ independence, health, mobility, and quality of life. Several administrators commented that physical activity could be beneficial for all residents regardless of their physical or cognitive status.
We asked the administrators to tell us whether the term physical activity was included in their vision, mission, or philosophy of care. Although most of them responded that the term physical activity was not explicit, they identified statements that they felt were consistent with the goals of physical activity. These statements included “enhancing the quality of life,” “maintenance of independence,” “keeping residents’ abilities through restorative care,” “wellness,” “enhancing the lives of the community we serve with dignity and respect,” and “safe and comfortable home environment.”

The absence of Ontario Ministry standards specifically for physical activity was a consistent observation of the administrators. Some administrators indicated that there were standards pertaining to recreation and leisure and restorative care. However, one administrator commented that the standards related to leisure services were broadly defined: “Leisure services organized to provide age-appropriate recreation, leisure. . . . [administrator reading content of the standards]. So that can be quite broad.”

Some administrators mentioned that program-specific policies and procedures had been developed by their recreation and restorative care departments. One administrator commented that there had been a discussion by staff members of the need for policies and procedures related to physical activity: “That’s something we’ve talked about. . . . A lot of [the residents] like going outside for walks, but we don’t have any [policies or procedures] developed.”

Administrators were asked to describe how residents’ physical activity needs were communicated in their facility. In general, residents’ councils and family meetings were the primary venue for communicating residents’ general concerns and needs. When the topic of physical activity was brought up by residents, they tended to focus on entertainment and social events. When family members discussed physical activity, they tended to focus on the need for activities to maintain residents’ physical function. For example, one administrator commented that some family members felt that their parents had “lost their abilities” because there were “not enough staff to walk residents.”

Some administrators felt that the topic of physical activity was not often raised because residents with cognitive impairment could not voice their concerns, other residents did not understand the benefits of physical activity, and residents were generally satisfied with the level of services provided. One administrator indicated that the topic of physical activity was not often raised as a concern by family members because residents complained that there were too many activities:

A lot of seniors . . . when they’ve been in their homes and they get admitted . . . [think that] we work them to death with the activities, they’re not used to that. And I’ve had complaints from residents that there’s too much going on, we can’t get to everything, we get tired. So it might be that families are just, [thinking] yeah, well there’s a lot going on, so they must be doing something.

One administrator said that the topic of physical activity was brought up more often in summer than winter because residents and family members would see joggers and bikers outdoors and this in turn “spurred them on” to ask for more activities.
Challenges to the Promotion of Physical Activity

Despite having positive personal views about the value of physical activity, most administrators described significant staffing and funding constraints to providing physical activity programs. Common problems included not having enough staff or volunteers to transport residents to their activities and inadequate time for staff to incorporate physical activity into daily care or to provide individualized attention to residents. Cutbacks in funding had resulted in the loss of physiotherapy, recreation, and occupational therapy staff.

Several administrators mentioned that the level of resident acuity had increased substantially over the past 5 years. As a result, more residents were less independently mobile and needed assistance to get to and participate in their activities. One administrator explained “If you don’t have enough people to transport [the residents] then naturally they aren’t going to be [at the exercise program]. So I think it’s important to have a certain level of staffing.” Another commented that although recreation staff-to-resident ratio exceeded ministry standards, more staff was needed to help transport residents. One administrator described shortcuts that staff would take to try to manage demands on their time. For example, a health care aide with 14 residents to bring to the dining room would wheel the residents rather than helping them walk.

Some administrators described the negative consequences that funding and staffing constraints had on the provision of physical activity for residents. For example, one administrator discussed the results of losing a part-time activity person because of cutbacks:

This means less exercise [for residents] because one activity person has to go on to two floors, so one floor is kind of neglected . . . but you know, it’s like that. We have to live with it, but it doesn’t mean that there is no demand [for exercise].

Another administrator indicated not having “a lot of control” over the recent cutbacks in physiotherapy funding. To help fill the gap in services, an in-house rehabilitation assistant was used for “things that don’t require the professional expertise of a physiotherapist.”

Other administrators discussed how staffing and funding shortfalls affected decisions regarding resource allocation and how these decisions intersected with staff attitudes toward exercise. For example, one administrator explained that many bedridden residents with contractures did not receive restorative care because of both lack of staff and the refusal of some physicians to sign a physiotherapy referral because they did not see “the value of range-of-motion exercises for a resident who is bedridden. It hasn’t been engrained in them. They haven’t had the shift in thinking yet.”

Challenges in the Built Environment

Another factor that limited physical activity options and programs for residents was the built environment. Administrators observed that constraints in the built environment (e.g., steep ramps) had become more problematic because an increase in the level of resident acuity meant that residents had more difficulty with mobil-
ity and needed help to maneuver these constraints. For example, one administrator stated, “If you go down [the ramp], you’re gonna hit the wall down there. It wasn’t noticed when the building was first built because it was residential; now that we’re heavier care, it’s a problem.”

Some administrators indicated that the increased proportion of heavier care residents resulted in a corresponding increase in the number of wheelchairs, walkers, and large reclining chairs. This in turn created space issues or posed difficulties in transporting residents to their exercise programs. One administrator explained that a resident’s request for exercise equipment was denied because of space constraints, and another cited having to put a stair climber in storage because “it’s huge and we have limited space.” Finally, because of limited space and the difficulty of creating a pleasant aesthetic with multipurpose rooms, one administrator explained having difficulty trying to find a wall to install parallel bars:

This is also a dining room. Families come and have meals in here with their loved ones. They do recreational activities in here . . . crafts . . . some exercises in here, maybe. But we’re thinking [parallel bars] have to go there, but it would not look very nice . . . I mean in a sitting room.

With the exception of two facilities that had small rooms for restorative care and physiotherapy, none of the facilities had a designated room for exercise. Multipurpose rooms meant that staff were “constantly changing, moving back, and rearranging the furniture” before and after activity programs. One administrator felt that a designated space for exercise would be “psychologically better” for residents because “they know this is an exercise room.”

Balconies could only be used by residents if they could get assistance to maneuver over sills, which were needed to prevent ice and snow buildup in the wintertime. Some administrators indicated that activity programs were limited during outbreaks of communicable disease. On some of the dementia units the lack of a circular design was problematic because residents would walk to the end of the hall, and “getting them turned around can be a difficulty.”

The Intersection of Staffing and Environmental Issues

Although administrators had developed some strategies to overcome staffing issues, such as the use of volunteers, they were further challenged when staffing and environmental issues intersected. One administrator explained that when large events were scheduled, advance planning was needed because of the limited capacity of the elevator system:

We try to get as many volunteers and especially when it’s a popular event, such as bingo. We need to start sometimes 45 minutes in advance because the elevators get taken and it’s hard to get everybody down on time.

Another administrator explained having to carefully weigh the pros and cons of converting available space into an exercise room because without enough staff to assist the residents with their exercises, the room would “only be used a few hours every week—that would be it.” In another facility, residents could not use the greenhouse because the entrance to it was difficult for them to maneuver and
they needed supervision while working in there. When the weather permitted, residents would sit on benches outside the greenhouse because “they liked to watch.”

**Strategies to Overcome the Challenges**

The most common strategies used to help overcome challenges related to funding, staffing, and the built environment were the use of volunteers and enhancements to the physical environment. However, the number of volunteers and their role varied considerably across facilities. In some facilities they assisted residents in exercise programs, while in other facilities they helped with recreationally orientated activities such as bingo. For example, one administrator commented “[Volunteers] certainly do [assist] in the recreation area. . . . They do help with the walking program, and do the supervision. . . . I guess they’re under the recreation therapist.” Another administrator commented, “When the resource pot is low, you have to do with what you can. . . . So we have volunteers for many, many things and for the activities.” Several administrators commented that they would like more volunteers to help out with the recreational and exercise programs.

Although several administrators discussed barriers in their built environments, some emphasized the fact that several modifications or enhancements had been made to promote physical activity for residents. These features included circular designs on certain units, which allowed residents to “walk around and around”; indoor and outdoor walking paths; wider hallways and doorways; secure outdoor gardens; greenhouses; automatic door openers; handrails; balconies; and safe sidewalks. However, with respect to outdoor enhancements, they described seasonal variations in their use, as well as different levels of use according to residents’ physical and cognitive abilities.

Administrators offered a number of recommendations to promote physical activity for residents. Several identified the need for adequate staffing with both paid staff and volunteers, and another commented that a change in resources and mindset was needed: “There is a mindset among some people that once a resident reaches a certain level, restorative care will not do a lot.” Finally, one administrator discussed the need to develop evidence- and needs-based programs:

> We have all these best practices and research . . . yet activity seems to be the fun stuff. We don’t put as much effort into it . . . so I really want to look at what are the activities . . . and keep data on those activities . . . Like, how many people show up? . . . Are [the residents] actively participating, or are they all snoozing through the program?

**A Comparison of Nonprofit and For-Profit LTC Sectors**

Overall, we did not find any major differences in the responses of the administrators based on ownership. This might be related to the fact that our subgroup sample size was small (for-profit = 3 and nonprofit = 6), which meant that data saturation was not reached in these two subgroups.
Discussion

Administrators were readily able to provide examples of physical activity and exercise in their LTC settings, although they did not always make a clear distinction between the two. We asked administrators to describe both physical activity and exercise because both terms are used in clinical settings, although sometimes interchangeably. In general, the administrators indicated that exercise was a more robust and strenuous form of physical activity. Their most common examples of physical activity were recreation programs and activities of daily living. Based on their descriptions of recreational activities, the amount of physical activity that would result from engaging in these activities varied considerably. Recreational activities reflected the varying functional abilities of residents but generally appeared to be more socially than physically demanding.

Physiotherapy interventions that aimed to prevent a deterioration of health status or to improve function were mentioned by administrators. However, funding cuts that had reduced the amount of physiotherapy available to residents were commonly cited as a concern. Physical activity programs that involved carefully monitored exercise with goals such as improved strength, mobility, and balance were the types of examples least frequently identified. Similar findings have been reported elsewhere. In a needs assessment of 27 LTC homes in London, Ontario, only 35% of the exercise programs incorporated any weight-bearing exercises or walking despite the fact that all of these homes had ambulatory residents (Lazowski et al., 1999). Seated range-of-motion chair exercises were the norm in these settings (Lazowski et al.). This latter type of exercise might not be challenging enough for some residents (Lazowski et al.) and will not improve lower limb muscle strength or balance, both of which are essential components of effective fall-prevention programs (Gillespie et al., 2003; Norris et al., 2003).

The administrators’ descriptions of the complex care required by their residents, their staffing issues, and the constraints of their built environments all indicate that the provision of evidence-informed exercise programs in LTC is challenging. There is wide variation in the physical and cognitive status among LTC residents. It is unlikely that a “one size fits all” approach to exercise programming would be successful in this setting. Tailored exercises such as those delivered in small groups have been suggested (Binder, 1995; Brill, Drimmer, Morgan, & Gordon, 1995; Lazowski et al., 1999). However, more individualized approaches that become part of a resident’s daily routine require a greater human resource investment. Furthermore, if exercise is going to be integrated into all types of care delivery, staff will require appropriate training in safe and effective forms of exercise.

Our findings are consistent with a growing body of literature examining relationships between physical activity for older adults and the built and natural environments (Cunningham & Michael, 2004; Li et al., 2005; Sallis et al., 2006; Schutzer & Graves, 2004). Inclement weather, safety concerns, and lack of convenient exercise facilities have previously been reported as barriers to physical activity among community-dwelling seniors (Booth et al., 2000; Clark, 1999; King et al., 2000). These factors also surfaced in our study.
Aesthetics is another feature of the environment that has been shown to be a determinant of physical activity among community-dwelling seniors (King et al., 2000; Wilcox, Castro, King, Housemann, & Brownson, 2000). Administrators did not specifically discuss aesthetics as a factor that motivated residents to engage in physical activity, but they pointed out residents’ interest in gardens, terraces, and a greenhouse, suggesting that aesthetics was playing a role in the physical activity choices of residents. Unfortunately, these aesthetically pleasing features of the environment were not consistently accessible to all residents, and their availability was seasonal.

In the document “Commitment to Care: A Plan for Long-Term Care in Ontario,” Smith (2004) reported that some LTC facilities had converted designated activity rooms for alternative purposes (i.e., other than exercise). Administrators in this study identified similar concerns. Some noted that space had become increasingly insufficient as the amount of equipment required for LTC residents had increased. The combination of additional equipment-storage needs and the realities of decreased on-site physiotherapy services appears to be contributing to decisions to use previously designated exercise rooms for other purposes.

Although there are Ontario Ministry standards related to recreational activities for residents, administrators noted that none of them specifically address requirements for physical activity. This gap was also apparent at the level of the participating LTC organizations, where policies and procedures pertaining to exercise and physical activity were largely absent. These findings suggest the need for a collaborative initiative between the responsible ministry and key stakeholders to develop standards, policies, and procedures related to physical activities in LTC facilities.

Major barriers to the promotion of physical activity in this study were funding and staffing constraints. The changing demographics of LTC residents (older age and heavier care) means that many residents need some type of assistance to get to exercise programs in their facilities. Most of the study sites relied heavily on volunteers to transport residents to their activities or to assist in their activity programs, and some administrators indicated that they needed more volunteer assistance. Similarly, other authors have reported the need for more personnel to transport residents to their exercise or physical activity programs (Brill et al., 1995; Lazowski et al., 1999).

Walkabout interviews were a useful data-collection method that elicited descriptions of how residents interacted with their physical environment. Observations made during the walkabout helped interviewers tailor their probing questions. The walkabout also provided administrators an opportunity to reflect on the questions posed by the interviewer while being prompted by cues in the LTC setting. For example, as one administrator approached a ramp, this visual cue elicited a comment that it had become a safety concern because of the increased number of wheelchair users. In addition, the walkabout interviews provided spatial reference points for administrators, which helped elicit in-depth discussions regarding the challenges of limited space. For example, an administrator who observed resi-
students in wheelchairs “passing” each other in narrow hallways during the walkabout discussed the structural layout of the facility.

Limitations and Directions for Future Research

In qualitative research, data saturation is used to help assess the adequacy of sample size. Although we reached data saturation across the nine facilities, data saturation was not reached in the two subgroups (i.e., three for-profit and six nonprofit).

For future studies, it would be useful to collect data on the age of the facilities. This would help pinpoint what building codes were in place when the facility was constructed or renovated. In turn, this would help identify building standards that act as enablers or barriers to physical activity in LTC settings.

Recommendations

Several recommendations arise from this study. First, explicit ministry standards guiding the implementation of evidence-informed physical activity programs in LTC are required. These will fuel the development of policies and procedures for physical activity programs in LTC settings. These standards need to be developed in conjunction with estimates of the human resources required for their implementation.

Second, evidence-informed exercise interventions for frail seniors are currently available, such as Functional Fitness for Long-Term Care (Lazowski et al., 1999) and the Home Support Exercise Program (Johnson, Myers, Scholey, Cyarto, & Eccleston, 2003). However, these interventions are only feasible if adequate human and financial resources are available. Their implementation will also require making physical activity in LTC a priority and ensuring that funding formulas take these programs into account.

Third, the changing demographics of older adults who are entering LTC suggests a need to review the suitability of built-environment standards for LTC facilities. Shipp and Branch (1999) argued that environmental press—features of the built environment that are physically challenging—should be considered in the design of living spaces for older adults. The level of environmental press needs to be tailored to the functional ability of the seniors, so that it pushes them to engage in more physical activity without unduly compromising their safety. Without providing adequate attention to the environmental press in LTC facilities, ambulatory, as well as wheelchair-dependent, residents can suffer premature declines in physical functioning. There is also a need for all LTC facilities to have designated safe spaces for physical activities. Finally, considering the increase in the amount of equipment required for LTC residents (e.g., wheelchairs, mechanical lifts), there is a need to revisit the design standards (Ontario Ministry of Health and Long-Term Care, 1999) that apply to new construction and renovations and to ensure that space requirements are adequate for safe walking and other activities.
Conclusion

Administrators provided a critical perspective on organizational and environmental factors influencing physical activity for residents in LTC. When staffing issues and problematic features of the built environment intersected, they created conditions that were less than optimal for residents’ physical activity. Findings suggest that until there are adequate human and financial resources, it will be difficult to implement evidence-informed physical activity programs for residents in LTC settings in Ontario. A review of provincial LTC standards related to program requirements is warranted.

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Appendix: Administrators’ Interview Guide

1. The terms physical activity and exercise mean different things to people. What comes to your mind when I use the term physical activity? What comes to your mind when I use the term exercise?

2. People have different beliefs concerning physical activity for older adults in long-term care (LTC). What are your beliefs concerning physical activity for older adults in LTC?

3. Is physical activity mentioned in your facility’s mission, vision statement, or philosophy of care? If yes, please describe. If yes, may we have a copy?

4. I understand that the Ontario Ministry of Health and Long-Term Care has standards related to residents’ mobility and physical activity. Has your facility developed any policies or protocols related to these standards? If yes, please describe. If yes, may we have a copy of these policies or protocols?

5. Thinking about physical activity for your residents, what are some of the challenges that your organization faces when trying to incorporate physical activity in residents’ daily activities? How do you work around these challenges?

6. I understand that LTC facilities have various meetings such as residents’ councils in which residents, families, and staff can communicate their needs. Has anyone ever brought up the topic of physical activity in one of these meetings? If yes, what are the issues that have been discussed? If no, why do you think that this topic has never been brought up?

Your insights have been very informative. In closing, do you have any other ideas about how to promote physical activity with your residents?