Understanding and Enhancing Diversity, Equity, and Inclusion within Continuing Care Organizations

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Acknowledgements

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Methodology

This report is directed by a systems approach to the challenge of enhancing diversity, equity, and inclusion (DEI) within continuing care organizations. A systems approach is a tool to address complex, wicked problems. It recognizes contributing factors and exposes root causes and underlying patterns to complex issues. Rather than seeing challenges as parts, we see it as a whole made up of interrelated, hierarchical sub-systems. This research is composed of academic sources including peer-reviewed journal articles, case studies, and primary literature; and non-academic literature including reports from non-governmental organizations and news articles. These sources are used to recognize barriers to DEI and its impacts on residents and staff; root causes of issues that hinder DEI; and expose potential areas for further research and action. This research is further guided by community engagement, meetings with the Brenda Strafford Foundation, and insights from a community conversation that was hosted during the Catamount Fellowship, which included participation from professors, students, continuing care providers and staff, stakeholders, and DEI committee members.

1. Introduction

"I am no longer accepting the things I cannot change, I am changing the things I cannot accept." – Angela Davis

Diversity, equity, and inclusion (DEI) has been used within a wide variety of contexts, but only recently have these terms been intertwined into the context of healthcare. Within the context of continuing care settings across Canada, there is a growing need for inclusive care that recognizes and supports the diversity that exists among the older adult population and care workers. Enhancing DEI is not only important, but it's essential. As we will see, power, language, social and cultural dynamics, can easily create barriers to enhancing DEI. And within the sector of continuing care, every interaction can either delay or enhance DEI. DEI is not a one size fits all, it is a journey, a process – as it fits to any organization. It requires an in-depth understanding of historical contexts, power, and systemic racism. It requires addressing unconscious biases, language barriers, and exclusionary language.

This report will focus on older adults and continuing care workers who vary in terms of race, ethnicity, religion, language, ability, gender identity and expression, sexuality, socio-economic status, and generational experiences within the continuing care landscape. There not only needs to be a system where diverse care workers are providing inclusive and safe care for residents, but there also needs to be a system where white, cisgendered residents are acknowledging and supporting the diversity among care providers and fellow diverse residents. Therefore, this report will be focused on enhancing DEI from both a resident and staff perspective, while taking into account the generational diversity and sensitivity of these populations. The purpose of this report is to: 1) help long-term care homes understand and better meet the needs of the diverse individuals that live, work, and visit in long-term care home; 2) to explore the issues and barriers that hinder DEI within continuing care organizations; and 3) to develop

emerging initiatives to enhance DEI. More specifically, this report aims to answer the following research question: **"how might we improve and foster a diverse, inclusive, and safe community within continuing care organizations that is built on equality for all?"** In order to develop an answer to this question, we adopted a systems approach that looks at the underlying power dynamics that shape the organization, the factors that influence individuals to engage in systemic racism and discrimination, and its impacts on residents in continuing care. Why do power dynamics exist? Where do they come from? Why does systemic racism occur? What are the impacts and implications on residents, staff, visitors, and the organization as a whole? When we acknowledge the systems that hold discrimination and inequalities in place, we begin to understand and identify paths that could meet the needs of diverse groups within continuing care.

This report will first define DEI, and then lay out the long-term care/continuing care landscape/sector. The report then moves on to break down the statistics of the older adult population within continuing care. The impact of the COVID-19 pandemic on continuing care will also be discussed. The report further moves on to examine barriers and challenges including, power dynamics, exclusionary language, social and cultural dynamics, and generational diversity. Lastly, emerging initiatives will be discussed which includes insights from personal communication with the Brenda Strafford Foundation, faculty mentor, a community conversation hosted during the fellowship, and literature.

2. Diversity, Equity, & Inclusion

Before we can begin to explore and address issues of DEI, we need to set the context – what is DEI? What makes it important within either continuing care or the broader suite of healthcare organizations?

Diversity includes the variety of unique characteristics, dimensions, and qualities that we all possess. Race, ethnicity, age, gender, sexual orientation, religion, socio-economic status, physical abilities, and lived experiences, can all make up individual diversity (Canadian Centre for Diversity & Inclusion (CCDI), 2022). It is important to note that people can embody more than one marginalized social identity. Dr. Kimberlé Crenshaw coined the term **intersectionality** to describe how social identities can overlap to create compounding barriers for diverse individuals (CCDI, 2022). Within this complex system that is influenced by power and systemic structures, the use of an intersectional lens aims to better respond to the overlapping diverse needs of individuals within continuing and healthcare organizations.

Intersectionality

Gender

Religion

Class

Sexual Orientation
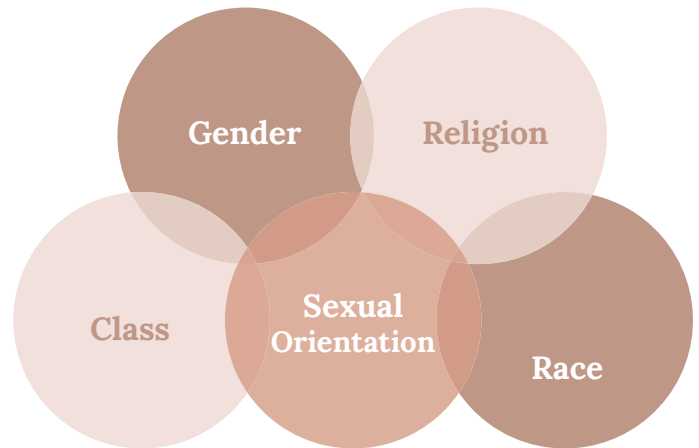
Race

Equity refers to everyone being treated according to their diverse needs in a way that enables everyone to participate, perform, and engage to the same extent (CCDI, 2022).

Inclusion is all about creating a culture that embraces, accepts, and respects diversity. It should be an equitable effort to meet diverse needs of individuals so that they feel valued, respected, and able to contribute their best effort to reach their full potential (CCDI, 2022).

What makes DEI so important in continuing care that lives depend on it?

DEI in healthcare organizations creates higher employee morale and higher employee retention – making the workplace feel safer and enjoyable; better care for diverse patients – no matter who walks in to the organization, DEI helps ensure there is someone on staff who can identify, communicate, and better serve an individuals needs; better recruitment – a wider net to attract new talent; stronger individual motivation – DEI helps ensure diverse individuals get to be themselves and express their unique traits; better problem solving – a wide range of diverse perspectives leads to creative solutions; and better results – diverse health teams who embrace DEI provide better healthcare (Jordan, 2020).

3. Canada's Long-Term Care/ Continuing Care Landscape

There are two encompassing terms for continuum of care outside hospital care: long-term care (LTC) and continuing care.

Alberta Health Services (AHS) defines **continuing care** as "a range of services that support the health and well-being of individuals living in their own home, a supportive living or long-term care setting. Continuing care clients are defined by their need for care, not by their age or diagnosis or the length of time they may require service" (Alberta Health Services (AHS), n.d.).

Health Canada (2004) defines **long-term care** as "facilities [that] provide living accommodation for people who require on-site delivery of 24 hour, 7 days a week supervised care, including professional health services, personal care, and services such as meals, laundry, and housekeeping" (Health Canada, 2004).

For purposes of inclusivity, 'continuing care' will be the focal term throughout this report with occasional mention of LTC that is referenced by some of the literature.

As of 2021, there are a total of 2,076 LTC homes across Canada: 54% are privately owned (for profit and not-for-profit) and 46% are publicly owned (CIHI, 2021). In Alberta, there are a total of 186 LTC homes (CIHI, 2021). In Canada, older adults aged 65 and older represent 19% (over 7 million) of the total population and are projected to account for over one-fifth of the Canadian population by 2025 (Statistics Canada, 2021). Across Canada, 415, 530 older adults aged 65 and older live in 5, 801 LTC homes, representing 7% of Canada's older adult population (Flanagan et al., 2021).

Of 2,076 long-term care homes across Canada (as of 2021),

(CIHI, 2021)

54% privately owned

46% publicly owned
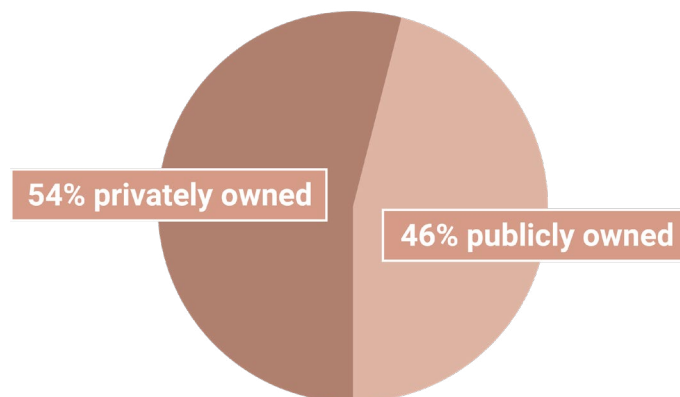
Who is continuing care for? Continuing care spaces are reserved for individuals who have highly complex and unpredictable health needs (AHS, n.d.). According to the National Institute on Aging (NIA), many factors increase the risk of needing continuing care: (1) age; (2) gender – women are at higher risk than men because they often live longer; (3) marital status – single people are more likely than married people to need care from a paid provider; (4) lifestyle – poor diet and exercise habits can increase the risk; (5) lastly, health and family history (NIA, 2017).

4. Statistics: Who's Impacted?

The aging population is not only growing, but it is also becoming more diverse in regards to race, ethnicity, physical ability, gender identity and expression, sexual orientation, religion, culture, and primary language

Why is this important? Why now? The aging population is not only growing, but it is also becoming more diverse in regards to race, ethnicity, physical ability, gender identity and expression, sexual orientation, religion, culture, and primary language. Visible minority older adults (65 years and older) in Canada are becoming the fastest growing among the aging population with a 31% increase in population between 2006 and 2011 (Laher, 2017). In 2017, 85.7% of older adults identified as white, 4.6% identified as East or Southeast Asian, 3.1% as South Asian, 1.3% as Black, 0.7% as West Asian or Arab, 0.3% as Latin American, and 2.3% from other ethnic and cultural backgrounds (Public Health Agency of Canada, 2020).
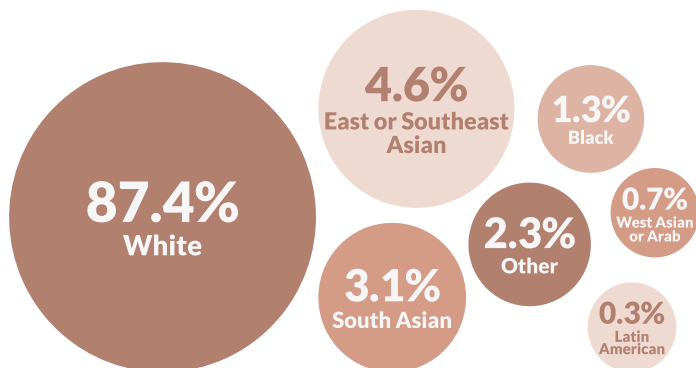
Among all older adults in the Canadian population, 30% were foreign-born and 63% of immigrant older adults who arrived from 2012-2016, reported that they were unable to speak the official languages (Government of Canada, 2021). In 2014, 3% of Canadians aged 18 to 59 self-identified as lesbian, gay, or bisexual (Government of Canada, 2018). There is inadequate data on older adults aged 65 and older who identify as LGBTQ+ in Canada. However, in Alberta, available data estim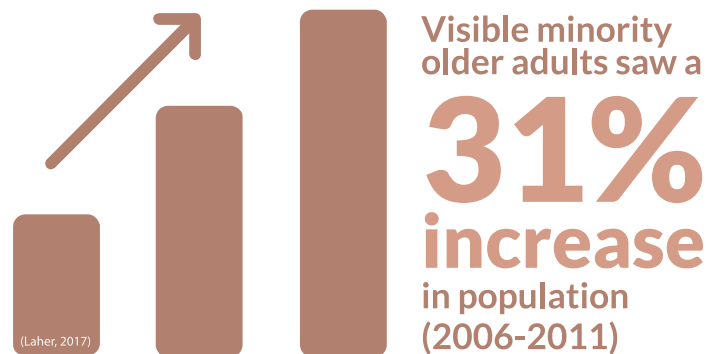ates that there are around 16,000 to 81,000 LGBTQ2S+ older adults as recently as 2020 (Government of Alberta, 2020). Insufficient data and gaps in assessments regarding Canada's LGBTQ+ older adults is one of the factors that hinders initiatives for DEI. The growing and diverse aging population makes it imperative that we recognize the changing needs of older adults within continuing care homes to enable better policy planning processes to address gaps in DEI to measure and reduce disparities (Flanagan, et al., 2021).

87.4%
White

4.6%
East or Southeast Asian

1.3%
Black

3.1%
South Asian

2.3%
Other

0.7%
West Asian or Arab

0.3%
Latin American

(Laher, 2017)

Visible minority older adults saw a

31%
increase
in population
(2006-2011)

16 000 - 81 000
LGBTQ2S+ older adults in Alberta
(Government of Alberta, 2020).

Among all older adults in Canada,

(Government of Canada, 2021).

30% Foreign-born

70% Data not included
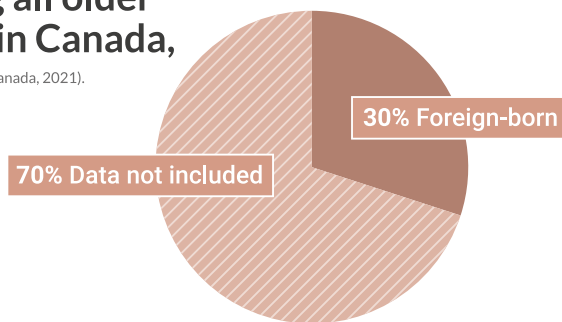
Of the immigrant seniors who arrived in Canada from 2012-2016,

(Government of Canada, 2021).

63% were unable to speak the official languages

37% Data not included
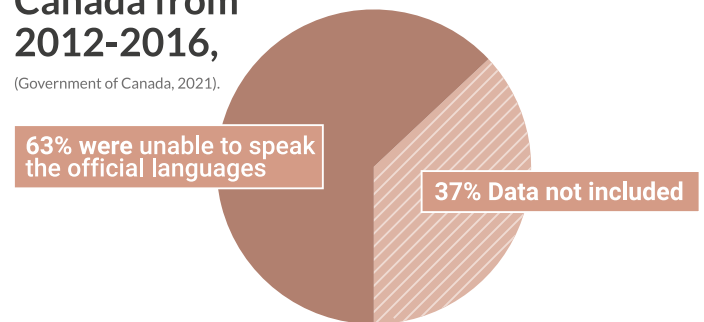
5. COVID-19 Impact On Continuing Care

Residents and staff in Canada's continuing care and LTC homes have been largely impacted by the COVID-19 pandemic. Residents and staff experienced a higher risk of death, staffing challenges, and mental health impacts of social isolation. As reported by the Canadian Institute for Health Information (CIHI) (2021), LTC residents accounted for 3% of all COVID-19 cases and 43% of COVID-19 deaths. According to Statistics Canada, long-term care homes were much more likely to be affected by staffing challenges compared to other types of facilities (Clarke, 2021). This includes a decrease in the number of employees; increase in critical staffing shortages; increase in absenteeism; increase in overtime hours; and an increase in number of hours worked (Clarke, 2021). Further, healthcare workers face an increased risk of mental health impacts due to increased risk of exposure and demanding work conditions (Clarke, 2021), which highly impacted the quality and delivery of resident care (CIHI, 2021).

A further study interviewed immigrant women working in LTC in Calgary during the pandemic. Four areas highlighted by the women included: the financial costs of the pandemic; exacerbated physical and mental challenges in healthcare; institutional mis(management) in LTC; and lastly, the need to center the voices of healthcare workers in government decision making (Lightman, 2021). These statistics and findings demonstrate the challenges associated with meeting the needs of older adults in continuing care during the COVID-19 pandemic. However, further research beyond the scope of this paper needs to be done on the mental health consequences for continuing care residents resulting from these changes, and social isolation during the pandemic.

6. Barriers & Challenges to DEI
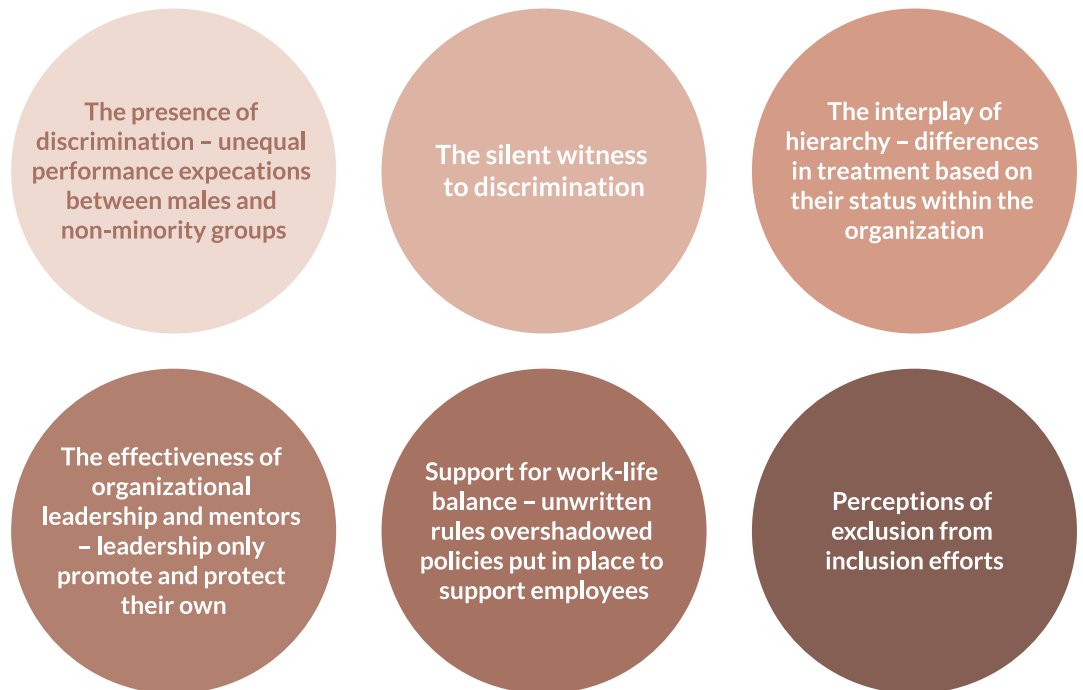
6.1 Power Dynamics/Systemic Racism

Power structures and hierarchies within healthcare organizations are a barrier to diversity, equity, and inclusion. Continuing care work is organized in hierarchical ways that demonstrate differences in power where most of the care work is provided by lower-paid, immigrant, and racially diverse women (Sloane et al., 2021; Syed, 2020). Syed (2020) highlights Canada's LTC work has significant income disparities between workers; racialized occupational segregation; significant sex segregation; and various forms of racism and racialization against care workers. This racially and sex stratified workforce is largely a result of systemic racism, power structures, and gender binary thinking that limit women and racialized minorities, which in turn, is a root cause of racial disparities that shape continuing care (Sloane et al., 2021; Hassen, 2021; Syed, 2020).

Systemic racism ranges from **institutional** – practices and policies, payment practices that concentrate Black, Indigenous, and Women of Color in the bottom of the hierarchy; **cultural** – color blind racism, microaggressions, language use, food choices, and decorations within continuing care settings;

and **interpersonal** – stereotypes, racially based decisions around hiring, and insults/racist comments by white residents directed at BIPOC care workers (Slone et al., 2021; Hassen, 2021).

Results from Aysola et al. (2018) found six factors that affected inclusion within healthcare organizations: (1) the presence of discrimination – unequal performance expectations between males and non-minority groups; (2) the silent witness to discrimination; (3) the interplay of hierarchy – differences in treatment based on their status within the organization; (4) the effectiveness of organizational leadership and mentors – leadership only promote and protect their own; (5) support for work-life balance – unwritten rules overshadowed policies put in place to support employees; and (6) perceptions of exclusion from inclusion efforts. Challenges with inclusion had negative impacts on job performance, satisfaction, well-being, and stress (Aysola et al., 2018). Respondents ascribed their experiences to the systemic culture within the healthcare organization (Aysola et al., 2018).

Six factors that Affected Inclusion within Healthcare Organizations

The presence of discrimination – unequal performance expecations between males and non-minority groups

The silent witness to discrimination

The interplay of hierarchy – differences in treatment based on their status within the organization

The effectiveness of organizational leadership and mentors – leadership only promote and protect their own

Support for work-life balance – unwritten rules overshadowed policies put in place to support employees

Perceptions of exclusion from inclusion efforts

6.2 Unconscious Biases & Discrimination

The Centres for Learning, Research, and Innovation in Long-Term Care (CLRI, 2020) define **unconscious bias** as the "assumptions or learned stereotypes that occur automatically and unintentionally.

This type of bias is deeply ingrained and has the ability to influence behavior by encouraging harsh, negative judgements to be made" (p. 68). Stamps (2021) and Marcelin et al. (2019) show that discrimination is largely caused by unconscious biases, resulting in poorer health and mental health outcomes; health disparities; and poor decision-making in healthcare organizations towards racialized residents and LGBTQ+ individuals. Fasullo et al. (2021) and Caceres (2019) found that LGBTQ participants had a fear of discrimination in LTC settings and limited trust in caregivers, leading to the invisibility of their identities and decreased quality of care. Ulusoy and Schablon (2020) explore interpersonal discrimination in in-patient geriatric care from residents and they find that migrant care workers are largely exposed to racist verbal attacks and insults, sexist verbal attacks, rejection, hindering care, harassment, insinuating incompetence, and accusations. These limited studies conclude that unconscious biases can have negative effects on healthcare delivery and can affect clinical judgment of nurses towards patients and residents (Marcelin, 2019; Stamps, 2021).

LGBTQ+ older adults and the Stonewall generation are now the first 'out' generation. LGBTQ+ older adults are fearful of the misunderstanding, stigma, and discrimination they are likely to experience from staff and residents in continuing care homes (Mozes, 2021). These fears can lead to social isolation within continuing care: not interacting much with others, remaining silent about their sexual orientations, and experiences of loneliness (Government of Canada, 2018). Other risk factors associated with isolation of LGBTQ+ older adults include: heterosexist or homophobic culture within organizations that provide care services; lack of support or feeling unwelcome; and loss of social network (Government of Canada, 2018). Further sources claim that continuing care providers are often unfamiliar with the specific history and challenges faced by LGBTQ+ folks, and that the care homes lacked plans tailored to their safety (Mozes, 2021).

Mistreatment occurs in various ways: overt discrimination – refusing services and misgendering; and/or more discreetly – not including LGBTQ+ older adult in a program, or disbelief when they report physical and/or verbal harassment (Mozes, 2021). Because of this, LGBTQ+ older adults feel the need to go 'back into the closet.'

6.3 Exclusionary Language

Language is a powerful tool. It can be moving just as it can be isolating.

Exclusionary language can be defined as the use of language that excludes individuals on the basis of race, gender, sexuality, age, class, and physical ability.

Historically, exclusionary language has been maintained by those in power in order to separate themselves from perceived 'others.' Today it trickles down into everyday use, often unconscious, and unaware of the origin, especially as they relate to race, gender, sexuality, age, class, and physical ability. Therefore, exclusionary language can be isolating and discriminatory, even when one is not intending to be. Developing standards for inclusive language is key to achieving an equitable and inclusive healthcare organization.

Inclusive language is one that is free from words that reflect discriminatory views, exclusion, and stereotypes towards underrepresented populations (Sullivan & Simmons, 2021).

Language that marginalizes Black, Indigenous, and People of color (BIPOC), is often unintentional and unconscious which can exclude and discriminate as a result of unconscious biases (Armstrong, 2021). Armstrong (2021) suggests that using exclusionary terms like "poor" or "minority" can perpetuate disparities and undermine individuals. However, using terms like "underrepresented" acknowledges the social structures that negatively impact BIPOC communities (Armstrong 2021).

The language that we use matters when interacting with people from underrepresented groups because it has the potential to impact not only the residents in LTC, but also care workers/staff from diverse backgrounds (Lennon, 2021). For example, in one study, women reported less motivation when presented with a job description with masculine gender-exclusive language (Sullivan & Simmons, 2021). The literature concludes that organizations should use inclusive language to make employees, caregivers, patients, and residents of all identities feel safe and seen; amending language is a first step in fighting systemic issues and closing the gaps in healthcare; and lastly, that using inclusive language within policies in organizations can promote equity, develop a sense of belonging, and eradicate biases (Sullivan & Simmons; Armstrong, 2021).

6.4 Social & Culture Dynamics

6.4.1 LANGUAGE BARRIERS:

Promoting diversity and inclusion by addressing language barriers in communication nourishes an inclusive organization where employees and residents both feel heard and share knowledge effectively. Laher (2017) found that ethnically and linguistically diverse older adults in LTC homes are more likely to feel lonely, face fewer social interactions, and a lack of sense of community and belongingness because of language barriers, literacy, and discrimination. Ali and Watson (2017) examine language barriers in healthcare and their impact on patients with limited English proficiency, which can be expanded to include residents in continuing care. Their findings suggest that language barriers were the biggest obstacles in providing effective and adequate quality care to patients and that language barriers, in any setting and location, can negatively affect nurses ability to communicate effectively (Ali & Watson, 2017). Similarly, Bischoff, Denhaerynck (2010) and Bowen (2015) found that language barriers result in unequal health outcomes and unequal treatment. Patients who face language barriers have poorer health outcomes, increased risk to patient safety compared to patients who speak the dominant language, and increased likelihood of malpractice claims (Bischoff & Denhaerynck, 2010; Bowen, 2015).

This risk increases when residents experience dementia and cognitive impairment in conjunction with language barriers (Bowen, 2015; Cooper et.al., 2017; Laher, 2017). Further, there are significant disparities in the use of LTC homes and unmet home care needs between older adults whose first language is English and those whose first language is not English, and between racialized and non-racialized older adults (Laher, 2017). Further research beyond the scope of this report needs to be done with a focus on how immigrant, non-English speaking care workers are also impacted by English speaking residents.

6.4.2 LACK OF DIVERSE FOOD:

With an increasingly diverse aging population, emphasis needs to be placed on ethnic/cultural-centered continuing care. Food choices within continuing care settings can either be a powerful way to build diversity and inclusion or it can promote exclusion and alienation (Raj, 2021). Research shows that culturally diverse older adults can experience culture shock when transitioning to continuing care homes, which leads to poor health outcomes (Cote, 2017). Culturally diverse residents also experience more nutrition problems and a decrease in quality of life compared to those who transition to homes with culturally sensitive practices (Cote, 2017). A further study found that a major barrier to accommodating residents' cultural food preferences was a lack of sufficient resources (Ducak et al., 2011). Ducak et al. (2011) attribute this barrier to the increasing transportation and food costs of items imported internationally to cater cultural and religious preferences. Moreover, Syed (2021) found that unmet cultural food and dining preferences are one of the risk factors for weight loss and poor food intake in older adults and immigrants living in continuing care homes. Chaze et al., (2019) conducted a study to examine websites of LTC and how they demonstrate inclusion within their organization. Of the 10 randomly selected LTC homes, only one home offered a food menu that was diverse and incorporated ethnic foods consistently (Chaze et al., 2019). Findings conclude that the menus reviewed displayed a noticeable lack of diversity, and that LTC homes were not consistent in providing residents with high quality food (Chaze et al., 2019).

6.5 Insights from Community Conversation: Generational Diversity & Lack of Exposure

When trying to approach DEI from a resident perspective within continuing care, generational diversity can be a challenge because most older adult residents have lived through times that were far less progressive than today. Challenges of generational diversity raise issues of limited communication between continuing care staff and residents; resistance/reluctance to change; each generation's experiences, perspectives, and values; and interpersonal conflict (Personal Communication, 2022). Society when older adults were growing up was much different than it is now. Younger generations today are known to be more diverse and vocal with their perspectives compared to older adults. Some older adults within continuing care, or more generally, our older loved ones, may express racist behaviors and attitudes. This is largely due to lack of exposure, awareness, and the limited diversity seen in continuing care organizations. Their views are coming from a perspective that they have known their entire lives; they genuinely do not believe they are being racist. They also do not have the emerging language to articulate or discuss issues related to DEI. Often, older adults do not or are not able to play an active role in society, causing them to be fixated on their mindsets that they have become accustomed too. However, the idea of being 'too old' for change is simply unrealistic and prevents progress. We need to gently approach initiatives to DEI in continuing care settings by keeping in mind this generational diversity and sensitivity to emerging social topics.

MICRO INITATIVES

Intended to encourage residents, care workers, and visitors to engage in personal reflection and become exposed to diverse backgrounds through **awareness** strategies and **minimal direct interaction.**

MACRO INITATIVES

Focused on approaches that target organizational change through exerting **greater effort and direct action.**

7. Emerging Initiatives

After examining the factors that act as a barrier to DEI, we can move towards fostering a diverse, safe, and inclusive environment for care workers, residents, families, and visitors within continuing care organizations.

Serving diverse populations is not a 'one size fits all,' it requires a multi-level approach at the organizational, cultural, and interpersonal (care provider/resident) levels (Hassen, 2021). As mentioned above, given the generational diversity of residents, continuing care organizations should first work towards applying a gentle approach to DEI. Lived experiences and diverse histories of residents and individuals who work in continuing care must be considered when enhancing DEI. I will begin by outlining gentle, 'micro' approaches and initiatives to enhance DEI, focusing on exposure and awareness with staff, residents, families, and visitors. Then I will move on to outline macro initiatives which would include organizational, 'macro' level change. All initiatives mentioned below emerged from a community conversation hosted during the fellowship, literature review, and meetings with community partners at Brenda Strafford Foundation as well as my faculty mentor. The purpose of applying a gentle, sensitive approach is to find a way for residents, care workers, and visitors to engage in

7.1 Micro Initiatives – Exposure & Awareness

personal reflection and become exposed to diverse backgrounds through awareness strategies and minimal direct interaction. Beginning with educational workshops or training at the organizational level may not be as impactful as minimal exposure. A shift in mindset will gradually change throughout the organization as older adults and care workers are exposed to diverse backgrounds through the below outlined initiatives.

- Changing organizational culture through exposure and awareness (CLRI, 2020; Personal Communication, 2022):
  - Posting awareness posters on stereotypes, racism, and discrimination

- Posting visible and gender inclusive signs
- Welcome signage in different languages
- Having 'hate free' and 'safe zone' signs
- Decorating organization so that it is reminiscent of home
  - Include diversity dimensions!
- Posting a world map and having residents and care workers note/pin their country
- Posting pride and transgender flags and symbols that raise awareness about the LGBTQ+ community
- "What would you do?" posters

- Great conversation starters in LTC homes that are intended to depict microaggressions and encourage residents, care workers, and visitors to engage in personal reflection
- 'Golden Rule' posters that list the key guiding principle for religions and/or cultures
- Diversity holiday/events calendar which would include events from different religions and cultures
- Immersion, celebration, and recreational activities:
  - A movie night and book club on racism and discrimination with residents and care workers
    - Some movie recommendations include: Little Miss Sunshine, Remember the Titans, Ruby Bridges, and Fruitvale Station
    - Some book recommendations include: Something Happened in Our Town, and Harbor Me
  - Diversity bingo that uses concepts related to racism, stereotypes, and discrimination
  - Hosting a cultural gallery and/or 'culture of the week' for care workers, residents, and families
    - Add a diversity lunch party by incorporating traditional foods!
  - Having a community dialogue/sharing circle with residents and/or families
  - Buddy program to help mitigate social isolation
    - Can be in the form of pen pals, phone pals, or virtual pals.
    - Could also incorporate a language exchange system.
  - Offering culturally diverse foods:
    - Work with local vendors that supply ingredients from different ethnic traditions and employ diverse chefs (Raj, 2021)
    - Vendors could come in and let residents sample food for their input to increase satisfaction
  - Recreational activities (Personal Communication, 2022):
    - Country of focus: Choose a country to celebrate and engage residents and care workers by having a country information booth, traditional food, music, and TV programs.
    - Armchair travel: Sensory experience/virtual tour to learn about foreign lands and important historical events
    - Cooking club: Enjoyable way for residents to participate in the creation of a diverse meal

7.2 Macro Initiatives – Organizational Change

Now that small changes through awareness and immersion have been made throughout the organization, and residents and care workers have been exposed to diverse backgrounds, organizational and macro level initiatives can begin by exerting greater effort and direct action. Some pathways include:

- Reviewing policies and revising them to use gender neutral and inclusive terms
- Including preferred pronouns in emails
- Satisfaction surveys to learn about how your LTC home is perceived and to determine if its reflective of DEI values (CLRI, 2020)
- Exit interviews for providing insight as to why care workers/staff/employees chose to move on, what they enjoyed, and what could be improved (CLRI, 2020)
- Incorporating a shared language of anti-racism (Hassen, 2021)
- Ongoing education, training, and learning opportunities for both residents and care workers (CLRI, 2020; Personal Communication, 2022):
  - Elements and topics of successful education and training (depending on needs and interests):
    - Respectful cross-cultural communication (including inclusive language)
    - Indigenous and LGBTQ+ cultural competency
    - Unconscious biases training and promoting bystander advocacy
    - Increased staff retention, increased sense of belonging, and staff and resident satisfaction
    - Including perspectives of individuals with lived experiences to increase the impact of learning sessions (i.e., through storytelling).
  - Discussions surrounding the history, culture, and language residents and care workers in the LTC home to enhance understanding of:
    - Cultural traditions
    - Spiritual and religious beliefs
    - Immigration experiences, (settler) colonialism, historical trauma, and experiences of LGBTQ+ individuals
  - Could all be in the form of workshops, e-learning, dialogue/sharing circle, or lunch-and-learns

Concluding Thoughts

As we have seen by this research, approaching diversity, equity, and inclusion, is not a one size fits all approach. It is multidimensional and multifaceted. With an increasingly diverse older adult population, there is a growing need for inclusive care that recognizes the unique diverse needs, concerns, and experiences of older adults. As mentioned in this report, residents and care workers have experiences that are influenced by a range of background factors including: race, gender, sexuality, language, ability, religion, and socio-economic status. The journey then must begin by personal reflection, checking unconscious biases, and looking inwards. In continuing care organizations, it is all about starting conversations around equity and inclusion, getting older adults and care workers exposed to diverse backgrounds. Continuing care organizations should first focus on spreading awareness information that support diversity and inclusion within their homes. Then comes embracing diversity by reinforcing and exerting greater action through policies and organizational change. Change happens through both: self-awareness and organizational awareness. Diversity, equity, and inclusion, is a journey, a process; not a destination.

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