Understanding music care and music care delivery in Canadian facility-based long term care

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Abstract

In light of current confluences in long term care (LTC), a renewed understanding of music care and music care delivery is needed in Canadian LTC facilities. Ten domains of music care are presented as a conceptual framework in which to clarify these new realities as well as form a basis for music optimization in LTC. In this mixed method study, seven emergent factors which influence music care delivery from a phase one qualitative study in five Ontario LTC homes form the basis of a phase two, pan-Canadian survey in 50 LTC homes. Factors for music care delivery include attitudes towards music care, the nature of music, facility location and design, planning and sustainability, education and awareness, and gaps between theory and practice. Research questions in this exploratory sequential design explore how music care is understood and delivered. Results show several key aspects of understanding music care in Canadian LTC facilities: music is essential, music impacts quality of life and quality of care, music strengthens social agency, staff values music less than residents, music care needs to be understood to be optimized, music care and music therapy are distinct, and music enhances culture change. Phase two findings enriched phase one findings with both congruencies and incongruencies of music care delivery. Six recommendations for LTC leadership are posited. Music care education is proposed as a significant means for music care understanding, optimization and delivery that enhances the resident experience through improved quality of life and quality of care.
Section 1 – The problem with music in long term care

Background

Music has been implemented in Canadian LTC facilities for decades, and has been linked to improved quality of life (QoL) for the aging population (Creech et al., 2013; Clift et al., 2010; Hays, 2005; Hays & Minichiello, 2002 & 2005; Coffman, 2002). It is one aspect of living in LTC that may enhance resident experience by providing opportunities for enjoyment, meaning, social engagement and agency. In LTC practice in Canada, music has traditionally been understood and delivered through programs, technology and music therapy.

As a component of activation and programs, music implementation has included activities that incorporate listening and music appreciation, musical games that provide cognitive stimulation, music as background sound to another activity (Weissman, 1983; Douglass, 1985; Karras, 1987; Clipp & Cox, 1994, Hagen et al., 2003). In some instances, opportunities for residents to participate in music-making are offered i.e. singing, bell choirs, drumming circles. Music is often integrated into special events i.e. Valentine’s Party, Western Days, and may include music to dance to. Delivery is done by programming staff including activationists, recreation aides, or recreation therapists as well as spiritual care providers, community musicians or volunteers.

Music has also been implemented by LTC caregivers and family caregivers through technology. Residents in LTC listen to music via television, movies, CD players or radios, playing music in their rooms or as part of the ambient soundscape (de Medeiros et al. 2009; Lachine Hospital, 2012). Certain digital devices are also used in some facilities to deliver music like mp3 players or iPods (Delauro, 2013). Digital radio and music streaming has
become available within the last several years, i.e. 3GDR – Golden Digital Radio, seniorsradio.com.

Music therapists have implemented music therapy treatments in LTC settings for more than thirty years (Lynch, 1987; Clair AA, 1996; Kydd P, 2001; Lin & Chen, 2007). Music therapy is the “skillful use of music and musical elements by an accredited music therapist to promote, maintain, and restore mental, physical, emotional, and spiritual health” (Canadian Association of Music Therapy). The American Music Therapy Association has further stated that music therapy is an “efficacious and valid treatment for older persons who have deficits in physical, psychological, cognitive and social functioning” (American Music Therapy Association). In the context of LTC, music therapists offer 1:1 treatments as well as group sessions that are outcome-based i.e. increased range of motion, social engagement, cognitive stimulation, pain distraction and comfort.

Historically, music care delivery in Canadian LTC has relied on programs, technology and music therapy. Yet there are several current confluences in LTC which call for an assessment of how music care is understood and delivered. This assessment is important in order to creatively optimize the use of music in LTC in the face of these new realities. Can music be used more intentionally and pervasively in LTC? Could it include programming, technology and music therapy as part of a broader understanding of caring through music? If so, what would it look like?

**Current confluences in LTC**

Several converging realities in residential LTC in Canada provide the context in which music care needs to be evaluated.
Person-centred care (PCC) is the current working philosophy in health care. The overriding message is that there is a collaborative and respectful partnership between the service provider and user (NARI, 2006). The essence of PCC in LTC is the relationship between the elder and the caregiving staff. The importance of care is on the quality of life of the elder being cared for (cited in Jones, p 14). The resident is honored and not lost in the daily tasks of caring. So does music fit in person-centred care? Do personal support workers, nurses and other care providers have the confidence, training and resources to integrate music into their caring practices?

PCC is at the heart of the culture change (CC) movement, a North American movement that was started in 1977 with the Live Oak Regenerative Community in California (Barkan, 2003). Several other models have been developed such as the Eden Alternative (Thomas & Johansson, 2003), the Wellspring Model (Kehoe & Van Heesch, 2003), Neighbourhoods (Ragsdale & McDougall, 2008), and the Pioneer Network (Fagan, 2003). The goal of the movement, according to Fagan (2003), is to “transform eldercare by altering the attitudes regarding aging in the elders themselves, and in their caregivers as well as to improve governmental policy”. The CC movement claims there is a need for transformation in how LTC is delivered. Fagan asserts “in nursing homes...we supply our elders with necessities of survival, but they are too often deprived of the necessities of living” (p 127). Culture change is a transformational journey that aims to create vibrant communities where the frontline staff is empowered, and the residents flourish and experience an enhanced quality of life (cited in Jones, p 2). If music is to be a part of the shift, then where are the measures indicating that music is making a difference to QoL in
LTC? If the impact of music care is not measured, then how can it be improved or sustained?

Essentially, CC is a move from the traditional medical model of care, to a social construct of care. For example, in the traditional model of LTC, care is organized around tasks and schedules i.e. bathing, feeding. The PCC model directs personal support workers to focus on what each resident wants to do that day, starting with when they want to get up, when they want to eat and which activities they want to attend. (Jones, 2010). The implication of this shift is that *individualized and small group programming* as opposed to large group gatherings are normative in LTC. The opportunity to provide individualized music (Gerdner, 2005; Cohen, 2014) is more of a possibility in this model. Smaller music-making groups like drum circles or song writing groups may emerge (Allison, 2008). Resident-driven and preferred interests can drive the daily activities and programs. While this model is compelling, how is the quality of music care delivery and implementation ensured if there is little to no understanding of how to link music to personal and individualized needs?

With the priority of culture change, the *social agency of music* is becoming more valued in LTC settings. Music’s dynamic and ability to strengthen community by reducing isolation and depression in residents, and providing meaningful music-making or music-based activities together, is becoming more recognized. For example, music is a key component of the Java Music Club program, a mutual peer support group in LTC. Kristine Theurer (2014), the program developer found in her research of the Java program that the inclusion of music increased self-determination of residents as they chose songs to be sung, strengthened supportive relationships as singing brought them closer together, and
increased expression of challenges by enhancing self-expression after the music. While Theurer’s findings are encouraging, there is a dearth of research data around LTC programs that involve music and their impact on whole person care.¹

Currently there are multiple music care specialty services in LTC. The standards for these services vary across Canada. In some locations, music caregiving services are provided by local musicians who may volunteer their time or receive a small honorarium. Other locations hire music therapists. Still other locations are using certified music practitioners, harp therapists either on a volunteer, contract or fee for service basis. There is currently no standard practice in music care delivery by specialists. This raises several questions. How do administrators and key stakeholders recognize value for service? What is a baseline understanding of music care expertise from music care specialists? What do residents gain from their services?

There are also multiple music-based interventions used by different scopes of practice. For example, melodic intonation therapy, a pitch-based technique used to form neural pathways post stroke for language reacquisition may be used by speech and language pathologists. Rhythmic auditory stimulation, used as a form of gait therapy in the Parkinson’s population, may be used by physiotherapists. This raises an important question: where is the common music care understanding that applies to all music-based interventions?

The LTC population has changed over the last decade. Baby boomers are emerging as both family caregivers for aging parents as well as residents themselves in LTC. The

¹ Whole person care theories vary in nomenclature. What whole person theories have in common is defining a person as more than their medical diagnosis. Whole person care sees a person in their entirety, encompassing biological, emotional, cognitive, social and spiritual processes in their fluidity and interconnectedness.
Canadian Healthcare Association recognizes that baby boomers will have a dramatic impact on the Canadian health system in the next five decades. Not only will the seniors demographic double in the next twenty years, baby boomers come with expectations. Baby boomers are known for either a high consumer mentality, or for their resistance to consumerism altogether (CTV News, 2014). In either case, music is highly valued by baby boomers. They will require a more expanded and enriching experience of music integration into care. In the CMA’s 2014 National Report Card on health issues, 26% of baby boomers currently provide care for an elderly relative (CMA, 2014). This first-hand view of seniors’ health services and facilities is causing baby boomers concern that they won’t have access to the kind of care they expect which will include the benefits of their musical experiences.

The majority of LTC residents in Canada have some form of dementia. For example, in Ontario, persons with dementia make up 58% of the LTC population. Twenty-nine (29) percent of those have severe cognitive impairment and 45% show aggressive behavior. Evidence suggests that music reduces responsive behaviors (Hicks-Moore, 2005, Ziv et al, 2007, Suzuki M et al, 2004, Raglio et al., 2008, Hulme C et al, 2010) and activity disturbances (Svansdottir HB & Snaedal J, 2006) in people living with dementia who are living in LTC. Music may be a viable option to pharmacological interventions in responsive behaviors like wandering, hitting, inappropriate rination/defecation/dressing/undressing, repetition, hiding/hoarding, tugging, and eating inedibles, by redirecting behaviors into meaningful activities with emotional content and potential meaning. How do we determine what kind of music works best in dementia care?

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2 This was the basis of a 2013 conversation the researcher had with Dr. Denis Symons, a LTC medical doctor in Oakville, ON, who is looking for non-pharmacological solutions to treating residents with BPSDs and thinks that music may be an option.
Long term care is not only comprised of elderly people. Long term care means just that – adults who need care for the long term. It is not unusual to have younger adults between the ages of 18-45 in LTC. Many *younger residents* are victims of nonfatal gunshot wounds and car accidents. Others are HIV positive or suffer from chronic health conditions like MS (Marshall, 2008). This younger population has different psychosocial needs. They most certainly will have differing musical preferences than older adults.

Based on the needs in all of these LTC confluences i.e. the need for intentionality, integration, differentiation in approach, the main problem with music in LTC is the lack of clear definition and understanding of its intention and effects. The critical questions raised by the confluences serve a two-fold purpose. First, they underscore the scope of need for clarity and effective application. Second, they point towards the recommendations that will be put forward in section 7.

**Researcher’s personal story**

It was the experience of caregiving my grandmother from 1991-2004 that has catalyzed my interest in what music care is and how it is delivered in residential LTC. Nanny, as we affectionately called her, lived in a nursing home environment for fourteen years and I was one of her primary family caregivers. Nanny was a great cheerleader in my musical endeavours and in those of my siblings. She loved music. She played violin and enjoyed dancing. When Nanny moved to a nursing home at age 81, she engaged in all activities that had anything to do with music. Our weekly visits always included a song. When Nanny was diagnosed with vascular dementia in 1999, music was the means by which we connected. As my mom and sisters and I surrounded her at the end of her life, gentle music played beside her. She took her last breath on the last cadence of the last song.
playing on the CD player. It was *All Through the Night* a lullaby that gently rocked her to sleep.

This and other experiences of volunteering in long term care homes, as well as my work with the Room 217 Foundation, a Canadian charity dedicated to whole person care through music, has led me to develop a more thorough understanding of music in care that will be accessible to care stakeholders and will be beneficial to residents in LTC. I define music care as the informed and intentional implementation (use) and integration (assimilation) of music for improving quality of life and wellbeing and quality of care in LTC communities.

Little research has been done on the reasons why music care is successfully or unsuccessfully implemented and integrated in LTC homes. My experience has shown me that while some LTC homes make music care delivery a priority, even care essential, others regard music as an addendum. Moreover, we live in a country of intense LTC regulation yet without best practices for services or in this case, standards for music care delivery, creating ambiguity around its implementation and particularly its integration.

**Research problem**

The problem that will be researched in this study has to do with the ambiguity of music care in Canadian LTC. What is music care? How is it defined? How is it understood? Is it music therapy? Is it playing the radio? Is it music programming? Lack of clarity may play a large role in the apparent disparate experiences across Canada when it comes to music care delivery. This researcher proposes that a clearer understanding of what music care actually is will help to improve and optimize music care delivery integration and
implementation in Canadian residential LTC. This paper, then, addresses the following questions:

1. How is music care understood in Canadian LTC facilities?
2. What are the perceived factors of music care delivery in facility-based Canadian LTC?

The theoretical framework used for understanding music care in this report is 10 Domains of Music Care, a taxonomy developed by this researcher and colleagues in the Room 217 Foundation. 10 Domains of Music Care forms a general classification for understanding the dimensions of how music is used in health care settings. It is based on a paradigm that states:

"Music care is an approach that allows the therapeutic principles of sound and musical effect inform our caring practices. Music care is not a specific practice, rather a paradigm within which music is inherently understood to be part of life, playing an integral role in all aspects of caregiving and care settings. Music care is intended to be person-centered and improve not only quality of life and wellbeing, but resident experience and quality of care, thus contributing to overall culture change in health care (Foster et al., 2014)."

An overview of this major research paper is provided. Chapter 1 outlines the problem of music care in Canadian residential LTC and why this research is important. Research questions are stated as well as the theoretical construct for presenting the research. Chapter 2 provides a landscape of Canadian residential LTC highlighting the current needs of an aging population in Canada including priorities for quality of life and quality of care in cultures of caring. 10 Domains of Music Care, the conceptual framework for this paper, is defined and elucidated by the literature. Chapter 3 delineates the mixed research methodology including design, sample, and data collection. Chapter 4 gives a detailed analysis on the findings of phase one. The seven factors of music care delivery that
emerged from phase one inform and provide the basis for the second phase. Chapter 5 presents findings from phase two. Chapter 6 describes the interaction between Phases 1 and 2, and draws conclusions and discusses implications. Chapter 7 concludes the paper by connecting the research and implications with viable recommendations.

It is important to note that the research focusses on LTC settings only and will not be addressing how music care is understood in other health care settings i.e. acute care settings, day or community programs or other settings with seniors i.e. seniors community programs, retirement homes. Each of these contexts have their own set of determinants which may or may not match the results of this research.

It should also be noted that participants in the study include LTC leadership and residents. Family members, volunteers, owners and/or corporate executive leadership are not included as participants in either phase.

Statistics stated in this study are descriptive only with the potential for further refinement and inferential analysis. At this stage, music care research is conceptual and broad-natured with a view to laying a foundation for further specific research that could lead to more accurate metrics.
Section 2 – Literature Review

In this section, the key constructs of music care in Canadian LTC will be reviewed in both the research and grey literature. Explaining LTC in Canada, as well as issues within the aging population like quality of life and quality of care within caring cultures, may provide a backdrop on which music care may be understood and delivered. It is important to note that music care as a concept and practice in LTC is not supported in the literature as an integral concept. This section will introduce a conceptual framework for music care comprised of certain aspects of LTC and care in general which are found in the literature.

Long Term Care in Canada

Facility-based LTC in Canada is one of the pillars for continuing care in the Canadian healthcare system. In facility-based LTC, “care is provided for people with complex health needs who are unable to remain at home or in a supportive living environment. Health service is delivered over an extended period of time to individuals with moderate to extensive functional deficits and/or chronic conditions” (CHA, 2009, p 36).

In Canada, LTC is comprised of three things: 1) Accommodation including room and board on a permanent basis; 2) Hospitality services including recreational, activation and social programming; 3) Health services including 24 hour professional nursing services, personal care, case management, intermittent health services, and physician services (pp 36-37). The extent to which these things are evidenced varies across provinces and within provinces. That is because facility-based LTC is not currently defined as a medical necessity under the Canada Health Act (cited CHA, 2009, p 38).
The location of LTC facilities varies across Canada. Mostly, LTC is delivered in designated facilities specifically designed for LTC purposes. However in more remote settings, LTC facilities include beds designated for LTC in an acute care (hospital) environment. LTC may also be delivered in chronic care or extended care hospitals or specially designed units within acute care hospitals. Placement into LTC differs across the country. Each province and territory in Canada has established its own placement process into LTC (pp 38-40).

Funding models for LTC vary. This is in part due to various ownership models and in part due to provincial regulations. LTC ownership and service delivery falls into three main categories in Canada: public not-for-profit government-owned and/or operated; private not-for-profit religious, ethnic, lay/charitable organization ownership; private for-profit ownership which includes chains, and smaller family operations of more than four beds operating as a private for-profit business (pp 74-78). Funding models impact how service is delivered, what services are delivered, how quality of care is measured because what is valued, prioritized and invested in will differ according to ownership and provincial regulations.

Because LTC locations and ownership patterns widely vary across the country, so does service delivery. Because LTC is not an insured service, there is “no obligation on the part of governments to provide a standard range of services” (p 9). The implication is that the variableness of LTC delivery itself in Canada sets the stage for how an intermittent health service and/or hospitality service like music care will be delivered.
The aging population

Canada’s population is aging. Various labels are used to identify the aging and older Canadian population. Health Canada refers to senior and older Canadians as adults 65 years of age and older (Statistics Canada, 2006). Some gerontologists distinguish between the young-old (aged 65-74 years), the middle-old (aged 75-84 years) and the oldest-old (aged 85 years and over) (Havens and Finlayson, 1999). Another concept, according to Laslett (1989), is that later life consists of a Third and Fourth phase. The Third phase, between ages 50-75, are seniors who enjoy a considerable degree of resilience in relation to independence, autonomy, cognitive functioning and wellbeing (Fillit et al., 2002). The Fourth phase, comprised of those aged over 75, the fastest growing group in Canada, is one of a period of disengagement and dependency, involving physical and mental decline, and a decrease in subjective wellbeing (Baltes & Smith, 2003).

The group that is referred to in either oldest-old or fourth phase when discussing facility-based LTC is most relevant because we are living longer. Statistics Canada recently reported this demographic trend; the number of people aged 100 or older increased 50% between 1996 and 2006 and is set to triple to more than 14,000 people by 2031. By 2031, 25% of the population will be over the age of 65 (CIHI, 2011; Carstairs & Keon, 2009, Statistics Canada, 2006.) With a growing propensity for longevity, the likelihood of older adults facing the need for LTC becomes greater. And, the need for more facility-based LTC care will become greater. Life expectancy at age 65 is now projected to be 84.9 years of age – 83.2 years for men and 86.4 years for women. Women make up 70% of the 85 and older age cohort (Statistics Canada, 2009). At the moment, facility-based LTC is seen as a
women’s issue because the majority of residents and staff are female (Armstrong et al., 2008).

LTC is also the main option of room, board and health care provision to younger adults with disabilities. While it may not be the preferred option (O’Reilly & Pryor, 2003), the reality in Ontario, for example, is that approximately one in six people who receive treatment in continuing care is between 19-64 old (CIHI, 2007). This number will probably increase as life expectancy in this age group increases through advances in medical technology.

According to the Canadian Healthcare Association, dementia and incontinence are the most likely conditions to necessitate admission to a LTC home in older adults (CHA, 2009, p 20). Dementia affects 8% of seniors over age 65, and because its prevalence increases with age, 35% of people 85 years and older are diagnosed with dementia (p 20).

**Quality of life**

In a landscape where the likelihood of living at least a portion of fourth phase in LTC is probable, where aging trajectories will likely include disease, impairment and degeneration due to longer quantity of life, and where government funding for LTC is not adequate, quality of life (QoL) becomes an issue.

Coon attempted to outline the factors enhancing QoL in LTC facilities including freedom of choice and control, individuality, privacy, continuity with the past, age-appropriate activities, pleasant ambiance of home and opportunities for enjoyment (Coon et al 1996.) Yet QoL in LTC has been perceived as diminished and negative when compared with community dwelling older people (Peace et al., 1997; Scocco et al., 1996.) This may in
part be because people living in residential LTC are, due to their care needs, largely dependent on others in order to realise their QoL (Isola et al., 2008.) Residents have limited choices and control within this setting (Volicer & Bloom-Charette, 1999.)

Music is one aspect of life that presents residents, no matter what their age, in LTC an opportunity for enjoyment and meaningful activity and the possibility of choice and control. Most older adults have participated in music in their lifetime. Evidence suggests that active music-making including singing, dancing, song writing, group activities using music, instrumental playing enhances wellbeing and quality of life in both third and fourth phase (Creech et al., 2013; Clift et al., 2010; Hays, 2005; Hays & Minichiello, 2002 & 2005; Coffman, 2002). Creech found that active music-making provides a source of enhanced social cohesion, enjoyment, personal development, empowerment and contributes to recovery from depression (Creech et al., 2013).

Quality of Care

In their compelling 2009 report on Canadian residential LTC, the Canadian Healthcare Association calls on the government to address the larger and pressing issue of quality of care.

*Facility-based LTC has traditionally been committed to the institutional model of care by focusing first and foremost on the completion of tasks: feeding, dressing, medicating and documenting. Unfortunately, the institutional model is still evident today though few homes will admit it. Mission, vision and values statements speak about individualized approaches to care and empowering stakeholders, but when you strip away the language and move past the colourful drapes, pets, and carefully-placed personal belongings, little has changed in some LTC environments. (CHA, 2009, p 25)*

According to this report, the priority in care has been on the tasks of physical care with a lack of priority given to emotional, cognitive, social and spiritual care. It is whole person-centred care that is purported in this briefing (p 25). The Canadian Healthcare
Association desires developing a culture of care, seeing the LTC resident not as their disease or condition, rather as a whole person who is worthy and with something valuable to contribute (p12).

Care is the bottom line in the report’s recommendations. For example, more equitable care in terms of adequate and sustainable funding was recommended as well as a focus on quality and accountability to Canadians (pp 119-121). The report suggests resident and family satisfaction surveys, LTC data collection, investment in staff education and leadership training and enhancement of LTC homes as learning communities be critical next steps in providing excellent care (pp 121-123). As well, the report recommends that developing cultures of care would require LTC be more reflective of home life rather than institutional life and address the needs of non-seniors, end-of-life care and mental health care (pp 124-125). Another strong recommendation was to respect volunteers and families by optimizing their use and welcoming them into the daily lives of residents (p 126).

Cultures of care are concerned about “creating a dignified living environment for residents and a quality working environment for staff” (Samuelson, 2003). This suggests that how the LTC environment is understood and shaped will have the greatest influence not only on the quality of life for residents but the quality of work life for staff and standards for quality of care. Music, by its nature, has the capacity to provide the kind of whole person care that is needed in LTC. Music care may bridge the gap between residents' desire for quality of care and how staff are able to deliver it. It is an affordable means of care that can be provided by all care partners, including families and volunteers.
Music in care culture

Music as care is not a new phenomenon and there are many historical accounts. For example, in the Bible, David’s harp playing lifted King Saul’s depression. Alexander the Great was restored to sanity by the music of a lyre. Buddhist monks have been singing healing chants for over 2,000 years. Nuns at the Cluny Abbey in France in the 11th century performed music for palliative patients.

Barbara Crowe suggests that there have always been two ideas about the healing capacity of music. The first idea is that music is part of healing content and is used directly as a curative agent. Global characteristics of music such as sound vibrations, melodic range, tempo, timbre, and harmonies contribute to healing content. The second notion is that music is part of the healing context. Music supports natural balance and attunes our mind-body-spirit to the universe. Every music care practice, whether it is old or new, is based on one or a combination of these two ideas (Crowe, 2004).

Music care is an approach that accounts for both of these ideas. Music care recognizes that musical elements like tempo, rhythmic patterns, melodic shape and range, timbre, dissonance, consonance, for example, in themselves have healing capacities. Music care is about using musical elements with intention, knowing that sound and music can have specific therapeutic outcomes. Music care acknowledges music as an integral part of the backdrop to care which creates a sense of well-being and balance. Music care integrates sound, silence and music into life, paying close attention to how interpersonal connection and human contact is enhanced through musical associations. In addition, the music care approach believes all of us can use music for health and well-being in our own lives and in
those we care for. Music care aims to enhance wellbeing and quality of life for all people regardless of age or status.

10 domains of music care in LTC

Music care is comprised of informed and intentional music implementation and music integration throughout the care delivery in any setting. The music care approach comprises ten domains of music delivery and is shown in Table 1 (Foster et al., 2014). These domains are meant to provide clarity and definition to the various aspects of music care and to help locate and place how or by whom music care is delivered.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Key highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Music</td>
<td>Outside musicians or entertainers invited in to LTC</td>
</tr>
<tr>
<td>Music Care Specialties</td>
<td>Specific music training for wellbeing i.e. harp therapy</td>
</tr>
<tr>
<td>Music Therapy</td>
<td>Skillful use of music in a therapeutic relationship</td>
</tr>
<tr>
<td>Musicking</td>
<td>Informal and spontaneous use of music</td>
</tr>
<tr>
<td>Music Programming</td>
<td>Formal use of music within LTC programs</td>
</tr>
<tr>
<td>Music Technology</td>
<td>Technology used to deliver music for a therapeutic goal</td>
</tr>
<tr>
<td>Sound Environment</td>
<td>Intentional sounds for wellbeing</td>
</tr>
<tr>
<td>Music Medicine</td>
<td>Prescriptive use of music strategies</td>
</tr>
<tr>
<td>Music Care Training</td>
<td>Training for caregivers to integrate into practice</td>
</tr>
<tr>
<td>Music Care Research</td>
<td>Evidence-based research using music strategies</td>
</tr>
</tbody>
</table>

Table 1. 10 Domains of Music Care

These ten dimensions of music care provide a contextual framework of how music care in might be understood in caring communities. The following discussion provides a brief overview of each music care domain and how it relates to LTC.

Community Music represents individuals or organizations from outside the LTC facility that partner with the healthcare and hospitality teams to provide live musical services or entertainment within the facility. In LTC, this could look like community, school, faith groups or individuals coming to volunteer to provide background music for happy hour, seasonal or event performances, leading music in religious programs, or providing
entertainment for a barbecue in the courtyard. In some cases, musicians, have created businesses that provide entertainment suited to the LTC population. Community musicians may require fee for service or may volunteer their time.

Several provincial and national organizations in Canada offer these kinds of services in health care settings. In Manitoba, for example, Artists in Healthcare, a not-for-profit, enables professional and student musicians to play in hospital and LTC settings (Artists in Healthcare Manitoba). The Health Arts Society, a not-for-profit and registered Canadian charity that started in British Columbia, has national reach and is motivated by the fact that residents are isolated from their arts community. Health Arts provides professional musicians to LTC settings who deliver music and music theatre with a concert-like atmosphere (Health Arts Society).

*Music Care Specialties* include individuals that bring their training and experience in music care to a healthcare setting. Music care specialty training is typically done through independent training schools and not offered in colleges and universities, but as independent certifications. Music care specialists in Canada that work in LTC include harp therapists, music thanatologists, bedside singers, and certified music therapists. Music care specialists require a fee for service.

Harp therapy is a term used to describe the various therapeutic applications involving harp music (Harp therapy). Benefits of harp therapy include relaxation, improvement in sleep, decreased pain and anxiety, stabilization of vital signs and improvement in mood (Sand-Jecklen & Emerson, 2010, Williams, 2006, Briggs, 2003, Aragon et al. 2002). Harp therapists receive training and certification from harp therapy...
training programs. Standards have been established by the National Standards Board for Therapeutic Musicians, an American group that sets standards for music care specialties (National Standards Board for Therapeutic Musicians, 2014).

An extension of this specialty is vibroacoustic harp therapy (VAHT). VAHT uses a vibrotactile device, usually a table, mat or recliner chair with speakers that are embedded within. A harp, fitted with an electronic pickup, is amplified through the vibrotactile device where music is delivered directly to the resident’s body in the form of sound vibrations. When the resident senses frequencies that specifically resonate in an area of her body, Benefits of VAHT include energy absorption, coherence (resonance and synchronization among diverse physiological systems in the body), absorption of energy, stimulation, lymphatic stimulation, pain and stress reduction, perceptual changes, mood elevation (Williams, 2014).

There are several music care specialties to assist in end of life care. Music thanatology is a field where practitioners provide musical comfort, using harp and voice at the bedside of patients near the end of life. These specialists are trained in a service at the bedside called music vigil. Music thanatologists act as midwives, matching music to the breath, sounds to the responses of the imminently dying. Music thanatology is a contemporary practice rooted in historical tradition developed over the last three decades (Chalice of Repose Project).

Bedside singing is another practice where singers are trained to accompany residents through their last days and hours using non-religious, unaccompanied singing. The two main groups that train bedside singers in North America are Threshold Singers (Threshold Choir) based in California and the Hallowell Singers (Hallowell Singers) based
in New England. While both of these trainings take place in the US, Canadian practitioners travel to take the training and bring their specialty into Canadian healthcare settings including LTC.

Certified music practitioner (CMP) is a growing music care specialty in Canada. This group is trained to serve those who are ill and dying with live music in order to facilitate and promote healing or assist in the life/death transition. Trained in the therapeutic use of music over the course of five modules, a CMP uses a variety of instruments i.e. guitar, keyboard, harp, flute, to provide live music at bedside (Music for Healing and Transition, 2014).

Music therapy is a specific scope of practice that uses music and musical tools to address clinical goals and objectives within a therapeutic relationship. In Canada, training takes between four to six years with an additional 1,000 hours of supervised internship. Music therapists practice in a variety of settings and within a variety of populations i.e. mental health, rehabilitation, palliative care, and are present in a growing number of Canadian LTC homes. They are accredited by a regulating body (Canadian Association for Music Therapy). Music therapy is outcome-oriented and results are evaluated on an ongoing basis. Music therapists are trained both as musicians capable of playing a variety of instruments and as therapists, capable of using various approaches within the therapeutic relationship. At this time, music therapists are not included on the RAI assessment as standard LTC service providers which means they are usually a contracted

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3 RAI-MDS 2.0 stands for the Resident Assessment Instrument Minimum Data Set 2.0. It is the most popular data collection instrument in Canadian LTC, used in more than seven provinces. It is used for care planning, policy development, quality improvement and benchmarking, reimbursement, research, resident needs assessment and service eligibility.
service provider. However, they may be part of an interdisciplinary team and their evaluations may be included in ongoing resident assessments.

*Musicking* refers to the informal or spontaneous music-making, within person-centered care of patients, families of patients, facility staff and volunteers, and is specific to the interest, ability and personal relationship to music of each care partner. Musicking may involve playing a musical instrument, singing, dancing, humming or any other act of music-making. Musicking is a term coined by ethnomusicologist Christopher Small. He assumes that “music is not primarily a thing or a collection of things, but an activity in which we engage” (Small, 1987). According to Small, music is not a noun but a verb and “to music” expresses the act of taking part in a musical performance (Small, 1998). In LTC, this could look like a resident playing her guitar or fiddle, or dancing. Musicking may also look like staff doing a spontaneous line dance during an afternoon shift. Musicking might look like a PSW humming during a bedside transfer. Musicking may also look like a family member who wheels their loved one to a piano to musick together. Musicking has a plethora of faces, but the key is its informality and spontaneity.

*Music Programming*, on the other hand, involves staff or volunteers within the facility who plan for and employ the use of music into a more formal recreational or therapeutic program. Music programming is a designed program that is music-based or includes music within the structured activities of the LTC home. For example, the Recreation Therapist uses music within a Sing-along program, or music listening groups. Music may also be a significant part of a travel program, or a games night like music bingo. Music programming may also include music wellness programs for staff, volunteers and/or families.
Music Technology is a dimension of music care where the intentional use of technology is used to suit the residents’ musical needs or staff’s treatment goals. Staff training to use the technology may be involved. Technological music delivery systems in LTC could also include televisions, radios, CD players, iPads, iPods, digital streaming and in some cases bedside terminals. An example of a music technology program in LTC is called the Music and Memory program which uses iPods to deliver a resident’s preferred music via a personalized playlist. This program has received international attention in the 2014 film documentary Alive Inside. While personalized music in LTC is not a new concept in the literature (Janata, 2012, Gerdner & Schoenfelder, 2010, Sung et al., 2010, Gerdner, 2005, 2000), delivering it using digital technology via an mp3 player with a personalized playlist may be. The Music and Memory program was started in the US by social worker Dan Cohen and is now used in many LTC homes in Canada. The protocol of this intervention includes identifying residents that would benefit (shown an appreciation for music), interviewing resident/family to determine preferential music of resident, loading the iPod with that music, using the technology for a specific goal i.e. reducing anxiety, enhancing feeding, sleep assistance, pain management (Music and Memory Project).

Sound Environment is an intentional setting of ambient sounds in the LTC facility that promote well-being. Environmental psychologist Roger Ulrich notes that music is an environmental factor in healthcare that influences health outcomes (Ulrich, 2000). The audio environment is one of nine domains in Ulrich’s conceptual framework for evidence-based environmental design (Ulrich et al., 2010). Sound, music and noise are

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4 Alive Inside is a film by Michael Rossato-Bennett that shows experiences of elders in LTC across North America whose lives have been awakened and revitalized through listening to music. It features the work of Dan Cohen and the iPod project. Alive Inside won best film at the 2014 Sundance Festival. [www.aliveinside.us](http://www.aliveinside.us)
environmental components that can increase or decrease stress of residents. Dr. Susan Mazer, founder of Healing Health claims “because music lives in time and not in space and is not installed or fixed, it can be a welcome addition to the sound environment” (Mazer, 2014). While both Ulrich and Mazer’s work is situated in complex and acute care settings, the Planetree Organization has published a white paper on creating an environment of living in LTC which embraces Ulrich’s ideas with a focus on creating a home-like setting.

Planetree claims the optimal sounds in LTC are the sounds of living (Planetree, 2014).

"Optimally, the sounds of a long-term care community are the sounds of living—conversation, laughter, music, nature. In reality, however, these sounds are often obscured by the sounds of institutional life—overhead pages, vacuuming, carts clanging down corridors and beeping alarms. Overhead pages can be eliminated with the use of quiet pagers or beepers that staff carries with them. Changing the setting on pagers to vibrate further reduces noise levels. Maintaining a quiet environment is indeed a community-wide pursuit. At Brewster Village in Appleton, Wisconsin, housekeepers re-structured their routine vacuuming schedule to vacuum between 11:00 a.m. and 12:00 p.m., a time selected for being the least disruptive to residents, most of whom were eating lunch. In addition, if necessary a silent sweeper is used when residents (called villagers at Brewster Village) are sleeping. The availability of the silent sweeper has mitigated the need for staff to pull out full size (and noisy) equipment for minor floor maintenance.

While intentional environmental sound for music care may include the re-structuring of routines or elimination of bothersome sounds in LTC, it may also include intentional use of sounds for specific therapeutic goals. For example, Snoezelen rooms are multi-sensory designed rooms that include lights, images, videos, tactile stimulus, aromas, and musical recordings. In a resource provided by St. Joseph’s Health Care called the Snoezelen Toolkit for Long Term Care Homes, Snoezelen is referred to as a “vacation” for residents. Goals for using Snoezelen may include but are not limited to engagement, relaxation, distraction, interaction, socialization, comfort, stimulation, relief or communication (Snoezelen Toolkit, 2014). The Pioneer Network suggested that the
intentional use of music in the LTC dining area may enhance the dining experience, whether the music is recorded or whether live musicians are used (Pioneer Network, 2010). Music has also been shown to decrease agitation at mealtime in residents with Alzheimer’s Disease (Hicks-Moore, 2005).

*Music Medicine* is the prescriptive use of music strategies for medically-related outcomes. It is embedded in both interdisciplinary and integrative perspectives with a strong emphasis on evidence-based musical interventions. Music medicine is found in a range of fields i.e. arts medicine, music performance, performance arts medicine, music psychology, medical humanities, ethnomusicology, music cognition, music neurology, music therapy, music in hospitals, infant stimulation (International Association of Music Medicine). In LTC, musical interventions and strategies that are in this domain may be found within restorative or rehabilitative programs designed to target a specific therapeutic outcome. For example, a physiotherapist may use rhythmic auditory stimulation (Thaut, 1996) in rehabilitating residents’ gait performance. A Speech Therapist may use melodic intonation therapy (Norton et al., 2009) to regain prosody and verbal ability with residents who have speech impairment. Music designed for neural entrainment (Sonic Aid) may enhance sleep or mitigate pain for residents. Music designed to support end of life (Room 217 Foundation) may promote dignity and relationship completion with residents and their families (Chochinov et al., 2005; Clements-Cortes, 2009).

*Music Care Training* is curricula that provides theory and practical skills to formal care providers and informal caregivers in the implementation of music in a way that promotes health and wellbeing. Music care training helps caregivers gain confidence to integrate music into regular care practice. An example of this would be the Room 217
Foundation's Music Care Certificate Program, a three level 52 hour training which provides a theoretical basis for using music therapeutically, develops confidence in music skills and offers strategies in how to integrate music into regular care practice (Room 217 Foundation). Music care training may occur at the corporate or facility level, in the community, online or as a continuing education course of study at a college or university.

*Music Care Research* includes the use of systematic evidence for music and its use in healthcare. Linked closely with music medicine’s interdisciplinary nature, music care research embraces a range of topics, fields of study, and applied contexts. There are several music care research centres in Canada. The Music and Health Research Collaboratory at the Faculty of Music, University of Toronto, is an international collaboratory of research groups that focus on the relationship of sound to the human experience. (Music and Health Research Collaboratory). McGill University’s Music Perception and Cognition Lab in Montreal focuses on auditory perception of sound including musical perceptual processes, timbre, cognitive and affective dynamics, multimodal integration (Music Perception and Cognition Lab). The McMaster Institute for Music and the Mind in Hamilton is an interdisciplinary group of researchers that looks at how music induces emotional reactions and how musical experience and training affect brain development, language, cognitive and social abilities in children and adults (McMaster Institute for Music and the Mind). The Conrad Institute for Music Therapy Research at Laurier University in Waterloo bridges the clinical practices of music therapy to research. Research clusters are formed around areas of interest i.e. neuropsychological music therapy, low frequency sounds (Conrad Institute for Music Therapy Research). There are other Canadian researchers involved in music care including Dr. Bin Hu at the University of Calgary (developing a musical app to improve gait
in Parkinson’s patients), Dr. Frank Russo, at Ryerson University (music and Parkinson’s patients as well as emotional effects of music), and Dr. Jessica Grahn at the University of Western Ontario (rhythm, neural processing and movement).

The work in music care research in Canada is groundbreaking; yet there is little if any collaboration between the research centres and the LTC community. There are a number of research institutes on aging in Canada i.e. Soldiage in Montreal, Atlantic Institute on Aging, Seniors Health Knowledge Network, Baycrest Centre for Learning, Research and Innovation in LTC, the Research Institute on Aging; yet there is little to no research being done in these centres specifically around music in LTC.

While the domains of music care provide a more comprehensive understanding of how music can be optimized in LTC, the more fundamental question is how do the leaders in LTC in Canada understand and subsequently deliver music care? This is at the heart of research in both phases one and two as presented in this paper.
Section 3 – Methodology

Mixed method design

This study was conducted using a mixed method design. Mixed method design assumes that using both quantitative and qualitative methods in combination will provide a more comprehensive understanding of the research question than using either method by itself. Mixed method design is understood as an advanced method procedure for research as it requires understanding both methodologies, and requires extensive data collection and analysis which can be time-consuming. “Mixed methods research is not simply collecting two distinct strands of research...It consists of merging, integrating, linking, or embedding the two strands. In short, the data are ‘mixed’ in a mixed methods study” (Creswell, 2012 p535.)

For the first sixty years of the 20th century, “mixed method research”, that is including qualitative and quantitative data, can be seen in the work of social scientists and educators like Gans, 1963, Hollingshead, 2949, Hahoda, Lazarsfeld & Zeisel, 1931/2003, Lynd & Lynd (1929/1959) (in Johnson et al., 2007 p113). These pioneers believed both qualitative and quantitative paradigms were useful as they addressed their research questions. Campbell and Fiske’s (1959) article is often cited as formalizing the use of mixed method research (Johnson 2007., p114, Creswell, p536). They introduced the term of triangulation which validates that the variance is the result of the underlying phenomenon and not of the method.

Not all researchers bought in to mixed design. During the late 1980s and 1990s, paradigm wars monopolized national research conferences (Reihardt & Rallis in Creswell
p537). Some said the two worldviews were “incompatible and set up a false dichotomy that don’t hold up under close inspection” (Reichardt & Cook, 1979). Others proported that mixed methods research has its own worldview: pragmatism, and emphasized that procedures need to work for the research problem at hand (Tashakkori & Teddlie, 1998 in Creswell).

Twenty-first century researchers blur the lines further. Schwandt proposes that we get rid of distinctions and points out that “it is highly questionable whether such a distinction [between qualitative inquiry and quantitative inquiry] is any longer meaningful for helping us understand the purpose and means of human inquiry. All research is interpretive, and we face a multiplicity of methods that are suitable for different kinds of understandings.” (In Johnson et al., 2007, p. 210). Bartel (2006 p 14) avers that research method is not simply data acquisition, but rather “an interaction among the question posed, the analysis required to answer the question and the data appropriate for the analysis”. By implication, the chosen design of research is critical to the integrity of data collection, analysis and interpretation.

In this study the rational for using the mixed method design is due to the complexity of the question. Conceptualizing music care has multiple dimensions. As well, little research is available on the question of perceptions and delivery of music care in Canadian residential long term care. The need to ground this new field of research in the words of those working in the LTC context provides a rich landscape for emergent data. The mixed method allows for both words and numbers to tell a more complete story in the genesis of this research field. Using both methodological approaches in this innovative research makes for a more thorough exploration of the topic.
**Exploratory Sequential Design**

The Exploratory Sequential Design, involves gathering qualitative data to explore a phenomenon and then collecting quantitative data to explain relationships found in the qualitative data (Creswell, 543). The purpose of exploratory design is to generalize qualitative findings based on a few individuals from the first phase to a larger sample gathered during the second phase. Phase one informs phase two. The premise of the design is that exploration is needed because measures or instruments are not available or variables are unknown, and that there is no guiding framework or theory. It is also useful when a researcher wants to generalize qualitative results to different groups, to test aspects of an emergent theory or classification, or to explore a phenomenon in depth and measure the prevalence of its dimensions (in Creswell and Plano Clark, 2011, pp86-87).

An example of a study that uses Exploratory Sequential Design was conducted by Meijer, Verlop and Beijaard (2001). They looked at the practical knowledge language teachers have about teaching reading comprehension to 16-18 year-old students. First, they interviewed and collected concept-mapping assignments from 13 teachers. They used this information to identify six categories of teachers’ knowledge. Using phrases from the teachers’ initial expression, they developed a questionnaire which 69 teachers completed. This tool assessed teachers’ practical knowledge and the variations among teachers when teaching reading comprehension (in Creswell p 544).

The purpose of this study is to discover how leadership in Canadian LTC homes understands Music Care, and how Music Care is delivered. The advantage for using exploratory sequential design is to explore the phenomenon of music care, how it is understood and delivery in Canadian residential LTC. The question is not only large and
complex, but there is very little literature on the subject. Using a design that allows for grounded background information as well as perspectives being heard before being measured is critical to design choice. The exploratory sequential approach keeps the initial research grounded and open, rather than measuring against pre-existing variables.

Exploratory design in this instance, allows the researcher to generalize the phase one findings in 5 Revera Ontario LTC homes to a larger sample beyond Revera, beyond Ontario and within 50 LTC homes across Canada owned and/or operated by a variety of stakeholders in the LTC context. In this regard, the emergent seven factors are tested, and the research questions may have more textured and enriched answers. As well, the approach allows an instrument to be developed which measures Music Care concept and status in the context of LTC.

The design for this study is depicted in Figure 1.

**Figure 1. Exploratory Sequential Research Design**

**Phase One Design – Qualitative**

Phase one was conducted in partnership and in full cooperation with Revera Inc. Revera is one of North America’s foremost providers of accommodation, care and services for seniors and other clients and provides Home Health, Long Term Care and Retirement Living as well as Nursing Rehab in in 248 locations across Canada and the US. Permissions
from Revera’s national office and from the University of Toronto were sought (including ethical permissions.)

There were 6 considerations for sampling: the Revera home that was local to the researcher; 1 home from each of the other 4 Revera regions; homes with and without a music care specialist; homes that are situated remotely, in an urban or suburban setting, rural; homes that are heterogeneous i.e. more than caring for the elderly, variable ethnicity; variable size. The Revera Program Lead contacted several homes and sought permission from the Executive Directors for participation in the study (See Table 1). Permission included okays from the ED, DOC and Program Manager of each LTC. The Program Manager of each LTC was designated as facilitator of the study.

Interview protocols were developed and piloted by the Revera Program Lead as well as the Program Manager for Community Living Inc. another set of LTC residences. Initial contact was made with the 5 different Program Managers. Each Program Manager was electronically sent a Project Overview (Appendix 1) as well as an Interview Protocol (Appendix 2) and an Observation & Document Protocol (Appendix 3). A date was set for site visits which would include an interview with the Executive Director, Director of Care, Program Leader, 1 resident and a music care specialist if they had one. Program managers gathered consent forms from participants which were given to the researcher prior to the interview. (Appendix 4)

Five (5) Revera LTC homes in Ontario were selected to participate in this study (See Table 2 for participating Revera LTC sites.)
### Table 2 – Phase One - Participating LTC sites

<table>
<thead>
<tr>
<th>Site</th>
<th>Reversa Region</th>
<th>Setting</th>
<th># of beds</th>
<th>Type of service</th>
<th># of program</th>
<th># of nursing</th>
<th>Music Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>Rural</td>
<td>100</td>
<td>LTC</td>
<td>4 FT</td>
<td>76 FT/cas</td>
<td>Yes – 5 hours/wk</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Remote</td>
<td>61</td>
<td>LTC</td>
<td>4 FT/PT</td>
<td>40 FT/cas</td>
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</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Suburban</td>
<td>120</td>
<td>LTC/secure unit</td>
<td>12 FT/PT/cas</td>
<td>90 FT/PT/cas</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Suburban</td>
<td>96</td>
<td>LTC/secure unit</td>
<td>5 FT/PT</td>
<td>123</td>
<td>Yes – 1 day/wk</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>Downtown</td>
<td>229</td>
<td>LTC/secure unit/Trans Care Rehab</td>
<td>11 FT/PT/student</td>
<td>185 FT/PT/cas</td>
<td>Yes – 2 sessions/wk</td>
</tr>
</tbody>
</table>

There were 22 interviews conducted amongst the home leaders including Executive Director (responsible for overall operations of each facility), Director of Care (a nurse who oversees all aspects of resident clinical care) and Program Manager (coordinates all activities and programs), as well as at least one resident (person who lives in LTC) and the music therapist if there was one (skilled professional who uses music with specific outcomes and interventions.) 6 residents were interviewed including 4 females (2 – 80+, 1 - 70+, 1 - 50+) and 2 males (1 - 80+, 1 - 50+). All were music lovers. One was an amateur musician and champion fiddler.

Site visits took approximately 4 hours. Interviews were 20-30 minutes long and were conducted in quiet places, either an office, or program room. At the beginning of each interview, the researcher explained what the study was about and asked whether or not the interviewee had any questions (Appendix 5). Anonymity and confidentiality were assured. Personal interviews were audio recorded and then transcribed using an Olympus S-14 recorder and transcription module. Visits were conducted and transcriptions were completed over a 4 week period. There were a total of 22 interviews conducted. Each
participating site was given a Room 217 DVD made especially for dementia care as a thank
you gift.

Data was also collected through observation and document protocols. At each site, a
tour was given and in particular areas germane to music care delivery i.e. Snoezelen room,
exercise areas, dining rooms, program areas. In three instances, observation included
participation in a music care program facilitated by a music therapist, observing its effects
on residents.

Two (2) documents were collected. Revera uses PointClickCare as its initial
assessment tool for residents. The Initial therapeutic Recreation Assessment form was
collected at Site 1 as an Exemplar (available upon request). This form indicates
psychosocial comments gathered which would include musical preferences, background
etc. As well, a program calendar for the month of March was collected at Site 5 as an
Exemplar (available upon request). Each site had a similar sort of hard copy program
indicating monthly activities that included music.

Data validation was built into the design via triangulating questions amongst all
interviewees. With the exception of the residents, whose questions needed modification
depending on their cognitive abilities, all interviewees were asked the same 6 core
questions. A second method of validation was used by method checking. Once the
transcriptions were complete, they were sent back to the Program Manager at each
participating site to give an opportunity for accuracy review by each interviewee. There
were no inaccuracies reported.

A coding approach shown in Table 3 was developed for data analysis. Codes
included:
Transcriptions had wide margins on both sides. The left side was for coding using the above codes with the corresponding short word themes from interviewees. The right side was for enlarging themes and ideas that emerged. As factors emerged that were common and unique, positive and negative, they were collected on another page for each interviewee. 8-10 pages of transcription per person were reduced to one written page including data coded as above. Upon closer analysis, perceived factors influencing implementation and integration of music care were put into 7 broad categories with sub-categories.

A phase one report was presented to the Clinical Management Team at Revera.

**Phase Two Design - Quantitative**

Phase two was a pilot study of 50 LTC homes in Canada with data being collected through an electronic survey in a stratified sample. Given that there are 2,577 operating residential LTC facilities in Canada (cited in CHA, 2009, p 68), the researcher and

<table>
<thead>
<tr>
<th>Code</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Factor implementation</td>
</tr>
<tr>
<td>INT</td>
<td>Integration responsibility</td>
</tr>
<tr>
<td>P</td>
<td>Philosophy</td>
</tr>
<tr>
<td>O</td>
<td>Opportunity</td>
</tr>
<tr>
<td>MC</td>
<td>Music Care definition</td>
</tr>
<tr>
<td>A</td>
<td>Attitude</td>
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<tr>
<td>B</td>
<td>Benefits</td>
</tr>
<tr>
<td>F</td>
<td>Fact</td>
</tr>
<tr>
<td>T</td>
<td>Task</td>
</tr>
<tr>
<td>IMP</td>
<td>Implementation</td>
</tr>
<tr>
<td>WHO</td>
<td>Who</td>
</tr>
</tbody>
</table>

*Table 3. Phase One – Coding Analysis*
supervisor agreed that 50 participants would be representative of the LTC residential home population for the purposes of this study.

Characteristics of study participants included role of respondent (either an Executive Director, Director of Care, Program Director or another leader in a local LTC home); philosophical working model (traditional medical or social); number of beds; age demographic of residents; geography (at least eight provinces represented also reflecting urban/rural settings); non-Revera homes (up to 5 more Revera homes were allowed to participate so long as they were outside of Ontario) as shown in Figure 2. Consideration was also taken into account of other LTC corporations like Chartwell, Schlegel, Extendicare and were proportionately limited as to how many of their homes could participate.

<table>
<thead>
<tr>
<th>Respondent Role</th>
<th>Philosophical Working Model</th>
<th>Number of LTC beds</th>
<th>Age of residents</th>
<th>Geographical location in Canada</th>
<th>balance of non-Revera homes</th>
</tr>
</thead>
</table>

**Figure 2. Characteristics of Phase Two Study Participants**

The sample was stratified. This was done for several reasons. In order to ensure population validity, participants were recruited conveniently by word of mouth at conferences that the researcher attended in the spring of 2014. These conferences included the national Culture Change conference in Toronto on March 24, 25; the New Brunswick Hospice Palliative Care conference in Moncton on April 26, 27; the Manitoba Long Term Care conference in Winnipeg on May 6; the Canadian Therapeutic Recreation Association national conference in Banff on May 14, 15. In order to achieve representation based on variables, recruiting was done one by one. In this way, variables could be kept in check in order to build a valid population sample. The Room 217 Foundation database, a resource
that the researcher has the ability to access, was also used in order to cover gaps in the sample i.e. recruiting participants from PEI).

REB permission was obtained by the researcher at the University of Toronto to conduct Phase Two research. REB permissions needed to be sought in the larger corporate style LTC operations i.e. Schlegel, Chartwell. In every case, the respondent needed permission to participate including EDs and DOCs. In some cases where the LTC home is run independently, permission was sought through the Board of Directors. Participant involvement was voluntary.

Once interest from a potential participant was noted, the researcher followed up with an email which expressed thanks for interest as further instructions for study involvement. A covering letter (Appendix 6), the survey protocol, (Appendix 7) and the University of Toronto REB letter of consent (Appendix 8) were attached for more specific information. A link to the online survey was sent once the participant had approval.

Further incentive to complete the study was communicated in the cover letter. Once the study was completed, the respondent’s name was entered into a draw for an iPod worth $300. (Once the survey closed, the draw took place and a respondent who is a DOC from a LTC home in Winnipeg won the iPod.)

A survey comprised of 42 questions was developed which would help to refine learnings from Phase One. The survey would give further explanation to how leaders in LTC understand what Music Care is, as well as confirm the delivery status of Music Care across the country.
The survey was piloted and critiqued by two sources: the Program Lead of six LTC homes in the Central East LHIN as well as the Research Coordinator at the Schlegel-University of Waterloo Research Institute for Aging (RIA).

The Survey was designed in 4 parts, and was created in Google Survey Monkey. The survey took approximately twenty minutes to complete. A brief description of each part of the survey follows.

*Demographic Information (3 questions):* The opportunity for informed consent was given. The participant was given the option of including their name. In this regard, they would be signing up to receive a copy of the full study report at its conclusion. This section identified the role they played at their LTC home.

*Information About Your LTC Home (6 questions):* Demographics were collected in this section including town, city and province where LTC home is located, years of working experience at LTC home, number of beds, resident ages and philosophy of care.

*Defining Music Care (14 questions):* The researcher’s definition of Music Care was given as an introduction to this section. Questions were asked about what the respondents perceptions and attitudes of Music Care are, the perceived value of music by stakeholders at their LTC home, their understanding of the effects of Music Care, and their own personal comfort with aspects of Music Care. This section was based on the first emergent factor in Phase One, “attitudes about music and music care”.

*Music Care Delivery in LTC (19 questions):* This section of the survey included specific questions of use and practices that were based on the other six emergent factors from
Phase One; served to enrich the findings around Music Care delivery status and provide either corroboration or new data to be considered.

Questions were comprised of multiple choice, likert scales (1-5), listing, open-ended questions. The survey was conducted in English only. Participants from New Brunswick and Quebec completed the survey in English.

While 54 respondents claimed to have completed the survey, 3 respondents were removed in data clean up as they had answered less than one section of the survey. Further clean up included separating towns/cities and provinces in separate fields, separating towns and cities into urban rural fields, and tidying up the data presentation in field 3 which described role. Respondents had replied “Other” if their role wasn’t literal. For example, in one case the respondent entered “general manager” under “Other”. Literally they are not the same thing, but their role as operational leader of a LTC home is the same thing. Any “Other” answer was entered into Google Monkey as a comment which impacted how the analytics read the numbers of respondents. The researcher reentered the “Other” information to reflect the role which most suited the comment. Fourteen percent of respondents were in the “Other” category.

Survey monkey analytic tools were used to provide descriptive statistics. Analysis which included factors of variability were also conducted including: roles, provinces, number of beds, philosophy of care, age of residents served, length of time respondent worked in the LTC home.

A summary report of data with accompanying tables and figures as well as Phase Two discussion was presented to the Supervisor.
Final Report

The Final Report is comprised of an abstract and seven sections, and has been delivered as a major research paper (MRP) to the Faculty of Music, University of Toronto, by the researcher, a candidate for the Masters of Arts in Music Education degree. The MRP has been presented to the Clinical Management Team at Revera, and sent to the survey participants who requested to have a final copy of the paper sent to them. It is the intention of this researcher to use the findings of this MRP in conference presentations, and journal articles.
Section 4 – Phase One Results

Phase one identifies seven emergent factors, each with subsidiary factors that influence music care delivery in Canadian LTC. The factors are as follows: 1) Attitudes about care and music care 2) Nature of Music 3) Facility location and design 4) LTC community culture 5) planning and sustainability 6) music care education and awareness 7) gaps between theory and practice.

1. Attitudes about care and music care

The reality of how LTC is delivered and experienced by residents lies on a dual track. Issues of a personal care nature i.e. hygiene, dressing, medications are handled by the nursing staff. Nursing staff is comprised of RNs, RPNs and PSWs who do the majority of direct personal care intervention i.e. bathing, feeding, clothing. Anything to do with activation or psychosocial care is handled by the program department. Program may be delivered through program or restorative aides, specialized staff i.e. chaplains, music therapists, physiotherapists. The dual track is a functioning mechanism based on a medical model of care.

If the dualism is more than functional, and is attitudinal, there is the potential to compartmentalize music care delivery into a program job or a nursing job. When asked about how music care was integrated from the resident’s original assessment form (completed by recreation) to daily experience and bedside care, all sites affirmed intentional program track implementation. Intentionality was harder to find on the nursing track. Flow between tracks seemed ambiguous, hit and miss. “Knowing” and “understanding” were assumed. For example, DOC3 said:
That (music care) would be considered more of a program thing. Programs would more or less follow up with that as far as entertainment that way. Program actually does that section of the interview. I believe they collect that information. But to implement it at the bedside, it wouldn’t necessarily be a nursing task. It would be more from a program perspective that they would implement those things. We would know. As an interdisciplinary team, we would all understand that this resident does or does not like music.

Dual tracks may also contribute to “silo” approaches in how a resident is viewed. MT4 said that this may happen because staff can become myopic, and focused on their individual role only. One attempt at bridging the tracks using music in an informed and intentional way was relayed by PROG5. An RN on the locked floor (dementia floor where residents with mild to severe cognitive impairment live) was having a challenge with one resident who was obsessively following her around on medication delivery. The RN asked PROG5 for advice on what to do with this woman. PROG5 suggested she redirect her back to her room, put on upbeat music (because she really likes it) and get her to dance. The nurse was skeptical but after a week, reported that it had worked. The resident was able to stay in one spot. PROG5 comments:

*We need to make sure that we’re looking at a person holistically rather than from only a nursing perspective or a recreation perspective. Rather than everybody looking at the person like this (draws long strips in the air looking like silos) I promote looking at people holistically.*

The dual track model, generated from Ministry regulations and funded accordingly, has recently undergone a shift. ED1 said that 2013 is the first year the Ministry has announced that funding can cross the two tracks of nursing and program. ED1 sees this as an opportunity to fund music care integration.

Another aspect of attitude towards music care is whether or not music is valued, especially by leadership, and what the general interest is, whether or not there are perceived benefits and how much of a priority music care is. Every leader believed music
care was important; several thought it was critical. ED2 believed that music care opens
doors for people that aren’t opened otherwise. At site 2, staff loves music and make
attempts to use it doing personal care. PROG 1’s belief in the therapeutic power of music is
adamant, so much so that music flows through most of Site 1 programming.

Conversely, ED3 believed that music is an “add-on piece”, “one of life’s pleasures”,
and is not convinced music is a therapeutic or medical intervention and doesn’t deserve
special attention.

_ I use it for pleasure only….it (music care) would be a hard sell for me because there’s so
many other things that residents need…we can’t take one pleasure above and beyond. _

Five (5) of the six residents interviewed said that music is the most important thing
in their life. RES4 alluded to the fact that some of the residents in site 4 don’t participate in
music because of mood, lack of interest, or lack of desire to participate.

The perceptions of general interest in each site varied, although the perceptions of musical
interest in sites 2 and 5 were most consistent. A Likert scale was used to measure interest,
1-5, 5 being strong interest and shown in Figure 3.

![Figure 3. Perceptions of Musical Interest by Facility](image)

Each of the leaders interviewed acknowledged the benefits of music on residents
and identified benefits they have witnessed in their site on residents, staff and family. Table
is a comprehensive list of perceived benefits of music care by the five participating Revera LTC homes in this study.

- Opportunity for social engagement and drawing people together
- Supports palliative and end of life care
- Contributes to residents’ happiness, pleasure, enjoyment, purpose
- Makes positive change in agitated behaviors i.e. more focused attention, calming and may have carryover effect
- Opportunity for reminiscence, triggering memories, cognitive stimulation
- Elevates mood
- Opportunity for movement and activation in a fun and meaningful way
- Brings comfort, familiarity
- Offers relaxation
- Makes atmosphere in facility/space more relaxed
- Enhances creative and fluid expression
- Enhances awareness of self
- Improves quality of life
- Supports rehabilitation i.e. regaining fine motor ability, language
- Shared activity for resident and family members
- Assists in transition to LTC
- Provides focus, “attention grabber” for residents with cognitive impairment
- Opportunity for reflection and spiritual renewal
- Means of distraction
- Brings out the best in residents
- Gives residents a way to care for each other
- Participation in music-making

### Table 4. Phase One - Perceived Benefits of Music Care

Stagnant thinking seems to permeate technological approaches to music care delivery. CD players and radios were observed to be the primary means of music transmission. TVs were used in residents’ rooms and home areas. For example, ED1 said “I think in most LTC, and I’m making a generalized statement, we don’t embrace technology.” Yet site 1 uses an iPad to facilitate the drumsticking program for increasing fine motor ability as well as a dance program. Site 5 has a computer for the younger residents to listen to music on. Younger residents in site 5 have their own iPods. Several sites are looking at using iPod technology for individualized programming for dementia care.
Short-sighted thinking in environmental leadership may lead to not prioritizing music spaces or systems in building plans. Site 1, for example just completed a major renovation in a lounge area and didn’t retrofit it with music delivery systems. PROG3 wonders if the building designers thought of music when the residence was built because there is no appropriate place to have performances. RES5-1 wishes there was a space in the building where residents could go and listen to music quietly. ED1 envisions a music studio place one day where residents could perform their own music.

There seemed to be a lack of creative thinking around community access for residents around musical activities. Reasons for not taking residents out to concerts or musical events included that events were too late at night, not enough staff, too expensive, too stressful for residents. But in sites 1 and 2, which are rural and remote, community access seemed well integrated and creatively thought through. For example, in site 1, 8-10 residents per month travel by bus to attend the fiddle club. They rotate who gets to go in order to accommodate more residents. In site 2, the dining room is at the front of the building with large open windows looking onto a driveway and neighbourhood. At one time the community piping band practised in the driveway so residents could hear and see the practice. ED2 is considering inviting the newly formed town band to rehearse at their site as well as taking the residents to the annual Christmas CHORALFEST. Community access to musical events is non-existent in sites 4 and 5 and rare in Site 3.

MT4 feels that many residents think of TV as their main source of musical stimulation. This is limited thinking.
Reluctant thinking appeared in site 3 as they had a bad experience with a music therapist seven or eight years ago. Both ED3 and PROG3 seemed reluctant to reformulate and try again with a different music therapist.

Group think amongst staff permeates Site 5. It is in a factory city where there are a lot of unions. The union mentality which offers a lack of flexibility to finish a caring response frustrates DOC5. Staff buy-in to integrate music into care, therefore, is difficult.

_They’re very much into working their strict hours having their breaks at break time. So there isn’t a whole lot of flexibility. And when you’re dealing with people, that’s an issue because people don’t always perform their bodily functions on time... Trying to set up a program and get buy-in is challenging. Trying to get them to participate in committees is considered a management function._

2. **The Nature of music**

Choice of music was perceived to be extremely important in music care delivery. PROG5 says the music needs to connect with the resident and have meaning to them. If not, ED2 says that what we think may be pleasurable, in fact becomes an irritation. PROG2 says music doesn’t work when it doesn’t connect with residents and this has happened at site 2 with some younger performers.

_It just depends on the music. Here, it is the country and western and old time music. If you put on a modern country or classical song, they don’t want it. It’s noise to them._

Music can be perceived in different ways. RES2 prefers live music, not recorded. RES4 starts her day with an iTunes playlist on her laptop computer. RES5-2 begins and ends each day singing. Some residents prefer to go to active music-making sessions like a drum circle or singalong. Others prefer to listen to recordings in home areas. RES3 does all of her music on the TV. She sings with the commercials and feels she gets musical pleasure and enjoyment from that medium.
Perhaps the greatest challenge around preferences is that each resident has a different preference. PROG1 cites this as the most challenging component of effective music care delivery.

We have 100 residents who all have different preferences. The difficult part is picking out what those pieces are they like and how to play them. If you know a resident comes in with a fairly limited income, we get them a CD player some other way. We have lots of donations. We have had residents come in with no family before and we know what their genre of music is. We’ll put the CD player with the CDs beside the bed for PSWs and nursing staff to put on during care.

Effects of music

According to most interviewees, adverse effects of music on residents can happen when the wrong music is used. ED5 comments:

I think sometimes it (music) can have the opposite effect on people. For example, if someone is agitated, putting on fast beats may agitate them more rather than trying to find some calming music.

Or the music may be over-stimulating for a resident. ED4 has seen that sometimes, using the wrong music increases responsive behaviors like pacing and mimicking.

Music was used in all of the phase one participating Revera homes. Reported uses of music can be found in Table 5.
• Entertainment for special occasions i.e. Valentine’s Day or regular Happy Hour or large gatherings
• Community access i.e. outside groups coming in or residents going to musical programs outside
• Part of a program i.e. themes, special occasions, background to exercise or art
• As program – Snoezelen, WII, Montessori-based, drumming circles, music circles with opportunities for music-making, sing-alongs, karaoke, hymn sings, music specific games i.e. Name That Tune,
• Music therapy – one on ones or small groups with specific therapeutic outcomes
• Spiritual care – church services, chaplain visits
• Dancing – within programs or as program i.e. iPad used as source
• In various areas using TV, radio or CD players - home areas, dining rooms, spas, nursing stations, residents’ rooms
• Integral to restorative programs i.e. drumstick program to improve range of motion, movement to music
• Palliative and end of life care – live or CDs delivered on carts
• CD library stored centrally or in home areas
• On visits i.e. chaplain or program aide one on ones
• Individualized programs on ipods (being investigated, not yet delivered)
• Memorial services, celebration of life services
• As a time filler

Table 5. Phase One - Ways music is implemented in participating LTC home

3. Facility location and design

While the rural and remote sites seemed to flourish with community access opportunities which enlarge musical implementation possibilities, their ability to retain qualified staff is a challenge. ED2 said that the closest music therapist lives forty-five minutes away. ED1 said that qualified part-time people like music therapists are hard to attract and keep in outlying areas from a big city. The two suburban sites were located in residential areas. Each had ample access to qualified music care specialists as well as musical opportunities in their area. The downtown site was the most aesthetically unappealing and was located on the edge of the highest crime area in the city just behind local social service agencies. Due to its location, it has become a transitional facility with more than 200 admissions per year. DOC5 says this means a higher workload for staff. It is
not a first choice destination for most residents and their families and so there is often a stigma attached to living in site 5. Family members do not typically engage in volunteering or supporting family members in any kind of care. Sustaining and building a music care environment is challenging because of the high turnover of residents. DOC5 feels this passionately.

When a bed becomes available in one of their (the families’) higher choice homes, the family will pull out the resident. And it’s demoralizing. We have people who might be here for 3 years before their first choice home comes up, or their next choice home comes up. By then, the (music) programs are in place. The relationships are in place and oftentimes, the resident is happy here and wants to stay but the family really wants to take them.

There were three representative facility designs represented in this study. Sites 1 and 2 were bungalow style each about forty years old. Site 1 was shaped like a horseshoe with a courtyard in the middle. Site 2 was an L shape with a fenced in back yard and patio. Both sites had pianos. Both sites had dining rooms where all residents ate. In these facilities, nursing stations became the hub of where the daily music listening occurred. More formal musical gatherings took place in the dining room.

Sites 3 and 4 were designed in a very similar way. Both were two-storey with a front set of two elevators. Administration offices including program were located in the front area on the main floor. There were two long spokes on each level which were named home areas. In each home area, there was a music listening space with CD libraries but it was not designated music only. There could be other things than music going on in that space. Sites 3 and 4 each had a Snoezelen room which included music for auditory stimulation. Each facility had a secured home area for dementia care. Dining rooms were located in each home area seating between twenty-five to thirty people. In both locations, there was no
space for large gatherings. In site 3 there was a sitting room/quasi-chapel area in the front. There multi-purpose gathering rooms where small music groups or circles could meet.

Site 5 was a medical model nine-story apartment design according to ED5. It constituted a city block with very little parking and a small garden. All program staff and rehab programs were housed in the basement. The main floor had a long front which went from side to side of the building. One half was the dining room which could seat about 80 and the other half is where music programs were delivered i.e. Happy Hour, drumming circle. There was no privacy. Everything was completely open. There were four elevators, two located centrally, two near the home area. A maximum of four residents in wheelchairs could ride an elevator at any one time. The second floor was secured. Each floor had a similar layout with the home area centrally located. In each home area there was a dining room for twenty to twenty-five as well as a TV room. Music could be used in either of those settings. Each floor had a spa. There was a CD player in each spa room.

ED1 felt strongly that ward accommodation, that is three to four residents per room, makes music care delivery more challenging. Sound proximity to people who are sleeping may be disturbing. Residents with different preferences may find music irritating. In Site 4 that many of the residents in private rooms had their own set up. Radios and TVs could be heard from residents’ rooms walking down the corridors.

4. LTC community culture

The majority of residents were older adults and persons who were elderly. Sites 3, 4 and 5 had secured units for dementia care. Sites 4 and 5 were the most diverse. The population of Site 4 was 60% Italian-speaking. According to MT4, language barriers did not
impede music care delivery. She had residents teach her Italian and Hungarian, for example, using music. ED4 didn’t see language as a barrier to effective music care delivery.

*Music has its own unique way of communicating feelings and the beat. I don’t believe the words have much of an impact.*

Site 5 had between 30-40% residents under the age of 60, many in their 30’s. Most of these residents had mental illness. Age differences within site 5 did impact music care delivery. PROG5 commented that the younger residents don’t want group programming. Rather they want individualized programming. Many of them have their own iPods. As well, many of the younger residents are able to come and go from the facility as they are deemed competent and don’t need staff supervision for community access. Younger residents don’t want to be in programs with older adults. PROG5 explains:

*A lot of the younger residents don’t want to be programmed. They may come to happy Hour to get the snack and then off they go. They don’t want to sit around in a group and do that kind of programming thing. So we try and think of things that are more specifically designed for them. One younger resident who loves country music, sings at the top of his lungs. He’ll sit at his computer all day long and play bowling and games like that while he has his own music on.*

Cognitive variabilities did not seem to impede music care delivery at each of the sites. Accomodations in programming were made for MCI. At site 5, there was a separate program called a Focus Program for this population including some music-focused programming like Movement to Music, Matinee Montessori, Snoezelen.

Staff’s appreciation and comfort level with doing music came into play in the implementation and integration of music care. Some staff did not appreciate or like music nor did they feel comfortable in doing music while other staff were singing, dancing and engaging with music in a natural way throughout the day. At site 2, the scheduled entertainer was unable to come due to weather conditions. So RES2 and I began to do some
fiddle jamming. Residents showed up in the dining room. Several members began to dance with residents. One staff member began to step dance. By observation, site 2 had the most staff participation and least inhibition to music care delivery of all five sites.

In sites 4 and 5, the nursing staff was a predominantly different cultural group than the residents. In site 4, the main resident population was Italian-speaking and the majority of the nursing staff was Jamaican. In site 5, the majority of residents were Caucasian and the majority of the nursing staff was Filipino. This ethnic mix sometimes caused misunderstanding in meanings of certain care practices. ED4 and DOC5 felt there needed to be an appreciation of each other’s cultural practices of care. For example, many of the Jamaican PSWs sing hymns as they do care – they’ve brought this practice with them. Filipino caregivers call elderly people “momma” and “poppa” which according to DOC5, offends some family members.

In site 4 program aides and the chaplain incorporated music in their 1:1 visits because they can and they want to. The chaplain is a flute player and so takes the instrument and engages with residents. Program aides may sing or listen to music with residents using songs as a catalyst for meaningful conversation and cognitive stimulation.

Family involvement varied in the various sites. Sites 1, 2 and 3 said that families did participate in the (music) programs by coming to gatherings, special events, or music therapy sessions with loved ones. I observed a group session with MT1. An elderly father and mother participated in the music-making session with their son who had been impaired by a stroke. MT1 relays:

The mom was able to tell me that he was playing the bell now and he wasn’t doing that last week or even before. They see him regaining some of his fine motor ability. That was really meaningful for the parents who are able to see him enjoy music again because he was a musician. I think it’s really meaningful for the family and for him.
Sites 1, 2 and 5 utilized many community groups to come in for musical entertainment. For example, there are banjo groups, accordion groups, school choirs, church groups, university music students. Site 4 seemed to have the least amount of community connection. It may be that the program manager is new and not from the area.

Volunteers from the community have decreased in site 2. PROG2 shared that some of the dependable volunteers are now becoming residents themselves. ED5 mentioned that they have very few volunteers for a residence with 229 occupants.

The number of residents in the LTC site, did not appear to be a significant factor in music care delivery.

5. Planning and sustainability

Funding was the most commonly perceived factor for sustainable music care delivery. RES5-1 laments:

...Money, which is very sad because our older residents of the province, we’re not given enough. We give money to everyone else. But we’re the poor relation of the health system. I’m sorry to say, we are the poor relation. I mean, a home like this is getting very old. It needs constant repair. I figure eventually they’ll have to pull it down and start again because of more and more repair. You can only do so much.

ED1 confirmed it by bringing to light that Ontario has the lowest funding for LTC amongst the provinces. ED5 gets frustrated because the ratio of PSWs for residents is 35:1 and they are expected to be on top of care plans that are fifteen to twenty pages in length for 229 residents.

MT1 realizes that the lack of budget for music therapy means that the care she can deliver through music therapy groups and 1:1 is limited. PROG1 has opted for more volunteer programs in order to release funds for five hours of music therapy. Site 4 budgets for one day of music therapy per week. MT4 has approximately fifteen residents in her
program. At site 4, there is a substantial waiting list for music therapy. MT4 and PROG4 concur that music therapy is highly valued by the families.

Lack of funding equals lack of staffing. ED3 would like to put funds towards more staffing.

*What we do for residents now – probably 30-40% of it is paperwork. It’s not hands-on for residents. I have 1 PSW for 12 residents and that’s toileting, bathing, feeding. That’s not a lot of time. I’d rather see fund go into direct care. If we had more bodies giving direct care, then maybe I could see what I’m missing with music.*

RES5-1 wants more staff to do music. She feels site 5 is “music-starved”. At site 5, the program manager who is a qualified music therapist, was hired to do 50% program and 50% music therapy. In reality, she is doing 95% program and 2 – 1 hour music therapy programs per week. She has been able to supervise music therapy students at site 5 in order to deliver more specialized music care.

All interviewees except residents were asked whose job is it to deliver music care? There were five differing responses given. (Table 6.) The lack of definition of music care as well as ambiguity about whose role it is may be why PROG3 and DOC4 were not sure about how to answer the question in the first place. MT4 wished there was a consistency of personnel for music care implementation. She is frustrated that there is no sustainability to music care initiatives that may be started i.e. music in the dining room. ED2 perceived that music care was delivered formally by program and informally by everyone.

<table>
<thead>
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<th>Role</th>
<th>Percentage</th>
</tr>
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<tr>
<td>Everybody</td>
<td>44</td>
</tr>
<tr>
<td>Program</td>
<td>22</td>
</tr>
<tr>
<td>Collaborative but falls to program</td>
<td>22</td>
</tr>
<tr>
<td>All but should be run by a professional</td>
<td>6</td>
</tr>
<tr>
<td>No response</td>
<td>6</td>
</tr>
</tbody>
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*Table 6 – Phase One - Whose job is music care?*
None of the 5 sites had a music care plan. This may be one reason for ambiguity in whose role music care delivery is. ED2 thought lack of music care integration was because music care is integrated to the program of the home, not the personal care plan of the individual.

*I think that music is offered more as something for the whole home as far as the programs go. For that man you met today, music has been a big part of his life and I'm not sure we have really said to him, how would you like music to be integrated into your day? He certainly is involved when there’s music in the home, but that’s maybe reactive rather than pro-active.*

Residents are placed in a home upon the recommendation of the local Community Care Access Centre (CCAC). All 5 sites concurred that there was no pertinent information on the CCAC forms that would be helpful for music care i.e. musical preferences, musical history. Revera uses the PointClickCare (PCC) system for initial assessment of residents as well as charting and note taking on an ongoing basis. The thinking is that all care providers can access all the history of the resident. In each site, it is the program manager’s responsibility to complete the Therapeutic Recreation Assessment portion. There are several sections where musical background and preferences may show up i.e. cultural heritage, lifetime leisure history, intellectual interests, spiritual interests, lifelong learning. Buried under psychosocial interests are boxes of several musical interest possibilities: drumming, singalong, musical instrument played: piano, guitar, violin, harmonica, musical preferences: jazz, classical, country, opera, oldies, religious.

Where each site’s story differed was in the next part – how music care was bridged across the dual tracks. ED3 admitted they had an unwritten plan that should probably be written down. PROG5 hoped that it would happen by word of mouth. PROG2 allowed
things to happen spontaneously. DOC4 had been on the job three months at site 4 and was unsure about music care delivery at all.

It seems that DOC1 would be willing to integrate more care into the nursing track if the details were put together.

*I think the only barrier would be getting the details together. You know, like what resident wants to be alone and the different resources for music and the equipment and things like that. I think every department here is receptive to it (music care.)*

PROG 1 suggested that programming in general, not just for music care is complex.

*It’s definitely a complicated scenario to manage a program calendar that meets the needs of younger adults versus an older population, especially if you’re talking about music preferences. And as well, just making sure that each different physical ability of the residents is adhered to, so people who are cognitively unwell, but might be physically well versus residents who are cognitively well but physically unwell. You’re always looking at balancing what that calendar looks like to make sure that you meet the needs of all the residents in the home.*

Furthermore, it appeared to be a challenge to keep up with what’s current musically. What was popular with residents five years ago may have changed because of resident turn over.

DOC3 says that’s why the music care program should be home specific.

*I think we could be a little more creative, inventive and innovative and come up with some home specific program based on their (residents’) preferences and that initial assessment to transfer what we’re gathering and come up with something. And continuously evaluate it. We can come back to it and say, maybe that group of residents liked that, but now we’ve had some turnover and we might have to tweak it a little bit. We’ll have to continuously tweak it because over a 10 year period, residents change and the musical preferences change. You have to keep up with the times. What worked before might not work now.*

6. Music care education and awareness

What people perceived and understood music care to be was the most salient component of this factor. Most often the music care definition given was determined by the interviewee’s personal experience of music, or experience of music care delivery in other LTC settings or having the ability to think outside of the box in general. Some interviewees
found the term “music care” straightforward. Others hadn’t heard of it before and one ED didn’t think she liked the term at all. When asked what “music care” was, two people didn’t know what to say and so did not offer a response. Each response to the question given centred around music being used to help people live their life to the fullest, enhancing quality of life.

RES2 described music care as “an attention getter and holder.” DOC1 saw music care as positively changing behaviors. DOC3 imagined that music care was a therapy that would improve a resident’s QOL. ED4 saw it as part of the whole entity of caring for people. ED5 saw music care as healing and soothing and said that it should be integrated daily. RES4 saw music care as the same thing as music therapy, enhancing the life of someone with music bringing whatever is missing in their life i.e. gentleness or strength.

Each ED admittedly said that this study has prompted them to think a little deeper about using music in the delivery of care in their LTC home.

A main factor surrounding music care delivery was a lack of musical knowledge, especially by the staff. ED3 admitted she may have been missing something and that more education about the benefits of music care might change her point of view. PROG4 said she didn’t want to “go to school, but needed more education.” ED4, DOC3, ED2 and DOC4 all agreed that there was a need for music care education including the benefits of music for staff, families and residents. Music care education needs to include practical answers to questions like, How do you know what music works when (ED5)? What music works best across cultures and generations (DOC5)?

Knowledge transfer of music care research may be lacking in LTC. There was no music care awareness with ED3. She would need evidence-based research to look at music
care delivery in a more integrated way. Several other interviewees admitted their lack of awareness of the scientific advances in music care.

7. Gaps Between Theory and Practice

Revera is committed to providing person-centred care. ED2 describes it this way.

*Person-centred care means that we are looking at each person as an individual. We want a person-centered approach so that people (residents and staff) are treated with respect and integrity and compassion and excellence. Those are our 4 values.*

Yet ED1’s frustrations are palpable.

*Our sector is still very much a medical model. We still receive 90-95% of our admissions coming from the hospital. The Ministry mandates that within the first 24 hours, you must do a head-toe-skin assessment. You must do a medical. You must take their vital signs. That’s the priority which tells the staff or implies to the staff that the tasks are the most important thing. When we start going down that road where tasks are the most important thing, we lose a person. I’m not blaming anyone. The regulations we have to live up to are there for a reason. But it creates a challenge for us. On the one hand you have the Ministry saying we want more person-centered care. On the other hand, when they do come into your home, it’s done as an inspection. You will always get nailed on your care plan not being up-to-date. You really want the PSW to spend time sitting and chatting with the resident, getting to know him/her. But when the Ministry walks into the building and finds out that the care plan has not been updated, the flow sheets are missing a day of entries and your hair brushes aren’t all labelled, we didn’t meet the standard.*

This shift from medical to person-centred LTC philosophy is still being worked out in practicalities. RES2 had a remarkable person-centred approach upon entry to the LTC. His transition was made smooth because of music. His reputation preceded him: local program staff knew his musical abilities and took full advantage of them in the transition. He had been playing music for fellow residents every day for the first three weeks. He said:
It’s better here (than at home) because I’m a little bit involved. At home I was alone, nobody to play with. And when people say to me “Are you going to play the piano today?” it’s a little upper eh?

That’s not the experience of other residents, however. RES5-1 and RES4 don’t recall being asked about music upon their entry, even with the PCC system.

Over the past decade, there has been another shift in the philosophy of caring for older people in Ontario. Nursing homes were primarily made up of older adults and persons who were frail and elderly. LTC now encompasses adults who need personalized, professional care at any age. This means that the make-up of a LTC home may be more diverse – younger and older, cognitively impaired and non-cognitively impaired, a variety of disease trajectories i.e. Parkinson’s, Multiple Sclerosis, Alzheimer’s Disease, a variety of behaviors i.e. aggressive, compliant.

The degree of expertise in caring for this sort of diverse population under one roof is staggering. It is possible that caregivers have not yet caught up with the necessary protocols and programs that the LTC philosophy needs, including the delivery of music care in a comprehensive sort of way that meets this diversity.

Pleasurable dining is one such example. The notion of LTC residents dining at each meal as if they are in a restaurant sounds good. But ED1 and PROG5 say that it is much more difficult to put into practice. Because there is no surround sound set up in the dining areas, the CD player has to be turned up on one side of the room which irritates and potentially agitates residents on that side of the room. And what music is to be played that satisfies the preferences of a potential sixty year age span? Sites 1 and 5 say that music brings more chaos to the dining experience than the research studies and books proport.
All sites except site 3 perceived that having a music therapist on staff as part of an interdisciplinary team is an asset to music care delivery. However, OHIP does not cover music therapy services. Music therapy is not listed as a category like physiotherapy, speech or occupational therapy in the Ministry reporting system. A music therapist is not recognized as other therapists with similar expertise and training. MT1 applies her music therapy minutes under recreation.

PROG3 wished that music care resources, ideas for implementation and integration could be shared amongst leadership groups i.e. DOC to DOC, ED to ED, Program to Program. PROG3 wished that sharing of music care resources become a regular agenda item at Revera regional program meetings.

Several interviewees mentioned ideas about how this study had prompted them to think about integrating music into their areas. ED2 would like to use music as an adjunct with pain medication to reduce side effects of drugs. Three (3) sites are in the beginning stages of an individualized music program using iPods in partnership with local Alzheimer’s Societies. PROG4 and PROG5 are examining ways they might provide community access musical opportunities for their residents. DOC4 has begun to think of ways to use music during care time.
Section 5 – Phase Two Results

Organization and analysis

Phase two findings can be organized into two categories: 1) conceptual data and 2) status data. Conceptual data helps to clarify how Music Care is perceived and understood by leadership in Canadian residential LTC. Status data helps to describe how Music Care is operationalized in 50 LTC homes across Canada.

Characteristics of study participants for data analysis include 1) leadership roles 2) philosophy of care 3) geography, 4) size, 5) age groups, and 6) experience.

Leadership roles: The LTC leadership roles that were recruited to participate in this study were Executive Director (ED - responsible for daily operations of LTC home and regulatory reporting), Director of Care (DOC - responsible for medical care and daily hygiene of residents), Director of Program (DOP - responsible for daily activities for residents). Other (O) leaders including Director of Volunteer Services, Music Therapist, Social Worker.

Philosophy of care: Currently in Canadian LTC, a shift is occurring in the philosophical model of care. The culture change movement, based on the work of Barry Barkan, Bill Thomas and Rose Marie Fagan⁵ and others, moves the philosophy of care from the traditional medical model of care defined in institutional terms (i.e. routines, rotations, hierarchies, care for) to a social approach which focuses on living, flexibility, collaboration, and mutuality. One scholarly literature review explains culture change as involving “a shift in philosophy and practice from an overemphasis on safety, uniformity, and medical issues

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⁵ Barry Barkan, from the Live Oaks Project, CA, Dr. Bill Thomas, founder of the Eden Alternative, NY, Rose Marie Fagan from Re-inventing Nursing Homes, NY, have been leaders in the Pioneer Network in the USA which has championed culture change, the shift from the traditional medical model to a social approach in LTC.
toward resident-directed, consumer-driven health promotion and quality of life.” (Foy White Chu, 2009).

**Geography:** Every effort was made to have representation from ten provinces and at least one territory. In the end, the LTC home in Whitehorse, Yukon, did not submit a completed survey on time, and the provincial REB for the two homes in Newfoundland would have taken two-three months to complete. Unfortunately, the researcher found out about this process too close to the deadline. All provinces except Newfoundland are represented in phase two results.

**Size:** Phase two is representational of the variety of number of beds in LTC residential homes in Canada. The breakdown of participants by number of beds is shown in Table 4.

**Age groups:** No longer can we assume that the Canadian LTC population is made up only of elders. LTC serves the chronically ill, disabled and mentally ill populations as well as the frail elderly. This means that age groups within a LTC home could range from 20-100+.

**Experience:** Years of experience working in the same LTC home by each respondent was collected.

Table 7 shows the breakdown of these characteristics representing the 50 LTC homes participating in phase 2.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Breakdown</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role</td>
<td>Executive Director</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Director of Care</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Director of Program</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>14</td>
</tr>
<tr>
<td>Philosophy of Care Model</td>
<td>Traditional Medical Model</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Social Model</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Not sure</td>
<td>12</td>
</tr>
<tr>
<td>Setting</td>
<td>Urban</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Nova Scotia</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>New Brunswick</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>PEI</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Quebec</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Ontario</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Manitoba</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Saskatchewan</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Alberta</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>British Columbia</td>
<td>8</td>
</tr>
<tr>
<td>Beds</td>
<td>Less than 60</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>61-120</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>121-200</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>200+</td>
<td>14</td>
</tr>
<tr>
<td>Age</td>
<td>Under 50</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>50-70</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>71-90</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>90+</td>
<td>92</td>
</tr>
<tr>
<td>Participants’ years of experience</td>
<td>Less than a year</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>1-5 years</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>6 years or more</td>
<td>46</td>
</tr>
</tbody>
</table>

| Table 7. Characteristics of Phase Two Participants |

Conceptual data

In Phase 1, the most salient factor for music care delivery seems to be the attitude towards music care. In the phase two survey, the understanding and value of, attitude and motivation towards music care was explored. Participants were given a working definition of Music Care prior to completing section 3 “Defining Music Care” of the survey:
Music care is an approach to care that implements and integrates music with intention, allowing the therapeutic principles of sound and musical effect inform us. Music care is not a specific practice, rather a paradigm within which music is inherently understood to be part of the life cycle, and therefore, plays an integral role in all aspects of caregiving and care settings. Music care is comprised of ten domains: community music, music care specialities, music therapy, music programming (formal and integrated), technology, environmental sound, musicking, music medicine, music care training and music care research. Historically in long term care settings, common domains of music care include programming, music therapy and community music.

The questions that followed specifically explored: i) understanding music care ii) valuing music in care iii) beliefs about the effect of music and iv) personal motivation towards music care.

Understanding Music Care

Fifty-two (52) percent of respondents had heard the term “music care”. The LTC homes using the traditional mode of care reported 39% having heard the term while those adopting the social model was 64%. Years of experience working in a LTC home suggest that the Music Care term is relatively new, as more than two-thirds of those with 1-5 years of experience had heard of the term compared to one third of those with less than a year’s experience or more than six years of experience. Role did not seem to impact whether or not participants had heard the term as 55% of EDs, 44% of DOCs, 52% of DOPs and 57% Other accounted for having heard the term. The findings show that the term Music Care is familiar in 70% of rural LTC homes compared to 41% urban homes.

Findings show that 86% of respondents do not think Music Care is the same as Music Therapy. Directors of Program and EDs seemed to understand the difference between Music Care and Music Therapy as only 9% in each case thought they were the same thing. Alberta and Quebec were the two provinces who were least able to
discriminate between Music Care and Music Therapy as 33% of homes in these provinces thought that Music Care is the same as Music Therapy.

Ninety (90) percent of participants thought that everyone, that is program staff, care staff, family and volunteers, should be engaging in music care.

Valuing music in care

The perceptions of the respondents around the value of music were measured. Each respondent was asked to rate how they perceived each of the leadership team, residents, staff and families valued music in care. Results are shown in Table 8. Of notable interest is that every measured demographic (philosophy of care, size, age, experience, role, geography) indicated that staff perceived the value of music in care least and residents perceived its value the most.

<table>
<thead>
<tr>
<th>Percentage of perceptions</th>
<th>Not valued</th>
<th>Neutral</th>
<th>Highly valued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of perceptions about leadership</td>
<td>8</td>
<td>18</td>
<td>74</td>
</tr>
<tr>
<td>Percentage of perceptions about residents</td>
<td>6</td>
<td>20</td>
<td>74</td>
</tr>
<tr>
<td>Percentage of perceptions about staff</td>
<td>12</td>
<td>38</td>
<td>50</td>
</tr>
<tr>
<td>Percentage of perceptions about families</td>
<td>8</td>
<td>26</td>
<td>66</td>
</tr>
</tbody>
</table>

Table 8. Phase Two - Respondents’ Perceptions about the Value of Music in Care

The demographic data further enriches these findings (see Table 9). In every instance, the residents valued music in care most highly and staff the least.
<table>
<thead>
<tr>
<th>Philosophy of Care - Traditional Medical Social</th>
<th>Not valued</th>
<th>Neutral</th>
<th>Highly valued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size – Less than 60 beds</td>
<td>17:17</td>
<td>22:33</td>
<td>61:50</td>
</tr>
<tr>
<td>61-120 beds</td>
<td>0:12</td>
<td>20:44</td>
<td>80:44</td>
</tr>
<tr>
<td>121-200 beds</td>
<td>7:7</td>
<td>13:33</td>
<td>80:60</td>
</tr>
<tr>
<td>200+ beds</td>
<td>9:18</td>
<td>55:32</td>
<td>36:50</td>
</tr>
<tr>
<td>Age – Less than 50 yrs old</td>
<td>17:19</td>
<td>17:43</td>
<td>72:38</td>
</tr>
<tr>
<td>50 – 70 yrs old</td>
<td>7:13</td>
<td>20:40</td>
<td>73:47</td>
</tr>
<tr>
<td>71-90 yrs old</td>
<td>6:12</td>
<td>18:37</td>
<td>76:51</td>
</tr>
<tr>
<td>90+ yrs old</td>
<td>7:13</td>
<td>15:35</td>
<td>78:52</td>
</tr>
<tr>
<td>Experience – Less than 1 yr</td>
<td>20:20</td>
<td>20:40</td>
<td>60:40</td>
</tr>
<tr>
<td>1-5 yrs</td>
<td>9:23</td>
<td>27:32</td>
<td>64:45</td>
</tr>
<tr>
<td>6+ yrs</td>
<td>0:0</td>
<td>13:44</td>
<td>87:56</td>
</tr>
<tr>
<td>Role – ED</td>
<td>9:18</td>
<td>18:36</td>
<td>78:46</td>
</tr>
<tr>
<td>DOC</td>
<td>11:22</td>
<td>22:33</td>
<td>67:45</td>
</tr>
<tr>
<td>DOP</td>
<td>0:4</td>
<td>22:48</td>
<td>78:48</td>
</tr>
<tr>
<td>Other</td>
<td>14:14</td>
<td>14:14</td>
<td>72:72</td>
</tr>
<tr>
<td>Setting – Urban</td>
<td>8:13</td>
<td>18:14</td>
<td>74:49</td>
</tr>
<tr>
<td>Rural</td>
<td>0:10</td>
<td>30:40</td>
<td>70:50</td>
</tr>
<tr>
<td>Canadian Provinces – British Columbia</td>
<td>0:0</td>
<td>0:0</td>
<td>100:100</td>
</tr>
<tr>
<td>Alberta</td>
<td>0:0</td>
<td>17:50</td>
<td>83:50</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>0:0</td>
<td>0:100</td>
<td>100:0</td>
</tr>
<tr>
<td>Manitoba</td>
<td>0:29</td>
<td>29:14</td>
<td>71:57</td>
</tr>
<tr>
<td>Quebec</td>
<td>33:33</td>
<td>33:34</td>
<td>34:33</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>0:0</td>
<td>25:50</td>
<td>75:50</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>0:0</td>
<td>0:0</td>
<td>100:100</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>0:0</td>
<td>0:0</td>
<td>100:100</td>
</tr>
</tbody>
</table>

| Table 9. Phase Two - Respondents’ Estimate of How Residents:Staff Value Music |

**Beliefs about the effect of music**

Findings show that all participants think that music is beneficial to their residents.

Specific ways phase two respondents thought music is beneficial to their residents are as follows:

- Brings back memories, reminiscence
- Relaxing/calming/soothing/comforting
- Stimulate
- Reduces behavioural concerns
- Provides recreational activities
- Provides opportunities for expression/communication
• Allows for self-recreation, self-reflection, self-esteem
• Enjoyment not limited by language or physical abilities
• Families can enjoy this activity with their loved one
• Allows for easy flow of emotions
• Interactive, social, communal activity
• Makes people happier, tap their toes, smile
• Uplifting, mood boost
• Brain (cognitive) stimulation
• Provides purpose
• Provides opportunity to sing
• Supports cultural interests
• Sensory stimulation
• Part of care routines i.e. baths, dressing

• Reduces agitation, isolation, boredom
• Provides focus
• Improves appetite
• Distracts from pain, anxiety, obsessive thoughts
• Motivation
• Reconnection to self
• Sense of meaningfulness
• Sense of belonging
• Promotes periods of lucidness
• Provides form of entertainment
• Promotes movement and dance
• Mitigates sundowning
• Enhance quality of life
• Enhance spiritual experience
• Improves gross motor skills

Fifty-five (55) percent of phase two respondents believe that music has no adverse effect on residents while 24% are neutral on this question. Twenty-four (24) percent of participants believe music can have adverse effects on residents and their reasons are listed below.

• If music is perceived by resident as negative or traumatic
• If music is too loud, too fast, disliked, can cause agitation
• Can elicit painful memories
• Preferences, influences and personal history determine reactivity to sound, tempo, mood
• Wrong music for the age group when the age range is from 27-86
• Too much background music
• Varying cultures or religions
• Singing irritates some people
• Music is perceived as noise by some people
• Distraction to listening or concentrating

• Can cause tension in 4 person room due to volume, preferences
• Can evoke painful emotions
• Sometimes environments need to be controlled and music can have negative impact and feel unsafe
• When music is not used purposefully, it can add to the noise
• Can induce aggression and delusional thought
• Some residents sensitive to auditory input
• Some residents have processing or hearing impairments that are encumbered with too much background noise
• Musical style mismatch
Findings show that 78% believe music can enhance culture change. Twenty-two (22) percent are neutral on this. Those whose philosophy of care is a social model believed in music’s ability to change LTC culture most strongly at 88% compared to the traditional medical model at 61%.

There were those who believed strongly that music should be prioritized in programming. Eighty (80) percent think that music should have programming priority while 2% didn’t think so. Eighteen (18) percent of respondents were neutral about prioritizing music in the program.

**Personal motivation towards music care**

Seventy-four (74) percent of participants feel very confident using music, while only 8% don’t feel confident. Eighteen (18) percent were neutral. Those with more than six years of experience felt the most confident at 83% compared to 80% of respondents with less than one year's experience and 63% of those with 1-5 years of experience. Fifty-four (54) percent of EDs felt the least confident while 86% of others felt the most confident in integrating music into their practice. (There may be bias in this result as music therapists were part of the “Other” demographic). DOPs were next most confident at 78%. PEI was the province with the most confidence reporting 100% confidence using music in care and Alberta reported the lowest confidence level of integrating music into care at 60%.

While participants reported confident in using music, there was still a strong motivation for music care training. Seventy-five (75) percent of participants are motivated towards music care education and training measures that would empower staff to integrate music into regular care practice. Eight (8) percent were not motivated while 18% were neutral. Lowest motivation for music care training was in Quebec as 67% of respondents
from Quebec were not motivated to take training. Other respondents least motivated to pursue music care training were 16% of homes whose model of care is traditional medical.

As the use of digital technology has expanded in care settings, comfort with the use of digital technology was reported. Twelve (12) percent were not comfortable using digital technology while 64% are very comfortable. Twenty-four (24) percent were neutral. There was little difference in results between urban (63%) and rural (70%) LTC homes. DOC (66%) and “Others” (86%) were the most comfortable using digital technology while DOP (57%) were the least. There was also a notably favorable difference in those whose culture is modelled more socially (80%) than those whose approach is traditional medical (50%).

**Status data**

In phase one, music care delivery in Canadian LTC was understood and defined by seven factors. Phase two probes more deeply into these factors. Conceptual data accounts in phase two findings of factor one “attitudes about music care”. Results for the other six factors follow as well as a report on general music delivery gleaned from the phase two survey.

**Music delivery**

Ninety-six (96) percent of homes reported using music while 4% claim music is not used. All roles but DOC reported 100% use. Two (2) urban homes reported that they don’t use music. Use of music was not limited to number of beds. It was used in every reported size of LTC home and is described below.

- community groups providing entertainment, concerts
- 1:1 music therapy
- 1:1 visits for reminiscence
- Java Music Club peer support group
- iPod music memory programs
- dances
- pub nights
- resident bell choir
- background during exercise
- focus during special events
- hymns, religious programs i.e. chapel, church services
- sing a longs
- dining room music
- music integrated into programing i.e. bingo, trivia
- musicking – residents become the musicians
- music listening for enjoyment
- integrated into recreational programs
- sensory stimulation
- encourage movement i.e. gait therapy

- exercise programs
- drumming
- karaoke
- socialization
- choir program
- transitional cuing in programs
- music games
- palliative care and end of life support
- in common areas at quiet times
- Glee Club
- celebrations i.e. birthday parties
- in the lobby
- interactive with instruments
- YouTube videos of residents’ favourite artists
- outside front entrance

Results that indicate who delivers music care are shown in Table 10.

<table>
<thead>
<tr>
<th>People who deliver music in LTC</th>
<th>Program staff</th>
<th>Care staff</th>
<th>Family/Volunteers</th>
<th>Music Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>98%</td>
<td>42%</td>
<td>74%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Table 10. Phase Two - Who Delivers Music Care?

Music therapists are employed in 48% of LTC homes. In those 24 homes, 20 music therapists work 1-2 days per week and 4 music therapists work 3 or more days a week.

Frequency of a music therapists’ work in LTC by size of home was measured and is reported in Table 11.

<table>
<thead>
<tr>
<th>Percentage of frequency of music therapy in LTC</th>
<th>1-2 days/week</th>
<th>3+ days</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 60 beds</td>
<td>17</td>
<td>0</td>
<td>83</td>
</tr>
<tr>
<td>61-120 beds</td>
<td>33</td>
<td>13</td>
<td>60</td>
</tr>
<tr>
<td>121-200 beds</td>
<td>48</td>
<td>10</td>
<td>42</td>
</tr>
<tr>
<td>200+ beds</td>
<td>57</td>
<td>0</td>
<td>43</td>
</tr>
</tbody>
</table>

Table 11. Phase Two - Frequency of Music Therapy by Size
All LTC homes reported using technology to deliver music care. Methods of technological music care delivery can be seen in Table 12.

<table>
<thead>
<tr>
<th>Technological methods of music care delivery</th>
<th>Radio/TV</th>
<th>Stereo/CD</th>
<th>Mp3/iPod</th>
<th>iPads/streaming</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>94%</td>
<td>96%</td>
<td>59%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Table 12. Phase Two - Methods of Technological Music Care Delivery

Reports of iPad/streaming were higher in LTC homes with beds less than 120 (14%) in contrast to homes with beds less than 60 (40%) and 61-120 (40%). Radio/TVs (95%), stereo/CD (98%) and mp3/iPods (62%) were used more in urban centres than in rural (89%, 89% and 45% respectively).

The nature of music

Musical style is often at the heart of musical preferences, a dynamic of music that is personal and varied. Results show that generally country music is the most preferred style in Canadian LTC while specific cultural music i.e. Chinese opera, Portuguese, Italian pop is the least preferred generally. Cultural music was most preferred in homogenous LTC i.e. all Portuguese residents. Comments were made in the comments section like “very individual”, “extremely varied”, “whatever meets the residents’ needs”, “according to the residents’ preferences”. Ranking of preferred styles in order of preference is seen in Table 13.

<table>
<thead>
<tr>
<th>Rating of preferred musical style out of 10</th>
<th>Country/Folk</th>
<th>Religious</th>
<th>Classical</th>
<th>Pop/Rock</th>
<th>Jazz</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.9</td>
<td>7.5</td>
<td>6.6</td>
<td>4.0</td>
<td>3.4</td>
<td></td>
</tr>
</tbody>
</table>

Table 13. Phase Two - Preferred Musical Styles
In terms of geographical representation, the rural population did not tend to prefer classical, pop/rock or jazz as much as the urban population. Results were equivalent for country/folk and religious music. Table 27 shows provincial findings of the most and least preferred musical styles of residents in LTC.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Most Preferred Style</th>
<th>Least Preferred Style</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country/folk 7.9</td>
<td>BC, AB, SK, NB, NS, PEI</td>
<td>PQ</td>
</tr>
<tr>
<td>Religious 7.5</td>
<td>MB, NS, PEI</td>
<td>BC, PQ</td>
</tr>
<tr>
<td>Classical 6.6</td>
<td>PQ, NS, PEI</td>
<td>NB</td>
</tr>
<tr>
<td>Pop/Rock 4.0</td>
<td>NS</td>
<td>SK, PEI</td>
</tr>
<tr>
<td>Jazz 3.4</td>
<td>NS</td>
<td>PEI</td>
</tr>
<tr>
<td>Other .8</td>
<td>ON</td>
<td>SK, NB, PEI</td>
</tr>
</tbody>
</table>

Table 14. Phase Two - Regional Differences in Musical Preferences

Facility location and design

One aspect of integrating music into LTC community culture is about areas where music is allowed to be made in the physical space. In 98% of LTC homes, music is allowed to be played in residents’ rooms. Table 22 shows whether there are dedicated areas for music-making and music listening. Number of beds in the LTC was the notable indicator reported for dedicated music areas (Table 15). Music listening areas for staff existed in only about one quarter of the homes.

<table>
<thead>
<tr>
<th>Percentage of dedicated music space</th>
<th>All LTC</th>
<th>By size of LTC (number of beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Less than 60</td>
</tr>
<tr>
<td>Music-making area</td>
<td>46</td>
<td>33</td>
</tr>
<tr>
<td>Music listening area</td>
<td>64</td>
<td>83</td>
</tr>
<tr>
<td>Music listening area for staff</td>
<td>28</td>
<td>17</td>
</tr>
</tbody>
</table>

Table 15. Phase Two - Dedicated space for music in LTC Homes
Community culture

Results for community access for residents to participate in musical outings outside of the LTC home were varied with the strongest variables being number of beds, care model and geography. Table 16 indicates the results.

<table>
<thead>
<tr>
<th>Percentage of opportunities for musical outings</th>
<th>1X per month</th>
<th>2-3X per year</th>
<th>1X per year</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>All LTC homes</td>
<td>10</td>
<td>35</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>By social model</td>
<td>17</td>
<td>36</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>By traditional medical</td>
<td>0</td>
<td>28</td>
<td>22</td>
<td>50</td>
</tr>
<tr>
<td>By less than 60 beds</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>83</td>
</tr>
<tr>
<td>By 61-120 beds</td>
<td>13</td>
<td>47</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>By 121-200 beds</td>
<td>9</td>
<td>32</td>
<td>32</td>
<td>27</td>
</tr>
<tr>
<td>By 200+ beds</td>
<td>17</td>
<td>33</td>
<td>33</td>
<td>17</td>
</tr>
<tr>
<td>By urban</td>
<td>13</td>
<td>39</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>By rural</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>80</td>
</tr>
</tbody>
</table>

Table 16. Phase Two - Frequency of Musical Outings

LTC homes operating in the traditional medical model never took residents on musical outings in 50% of the cases, whereas those who value a more social approach to care were more consistent in opportunities for musical outings for their residents. Mid-size number of beds i.e. 61-200 also indicated more consistency in community access than smaller and mega-homes.

Planning and sustainability

Eighty-four (84) percent of respondents reported having no music care plan for their LTC home. A few homes in British Columbia, Alberta and Ontario indicated having an intentional music care plan. Ten (10) percent of rural and 15% of urban homes had a music care plan. Having a music care budget was defined as dollars spent for all aspects of music care in the LTC home including resources, personnel, entertainment. Thirty-six (36)
percent of respondents reported having a music care budget. Fifty (50) percent of the rural homes indicated a music care budget compared to 31% of the urban homes. Reported budget numbers can be shown in Table 30. Sixty (60) percent of participants did not report having a budget for music care, while 6% budget under $2K, 28% between $2.1-10K and 6% $10K and over for music care.

*Music care education and awareness*

The occurrence of music care training in Canadian LTC homes never happens in 90% of participants’ homes, 6% sometimes and 4% most times. Having a person on staff with expertise in digital technology and who could help other staff learn to deliver music care via digital technology occurred in two thirds of the homes.

*Gaps between theory and practice*

The ready availability of music resources for staff or volunteers to use for music care happens 40% of the time, while twenty-two percent of the time, resources are not readily available. For residents, availability of music resources for residents to use in a non-structured (non-programmed) way are readily available 32% of the time while 22% of the time resources are not readily available.

Residents or families of residents are asked about the individual resident’s previous musical experience or musical preferences when assessed for LTC placement by CCAC or family doctors in 50% of situations. That number increased to 76% when residents or families of residents are asked about the individual resident’s previous musical experience or musical preferences when assessed once they are residents in a specific LTC home.
Section 6 – Conclusions and Implications

In phase one, 5 Ontario LTC homes were purposefully sampled to discover how LTC leadership perceives and understands music care, and how it is delivered. In phase two, a stratified sample which included 50 Canadian LTC homes completed a survey, designed to expand on the seven factors of music care delivery from phase one and to investigate how music care is understood.

This section will make meaning of the two phases in relationship to one another and emphasize key aspects of music understanding in LTC. Uses of music according to music care domain will be discussed. Congruencies and incongruencies in music care delivery found across phase one and two will also be discussed.

Keys aspects in understanding music care in Canadian residential LTC

The most salient factor in music care delivery from phase one was attitudes about care and music care. It is an important factor because how both leadership and staff think, feel and behave about music and how music is valued will determine the resident/community's experience of music as a means of care. The following explanation describes key aspects of music understanding found in this study.

Music is essential in LTC. In phase one all but one participant thought music was important. Several thought it was critical. Five out of six residents claimed that music was the most important thing in their life. Results from phase two confirm these findings: Residents value music in care the most. Leadership and families highly value music in care.
Staff values music less than residents in LTC. This may be one of the reasons why staff music listening areas are found in only 28% of LTC facilities. Music may not be perceived as a necessity for staff wellbeing. That being the case, staff may not fully understand all that music can do to bring quality of life and care to residents or that music care is perceived by staff as more “workload” on an already overtaxed schedule. It may be that residents perceive LTC as “home”, inferring that music is part of home life and that staff see LTC as “job”, tasks to be done. If a staff member does not appreciate music, then the economy of music in care may diminish for that employee. Staff’s inexperience with the therapeutic benefits of music may also explain this discrepancy or there may be scepticism because music is a non-pharmacological means of care. Survey results showed that in three provinces, PEI, NS and BC, staff highly value music. In this instance, it may be the value of music in the community-at-large and/or the value of the LTC home as a continuing part of the community-at-large that results in congruent valuation between staff and residents. As well, these provinces experience music as a coalescing agent in their community-at-large i.e. ceilidghs, kitchen parties, indigenous rituals. Shared musical community experience may be a determinant for staff and residents to value music in care more proportionately.

Music impacts quality of life, and quality of care in LTC. Another key understanding has to do with the impact of music on quality of life, quality of care in the resident experience in LTC. While the literature attests to the benefits of music to the general population and the benefits of specific music therapy or music medicine interventions i.e. programs, protocols, within a specific LTC populations i.e. dementia, Parkinson’s disease, literature that reveals how music in general specifically affects residents in LTC is less likely to be found.
Phase one interviews show that all leaders perceive that music benefits residents. Phase two corroborates these findings. Table 17 summarizes the collective results and groups the perceived benefits under headings of quality of life, and quality of care.

<table>
<thead>
<tr>
<th>Area of Benefit</th>
<th>Perceived benefits of music by LTC leaders</th>
</tr>
</thead>
</table>
| Quality of life | • Enhances meaning, purpose, spiritual experience  
• Promotes comfort, relaxation, calm, solace  
• Elevates mood  
• Motivates  
• Evokes pleasure and happiness  
• Allows for easy flow of emotions  
• Distracts from pain, anxiety  
• Reduces isolation and boredom  
• Supports palliative and end of life care  
• Improves focus  
• Improves self-awareness, reconnect with self through reminiscence  
• Provides continuity in transitioning from the community to LTC  
• Provides social engagement and sense of belonging  
• Supports cultural interests |
| Quality of care  | • Relaxes the atmosphere of the facility  
• Supports rehabilitation i.e. gait improvement, language reacquisition, improving gross motor skills  
• Helps to positively change behaviours i.e. agitation, wandering, crying  
• Stimulate senses, cognition, lucidity, appetite, activation  
• Enhance care routine i.e. transfers, feeding, hygiene  
• Promotes movement, blood flow, oxygenation |

Table 17. Benefits of music in LTC

In phase one, most interviewees have witnessed adverse effects of music on residents. In phase two, only 1 in 4 respondents believe music could affect residents adversely. Collective results show that adverse effects of music on residents can be described as irritation, agitation, and pain. Table 18 expands these findings.
<table>
<thead>
<tr>
<th>Adverse effect</th>
<th>Reported explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritation</td>
<td>Music perceived by residents as noise causes irritation and discomfort. Noise may be defined in terms of volume, mismatch of musical style and personal preference, or musical excess (too much music in the environment.)</td>
</tr>
<tr>
<td>Agitation</td>
<td>Music can induce aggression and agitation, even delusional thought, due to volume perceptions, heart rate or neural entrainment, and instrumentation. Agitated behaviours that escalate can become harmful to self and other residents and staff.</td>
</tr>
<tr>
<td>Pain</td>
<td>Music may evoke painful, sometimes traumatic memories and emotions for residents. For some residents, this will have a visceral effect resulting in irritation or agitation. For others, depression, apathy or withdrawal may result.</td>
</tr>
</tbody>
</table>

**Table 18. Adverse effects of music in LTC**

It is not surprising that leadership strongly believes in the benefits of music and is not as aware about the adverse effects of music. Few studies report music's adverse impact on residents in LTC. Popular culture documentaries like Alive Inside that highlight the positive effects of music on residents in LTC are helpful in promoting the use of music in LTC. However, music care doesn’t work in every case. Programs like Java Music Club\(^6\) or Buddy’s Glee Club\(^7\) or Health Arts Society\(^8\) don’t tend to elucidate on adverse findings of their programs in promotional materials.

*Music strengthens social agency in LTC.* Music is used in almost every LTC home included in the study and indicates the benefit of enhanced socialization. Both phase one and two results show that participants believe all caregivers can use music in their regular practice to enhance human connection and contact.

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\(^6\) Java Music Club is the first mutual peer support group designed for LTC by Canadian music therapist gerontologist Kristine Theurier. Music is a component of the program. [www.javamusicclub.com](http://www.javamusicclub.com)

\(^7\) Buddy’s Glee Club is a research-based singing program at Baycrest Geriatric Centre in Toronto conducted by Dr. Amy Clements-Cortes. [http://www.airspace.ca/sites/discoveryspace.upei.ca.airs2010/files/3.3_AmyClements-Cortes_ACC%20AIRS%20Buddys%20GLEE.pdf](http://www.airspace.ca/sites/discoveryspace.upei.ca.airs2010/files/3.3_AmyClements-Cortes_ACC%20AIRS%20Buddys%20GLEE.pdf)

\(^8\) Health Arts Society was started in BC by David Lemon. Currently there are chapters across Canada that promote live music in LTC in concert format performed by professional musicians. [www.healtharts.org](http://www.healtharts.org)
Music care needs to be understood in order to be optimized. In phase one, most interviewees had not heard of the term “music care.” Half of survey respondents in phase two had heard the term “music care.” Two-thirds of those who had heard the term music care operate from a social model of care. If the domains of music care were more understood in LTC and by the general public, a broader music care delivery in LTC could be optimized through demand.

There is a distinction between music care and music therapy. Music care may be misconstrued as music therapy. Music care recognizes that music can be used by all caregivers in an informed and intentional way. Music therapy is a specific scope of practice provided by experts in order to achieve specific therapeutic goals and outcomes. Music therapy is a dimension of music care and a historically significant means of music care delivery in LTC. This study shows how inconsistent music therapy services are delivered in LTC across the country in.

Music enhances culture change. Understanding music in light of the culture change happening in Canadian LTC made Revera a good choice in which to ground this research. Revera has provided leadership in culture change in its more than eighty homes across Canada. Seventy-eight (78) percent of respondents in the survey believe that music can enhance culture change. There may be bias in this finding as one of the strata for recruitment came from the Canadian LTC culture change conference. LTC needs to become a culture of imagination. A variety of words in phase one were used to describe the thinking in LTC leadership around music care: engrained, stagnant, short-sighted, lack of creativity, limited, reluctant, group-think. Most of these words came from the interviewees
themselves and were, in themselves, self-analysis or a summary statement to their responses. The survey instrument did not provide an opportunity to explore this thinking and did not directly or indirectly confirm these thinking patterns. However, music as an artful medium provides an opportunity for all members of the LTC community to become more inventive, creative, and resourceful.

**Uses of music according to domain**

Table 19 summarizes the collective uses of music in LTC from phases one and two and groups them according to music care domains.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community music</td>
<td>• Community groups doing entertainment</td>
</tr>
<tr>
<td></td>
<td>• Community access – residents going on musical outings</td>
</tr>
<tr>
<td>Music care specialties</td>
<td>• NONE REPORTED</td>
</tr>
<tr>
<td>Music therapy</td>
<td>• 1:1 visits</td>
</tr>
<tr>
<td></td>
<td>• Small groups</td>
</tr>
<tr>
<td>Musicking</td>
<td>• Drumming</td>
</tr>
<tr>
<td></td>
<td>• Karaoke</td>
</tr>
<tr>
<td></td>
<td>• Residents informally playing music</td>
</tr>
<tr>
<td>Music programming</td>
<td>• Choir, Glee Club</td>
</tr>
<tr>
<td></td>
<td>• Singalongs, Hymn Sings</td>
</tr>
<tr>
<td></td>
<td>• Handbell choir</td>
</tr>
<tr>
<td></td>
<td>• Dances, Pub nights, Happy Hour</td>
</tr>
<tr>
<td></td>
<td>• Music games i.e. bingo, trivia</td>
</tr>
<tr>
<td></td>
<td>• Celebrations i.e. birthdays, anniversaries</td>
</tr>
<tr>
<td></td>
<td>• Special events i.e. Valentine’s Day</td>
</tr>
<tr>
<td></td>
<td>• Time filler</td>
</tr>
<tr>
<td></td>
<td>• Java Music Club</td>
</tr>
<tr>
<td></td>
<td>• Recreation or exercise programs i.e. WII</td>
</tr>
<tr>
<td></td>
<td>• Religious services</td>
</tr>
<tr>
<td></td>
<td>• Chaplain visits</td>
</tr>
<tr>
<td></td>
<td>• Remembrance Services</td>
</tr>
<tr>
<td>Technology</td>
<td>• YouTube videos</td>
</tr>
<tr>
<td></td>
<td>• iPod/CD/radio/TV/computer for music listening</td>
</tr>
<tr>
<td></td>
<td>• Music libraries with CDs or iTunes library</td>
</tr>
<tr>
<td>Environmental sound</td>
<td>• Ambiance for common areas i.e. dining room, front entrance, lobby, spa, nursing stations</td>
</tr>
<tr>
<td></td>
<td>• Cuing for transitions</td>
</tr>
<tr>
<td></td>
<td>• Background music</td>
</tr>
<tr>
<td>Music medicine</td>
<td>• Sensory stimulation i.e. Snoezelen</td>
</tr>
<tr>
<td></td>
<td>• Rehab and restorative programs</td>
</tr>
<tr>
<td></td>
<td>• Palliative and end of life care</td>
</tr>
<tr>
<td>Music care training</td>
<td>• NONE REPORTED</td>
</tr>
<tr>
<td>Music care research</td>
<td>• Participation in Phase 1 or 2 of Foster Music Care study</td>
</tr>
</tbody>
</table>

**Table 19. Uses of music in LTC by Music Care domain**
Table 19 demonstrates a comprehensive understanding of how music care is being used in LTC as most of the music care domains are represented in reported uses. No reported use was found either in music care specialties or in music care training. Music care specialties are relatively new in Canada. Most LTC leadership may not be aware of their existence, especially in more isolated and remote areas. While almost all LTC homes report on using music in care, no homes in phase one and only 4% of homes in phase two engage in music care training. This is a troubling result as music can have both beneficial and adverse effects, thus raising the question how caregivers are trained to use music in an appropriate therapeutic way. Music care research was welcomed in both phases. Revere willingly provided venues for phase one and gladly received the summative feedback. A number of participating facilities in phase two have a research arm within their organization and admit this was their first time participating in music care research. Ninety-six (96) percent of survey respondents have asked to see final results. This indicates genuine interest in LTC leadership around music care and its delivery.

**Congruencies and incongruencies in LTC music care delivery**

Congruencies and incongruencies across the phases about music care delivery were found and will be discussed below.

*Music is mostly delivered by program staff.* The program staff delivers music care 98% of the time while the care staff 42% of the time. These results are not surprising as care staff is less trained to integrate music into tasks of caring, accordingly having no expectation of integrating music into care tasks. The incongruency, however, is clear: all
Interviewees and survey respondents thought that everyone should be delivering music, but the reality is otherwise.

*All facilities use technological methods of delivery.* CD delivery remains the highest delivery percentage at 96% of homes, while iPads/streaming are used 31% of the time. CD delivery may remain the most popular form of technological delivery because it is familiar to most residents. Headphones and wires do not get caught in clothing, bed sheets, or wheelchairs. CD players are cost efficient and can be easily moved. Streaming is a new technology. Not every LTC home is wireless or is technologically savvy. Phase two indicates that Directors of program are the least comfortable using digital technology. It may be that they are more social, interactive people and prefer direct engagement and contact with residents when delivering music care.

*Music needs to have priority in program delivery.* Most of phase one participants believed this to be true. Eighty (80) percent of survey participants strongly believed music should have priority in programming. This is consistent with the finding that music is in LTC.

*Residents’ musical preferences need to come first in music care delivery.* The literature shows that musical preference is an indicator of the efficacy of music care. This study found that country and folk music were the most preferred musical styles. This may be because these musical styles often tell stories that have strong human emotional bonds and may have accompanied residents through life passage i.e. first dance at a wedding, birth of a child. Folk music often tells the story of a region, and may even have been passed along to the residents at an early age in an oral tradition. Folk music may have personal and
cultural meaning for residents. Country/folk style preference may keep residents connected to their personal narratives. Religious music was the next most preferred style. All of the five homes in phase one had weekly hymn sings and use religious music in their church services. Jazz was the least preferred musical style. This was surprising as many World War II songs comprise jazz standards and these songs are often used in LTC programming, like dance, entertainment, and special events. Music that is preferred by residents needs to be the music that is used in LTC. Person-centred music care means that the preferences of families and caregivers music serve the preferences of each resident.

*Canadian LTC facilities are tight for dedicated music care space.* In the Revera homes, spaces often doubled for dining, programs, and music care delivery. In less than half of the 50 homes surveyed, there was a music-making space; only a quarter of the homes had a music listening area for staff. This may explain why staff-preferred music is often heard in LTC homes. There is little provision for them to listen to their preferred music in a designated area at lunchtime and on breaks. Almost two-thirds of the homes had dedicated music listening areas for residents. This is not surprising as staff will often “set up” a resident in an area to listen to music while staff carry on with other tasks. In all but one home, music was permitted to be played in the residents’ rooms, including double occupancy or ward designs.

*Musical outings for residents to attend musical events is challenging.* Community access for music events is influenced by number of residents and geographical location. The results show that the bed count in a LTC was a determinant for frequency of musical outings. Homes with 61-120 residents have the most outings per resident. Possibly, this
size of LTC home is the ideal size for musical outings for residents. It is often the size of homes in suburban settings and town settings where community access may be easier due to staffing and transportation availability.

*Varying ages of residents challenge music care delivery.* The ability to provide personalized or community music care programs that span seven decades based on musical styles and preferences is called “challenging” in phase one. Having expertise in this many music styles appears daunting to caregivers.

*Directors of Care have the greatest challenge engaging in music care.* This may be why only 18% of total respondents of phase two were Directors of Care. Directors of Care are typically concerned with medical matters and tasks like hygiene, feeding, bathing and transfers. They may give little thought to themselves or leadership to their team to integrating music into care tasks.

*Most LTC facilities do not have a music care plan.* Phase one demonstrates that the five Revera homes do not have a music care plan. Phase two indicates that 84% of respondents have no music care plan. Only a few homes in BC, Alberta and Ontario have an intentional music care plan. One reason for this may be that these are the provinces with the strongest number of practising music therapists in LTC. Based on phase one findings, the successful implementation of a music therapy program catalyzed more intentional music care planning on the part of the leadership.

*Funding is key for sustainable music care delivery.* In phase one, this is the most salient fact in sustaining music care delivery. Interestingly, 60% of survey respondents in phase two do not account for their financial investment in music care. This could mean that
leadership does not want to own the discrepancy between their beliefs and practice. Or it may indicate the ambiguity around where music care funding allotments need to be made. In a highly regulated LTC system government criteria determine funding. Often LTC is at the mercy of the regulating body to fund any perceived “extras.” Also, ambiguity of where to place music care – on the program track or the care track – may impact funding formulas. Results indicate that there is a wide variety of music care budgeting protocols and no standard practice.

*Music care education and training are practically non-existent in LTC homes.* While almost all LTC homes report using music in care, no homes in phase one and only 4% of homes in phase two engage in music care training. This may be because music care training is new. It may be that leadership assumes caregivers are cognizant of the impact their use of music in care is making on residents. The universality and accessibility of music generally creates the illusion that caregivers are equipped to use music in care.

*Caregivers may or may not be confident in using music in care.* Few phase one interviewees feel confident integrating music into their regular care practice, while 74% of phase two respondents state they are very confident in using music. This discrepancy may be explained by the form of data collection. In the interview process, feelings are explained and elaborated upon. In the survey response, a more specific answer with no explanation is selected. In phase one, most interviewees express discomfort in using digital technology, while in phase two and one-third express discomfort. Lack of education or in-servicing may be a reason for this discomfort.
**LTC homes are in varying stages of culture change.** While Revera’s model of care is social and one would assume having a greater affinity to using music in an integrated way, remnants of the dual track paradigm from the medical care model create ambiguity in actual music care delivery. This demonstrates that culture change doesn’t happen overnight and in the end must be embraced by all staff at local LTC homes.

**Valuing music in care and music care delivery readiness are not the same thing.** Less than half of the homes have music care resources readily available for staff, volunteers and residents to use. While music is valued, there is a disparity in the readiness factor for day-to-day delivery of music care. This may be due to lack of information, or lack of understanding in how to integrate resources into LTC. It may be due to budget constraints, or it may be due to a lack of forethought.

**Musical information upon intake is not consistent in LTC.** In phase one, community assessments rarely include music. All Revera homes in phase one did include questions about resident musical experience and preferences in the intake, but in phase two, only half of the homes include music questions in community assessments. Seventy-six (76) percent of the homes ask about a resident’s musical experience and preferences upon intake. This means there is no consistent assessment practice for a residents’ musical background prior to entry in Canadian LTC homes. This may be because a variety of intake forms are used. Referrals may come from different sources i.e. CCAC, family doctors. Some LTC homes may have overlooked this important transitional piece.
Study limitations

One limitation of this study is that it does not include data from regular staff, family and volunteers as well as Boards of Directors or agency officials of LTC in either phase of data collection. Any representative data of these groups would be based on perceptions of leadership.

While nine provinces are represented in phase two, data are not included from Newfoundland or the three territories. The number of homes from participating provinces does not represent the ratio of homes per province against the national total.

The stratified sample may represent LTC homes who already have bought in to music care. They were recruited at the Canadian LTC Culture Change conference, and other Canadian conferences where the researcher was a speaker.

The implications of this study are clear. Music matters in LTC. It is essential. Its currency impacts QoL and QoC in each facility. Music enhances culture change because of its social agency, creative nature and scope for optimization in the LTC care setting. Although there are gaps, motivation to deliver music care and to learn to use it more effectively is high. These results should motivate further research and direction for the use of music within the Canadian LTC community.

While congruencies in music care delivery are encouraging, incongruencies need to be addressed and will form the basis of recommendations put forward in the final section of this paper.
Section 7 – Recommendations

Because music care in LTC is essential, there are a number of immediate next steps that need to be taken. Recommendations that impact leadership, caregivers’ daily practice as well as vision for the future of music care in Canadian residential LTC are posited in this section. The results of this paper have brought to light a number of gaps or deficits in music care delivery. A model of thinking about music care was introduced that opens up, and in fact, expands music care delivery in Canadian LTC towards new possibilities. These recommendations will provide not only a nexus for moving forward but foundational steps for growth and development in music care.

Six imminent areas of need are identified as a result of this study, including music care education and training, optimization, integration, point person, sustainability, and research. Recommendations encompass these areas and can be incorporated into both to corporate management or facility strategic planning.

1. Equip LTC staff, volunteers, families and stakeholders with music care education and training.

Results from this research show that the implementation of music in care is conducted in LTC by staff without any basic training. The fact that only one in four respondents believed music can have adverse effects on residents underscores the need for a baseline music care training for LTC staff. LTC stakeholders will also benefit from evidence-based education that will substantiate budget and program rationales. Music will be content that staff, volunteers, families, stakeholders, and residents will learn about if LTC facilities become centres of learning as the CHA recommends (CHA, 2009). Places of training i.e. colleges, online courses, universities, for PSWs, nurses, recreation therapists...
and aides, activationists need, at the very least, a module or course of study on music care within their formative training. Curriculum for music care training needs to include music care principles, tools and strategies applied to the LTC context and a basic understanding of the impact of sound and musical elements i.e. rhythm, melody, timbre on the LTC environment and in whole person care.

2. **Optimize music care by intentionally locating existing efforts and developing new endeavours using 10 Domains of Music Care (Appendix 9) as a guide.**

   This research paper refers to the social agency of music as well as the therapeutic benefits music-based interventions can bring to enhance QoL and QoC in LTC settings. *10 Domains of Music Care* provides a theoretical framework on which to base, develop, strengthen and expand comprehensive music care programs in LTC.

3. **Integrate music into all aspects of care.**

   Harmonizing music with all aspects of LTC means thinking about using music in light of each resident’s experience and preferences along the LTC trajectory, from intake forms until end of life care. Music may become a first line of care response for behaviours rather than medication. Cross-functional uses of music rather than recreation-driven uses of music are to be encouraged. Caregiver singing and humming may accompany care tasks like transfers, bathing, eating. It is essential to locate optimal spaces where music can mitigate anxiety, and ease transitions. Music must be promoted as a means of staff and family self-care. Musical entertainment, music-making and community access to musical events become normative. Programs that integrate music in some form will be optimal. Integrating music will also mean that there are residents who may prefer to have silence
4. **Invest in music care as an accountable and sustainable component of LTC.**

At a facility level, to bury music care costs in program budgets causes music’s essential value to diminish and its integrative potential in LTC to be lost. As a result, no provision is made for accountability and sustainability of music care programming. Music care funding must be allocated between the two envelopes of nursing and program reflecting actual costs. There needs to be a funding model in place to recognize music therapists as an integral service provider in LTC and be compensated like other therapists.

5. **Appoint a music care point person.**

The music care point person will provide leadership and advocacy in music care. Ideally this person will be a full time music therapist who provides clinical music therapy services, oversees music care delivery readiness and training onsite for all members of the community, and assists with resident variabilities. At a corporate and regulatory level, funding into LTC must be released for innovative care approaches like music care that are cost effective, holistic and flexible.

6. **Inquire systemically about music care in LTC and translate it for use.**

If music care is to be an accountable and sustainable component of LTC, then evaluation and metrics of the impact of music in the LTC setting needs to be deliberate and robust. Research centres need to develop relationships with LTC providers to further inquiry. While evidence base and measures are helpful, knowledge translation for end users like PSWs and recreation aides will be most advantageous. Topics for further research that emerge from this study include:
• What are the effects of early music care assessment in LTC placement on resident sociability and belonging?

• What are the benefits of musical prescriptions for residents in LTC (quantitative measures)?

• What are the effects of music compared to pharmacological interventions in LTC residents with behaviours (quantitative measures)?

• What is the cost savings of music-based strategies compared to pharmacological interventions in LTC?

• How does environmental sound enhance QoC in LTC (quantitative measures)?

• What are the effects of music on QoL and QoC in LTC using validated measures?

• What are predictors for adverse effects of music on residents in LTC?

• How do LTC staff perceive the value of music in care (or family/volunteer perceptions)?

• How do music therapists become agents of LTC culture change while also maintaining clinical services?

• What are the factors for music care delivery in all types of LTC facilities in Canada (quantitative measures)?

• What is the impact of music care at the end of life for LTC residents? Their families? Other residents? Staff?
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Appendix 1 – Phase One - Project Overview

Factors in implementing and integrating Music Care in 5 Revera LTC residences

Project Overview

Background

Music is an intricate part of life passage and human experience. Its effects can invigorate or calm us, excite and persuade us, call us to arms and lift our spirits. Music helps us connect and recollect through shared events, shared emotions and shared ideas.

There is a 21st century awakening to the power of music in care. This is in part due to the neuroscientific capacity to measure the effects of music on the brain with various imaging techniques and therefore be able to more precisely describe musical effects on mind-body-spirit. It may be in part due to the capacity to deliver music with personalized devices i.e. mp3. It may also be in part due to an aging population that is made up of baby boomers. Music has historically been entwined with the identity and culture of boomers (Galbraith, 2005).

As boomers begin to enter long term care facilities, the practice of music care will be challenged and need to be a more accountable component of the care delivery system. While residential long term care encompasses various demographics of the population that need chronic care, it is predominantly older adults and frail elderly persons that inhabit LTC.

Current research suggests that music is beneficial to older adults in a number of ways as it reaches into every domain and offers whole person care. Music enhances social integration and pleasure and provides a background for transition into eldercare facilities (Clair, 1996; Rio, 2009; Foster, 2011; Rickard & McFerran, 2012). Music improves quality of life in Alzheimer care including connection, feeding, lessening agitation and depression (Aldridge, 2000; Engstrom et al, 2012; Janata, 2012). Music can be used for rehabilitation. For example, certain musical tempi and styles improves gait in various trajectories i.e. PD or stroke (Thaut, 1996, 1997). Music may assist in aspects of end of life care i.e. relationship completion, reminiscence (Clements-Cortes, 2009; Snyder, 2000). Music may improve the quality of sleep in older adults (Lai & Good, 2005) and enhance exercise and recreation (Clair, 1996, O’Konski et al, 2010). Music provides cognitive stimulation in a variety of care situations in residential LTC (Koen, 2008).

Music care in long term care settings has traditionally been delivered in three ways: as a specific intervention through music therapy, as entertainment through program and activation and as a means of person-centred care through technology.

There are currently no standardized methods or requirements for music care practice in long term care. Implementation of music care may be well integrated, irregular or somewhere in between. It is up to the
individual providers to define, determine and deliver music care according to what they understand and believe music care to be.

**Research Approach**

Executive Directors and Directors of Care in long term care facilities are the gatekeepers in putting policy into practice and offering care services, and this applies to music care. Their understanding of music’s capacity, attitudes and provisional practices are critical to the effective integration of music care among residents in long term care. Program staff (i.e. recreational therapists or activity professionals) is responsible to implement residents’ personal and communal activities as an outworking of care philosophy and strategies of the entire leadership team. Resident councils represent the people being served that are living in residential long term care.

This research project will take a qualitative approach to studying the factors in implementing and integrating Music Care in long term care facilities. Three major contexts will be explored: perceptions of music care by gatekeepers and program staff, implementation and integration of music care in 5 LTC facilities and factors that may explain gaps between perceptions and reality of music care delivery.

**Research Question**

What are the perceived factors Executive Directors, Directors of Care, Recreation/Program Leaders and residents have in implementing and integrating Music Care in residential long term care?

**Roles & Responsibilities**

**Researcher** – Bev Foster, MA student at the Faculty of Music, University of Toronto
- Contact Revera head office and work with Revera Liaison to solicit home participation
- Set up and conduct all research
- Transcribe, analyze and prepare final report
- Be accountable to U of T Supervisor and Revera Liaison

**Research Supervisor** – Dr. Lee Bartel, Associate Dean, Faculty of Music, University of Toronto
- Supervise all aspects of research project

**Revera Liaison** – Joanne O’Keeffe, Provincial Director Recreation and Rehabilitation, Revera Inc.
- Obtain program permission from Revera to conduct study
- Act as study liaison on behalf of Revera Inc.

5 Revera LTC residences in Ontario
- Provide written consent to participate for study participants including Executive Director, Director of Care, Recreation/Program Leader and resident
- Establish connection with Residents’ Council representative
- Establish a 3 hour block of time for researcher to visit facility and observe, collect relevant documents and conduct 4 X 30 min one on one interviews
- Provide a quiet and private space for interviews to take place
Evaluation Materials

- Interview Protocol (see attached)
- Observation & Document Protocol (see attached)

**Note**- these protocols will be pilot tested prior to use by Revera

Study Methods

This qualitative study has received approval by the University of Toronto research ethics committee and will be conducted with the full support of Revera’s provincial program leadership in 5 Ontario Revera LTC residences.

Study participants (LTC Homes) will be purposefully selected as a concept sample in conjunction with Revera, including 1 with a music therapist, 1 urban site with homogenous ethnicity (i.e. Ukranian), Uxbridge (local and rural), 1 urban with diverse ethnicity, 1 “remote”. A representation of residence size will also be considered.

Each site will receive a letter of purpose describing the study and a consent form for interviewees. There must be agreement that the Executive Director, Director of Care, Recreation/Program Leader and Resident Council representative will each, one-on-one, be interviewed by the researcher for a maximum of 30 min each in a quiet space on the same visit. Permission for the researcher to do observational and document collection will also be sought as applicable.

Data collection includes 4 interviews at each site following an interview protocol that will be audio recorded and later transcribed for analysis as well as the researcher walking through the facility following an observation and document protocol.

The researcher will analyze emerging themes from the interviews and integrate with data observed and collected (documents) and report findings to the University of Toronto Faculty of Music and Revera Inc.

Timeline

*Project start: January 21, 2013*
*Project end: April 30, 2013*

January 21 – Seek approval from Revera Inc.
January 22 – January 31 – Determine 4 more participating Revera sites (Mike MacDonald from Uxbridge has already agreed)
Feb 1 – set up site visit, send out research package to participating facilities and pilot protocols
Feb 15 – Mar 31 – conduct research and transcribe interviews
Apr 1 – April 21 – research analysis
April 22 – April 30 – finish writing research project report and submit to Revera and U of T
Appendix 2 – Phase One - Interview Protocol

INTERVIEW PROTOCOL

Factors concerning implementation and integration of music care in 5 Revera LTC residences

Time of Interview: ____________________________________________

Date: _________________________________________________________

Place: _________________________________________________________

Interviewer: Bev Foster

Interviewee: ____________________________________________________

Position of Interviewee: _________________________________________

Questions:

1. What is your role at this facility?
   - Describe what sorts of decisions you make concerning program, personal care.

2. Do you think music is an important part of resident care? Why or why not?
   - Have you seen any benefits of music on residents? (domains)
   - Have you seen residents adversely affected by music?
   - How would you rate the level of interest in music as care at this LTC?

3. How is music implemented at this LTC?
   - Programs?
   - Family involvement? Community access? Personnel? Volunteers?
   - Budget line?
   - Other?

4. How is music integrated into a resident’s daily life?
   - If it is not integrated, why not?
   - Is there any question about musical preferences on intake form?
   - Is there a music care plan for the facility or in personalized care plans?
   - Whose job should music care be?

5. I’m going to give you a term and I want you to tell me what it means to you: Music Care.
   - Have you heard of this term before?

6. In an ideal world, what would music care in a residential long term care facility look like?
   - How do you feel this LTC measures up to your ideal?
   - For you, what are the barriers to realizing this ideal?
Appendix 3 – Phase One - Observation Protocol

Factors concerning implementation and integration of music care in 5 Revera LTC residences

OBSERVATION & DOCUMENT PROTOCOL

Time to Observe: ________________________________________________________________

Date: __________________________________________________________________________

Places with Permission to Observe:
______________________________________________________________________________
______________________________________________________________________________

Observer: Bev Foster

Observation/documentation onsite supervisor:
______________________________________________________________________________

Observations:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Documents to catalogue or copy (i.e. assessment forms, program plans or logs):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Appendix 4 – Phase One - Participant Consent Form

Consent to participate in research

Dear participant

I am conducting a small research study as part of a requirement for a graduate course, Research Methods in Music Education (MUS2111H) at the University of Toronto. This course requires students to conduct research into the ways people learn, value, and respond to music. The title of my research study is: *Factors in implementing and integrating Music Care in 5 Revera LTC residences*.

In this study I am conducting audio recorded interviews with Executive Directors, Directors of Care, Recreation/Program Leaders, and 1 Resident Council representative observing implementation and integration of music care as well as collecting any documents used in delivery. The visit to your facility will take 3 hours (approx. 20-30 minutes each for 4 interviews, 30 minutes for observation and 15 minutes to collect relevant documents.

The design and conduct of this study is being supervised by Prof. Lee Bartel and has received approval by the University of Toronto research ethics committee. You are free to contact Dr. Bartel at any time at 416-978-0535 or you may contact the University of Toronto, Office of Research Ethics (ethics.review@utoronto.ca, 416-946-3273).

I hereby invite you to be a volunteer participant in my study. Your participation is entirely voluntary and you may withdraw at any time by indicating this desire to the researcher. Your identity related to any information you provide will be rigorously guarded. Your anonymity will be assured in any paper submitted for the course and in any related publications. Confidentiality will be maintained throughout the research process – your identity or that of your institutional relationship will not be revealed to fellow classmates. Any data collected will be guarded in a secure private location in my home office and will be destroyed 6 months after collecting.

Please read the following and sign to give me your permission.

With kind regards

Bev Foster, BEd, BMus, ARCT, AMus, MA student

I understand that the information I provide here may be quoted by Bev Foster in academic presentation or publication but that my identity or that of anyone I refer will remain anonymous and confidential. I understand I am free to withdraw from this study at any time. I hereby agree to participate and to allow information I provide to be used in this research study.

______________________________   ______________________________   ____________
Printed Name                        Signature                        Date
Appendix 5 – Pre-interview Agenda

Music Care Study - Site Visit Agenda

1. Picture of outside of building

2. Meet with contact and:
   - Establish interviewees’ names
   - Consent form
   - Time of meeting
   - Location
   - Confirm observation and document protocols (assessment forms, program plans, logs)

3. Interviews
   - Review purpose of study –
     - U of T Music Masters student – research project
     - Working with Revera – interest in Music Care - 5 Ontario homes, 1 in each region
     - Interest is in how music is being implemented and integrated into care
     - Triangulated qualitative study – 360 view
     - Results – paper, Revera – if we do outside publication, we’ll keep name of facility anonymous
     - Interviewees names are anonymous in write up – known by role
   - Questions?
   - 20-30 minutes – audio recorded – I will transcribe
   - Copy of report will be given to Joanne O’Keeffe if you are interested in reviewing it – mid-May
   - GIFT with thanks

4. Observation/Document protocol
Appendix 6 – Phase Two – Covering Letter to Participants

Understanding Music Care and Music Care Delivery in Residential Long Term Care

Research suggests that music is an important part of quality of life in older adults. Music becomes, therefore, an important part of quality of care for an aging population. Music care is an emerging approach that believes all of us can use music for health and well-being in our own lives and in those we care for. Music care is comprised of ten domains: community music, music care specialities, music therapy, music programming (formal and integrated), technology, environmental sound, music medicine, music care training and music care research.

As a requirement for my MA in Music Education from the University of Toronto’s Faculty of Music, I am conducting a research study in two phases that looks at how LTC leaders understand music care and how music care is delivered in residential long term care homes. Last year, I completed phase one of the study within five residential long term care homes in Ontario. In this qualitative study, seven factors emerged in considering what influences music care delivery.

In phase two, I would like to clarify LTC leaders’ understanding of music care as well as test whether the seven emergent factors hold true for other residential long term care homes. This time, the study will be quantitative, in the form of a survey. I would like to invite you to be part of this study in order to help me understand how music is implemented and integrated in your long term care community. The survey should take approximately 20 minutes to complete and must be completed by May 31, 2014.

Your participation in this research is voluntary. Your personal information will remain confidential. Please understand that use of this data will be limited to this research, as authorized by the University of Toronto, although results may be presented in formats such as journal articles or conference presentations. You will be asked to give informed consent at the beginning of the survey. You have the right to express concerns to me or my professor, Dr. Lee Bartel at the U of T Faculty of Music or the Office of Research Ethics at the University of Toronto (numbers are below).

I am grateful for your time and participation in the music care study. In appreciation for taking the time to complete and send back the study, your name will be entered into a draw for an iPod touch, valued at $300. There will be 50 participants in this study.

Thank you in advance for your time and effort. I hope the results of this study will serve to improve the quality of person-centred care to long term care residents in Canada.

Contact Information:
Primary Investigator: Bev Foster bfoster@room217.ca 289.354.0217
Supervisor: Dr. Lee Bartel lbartel@chass.utoronto.ca 416.978.3740
U of T Office of Research Ethics ethics.review@utoronto.ca 416.946.3273
Appendix 7 – Phase Two – Survey Protocol

Understanding Music Care and Music Care Delivery in Residential Long Term Care

Thank you for volunteering to complete this survey.

- The purpose of this survey is to clarify people’s understanding of music care in residential long term care homes and identify factors that influence music care delivery in this setting.
- The survey will take approximately 20 minutes to complete.
- You may leave any questions blank that you do not feel comfortable answering.
- All data you supply here will be encrypted with SSL for transmitting information securely over the Internet.

Section I – DEMOGRAPHIC INFORMATION

1. Do you agree to allow us to use the data you supply for report purposes as described above? (Y/N)
2. My name is: __________________________
3. My role at my LTC home is:
   o Executive Director
   o Director of Care
   o Director of Program
   o Other (Please specify): __________________________

Section II – INFORMATION ABOUT YOUR LONG TERM CARE HOME

4. Name of town or city and province where my LTC home is located: __________________________
5. How long have you worked at this LTC home?
   o Less than a year
   o 1-5 years
   o 6 years or more
6. Do you live in the same community as the LTC home where you work? (Y/N)
7. Please indicate how many beds are in your LTC home:
   o Less than 60
   o 61-120
   o 121-200
   o More than 200
8. Please indicate whether your LTC home serves residents in these age groups:
9. I would describe the philosophy of care in my LTC home as:
   - Traditional medical model
   - Person-centred model
   - I’m not sure

Section III – DEFINING MUSIC CARE

Music care is an approach to care that implements and integrates music with intention, allowing the therapeutic principles of sound and musical effect inform us. Music care is not a specific practice, rather a paradigm within which music is inherently understood to be part of the life cycle, and therefore, plays an integral role in all aspects of caregiving and care settings. Music care is comprised of ten domains: community music, music care specialities, music therapy, music programming (formal and integrated), technology, environmental sound, music for staff/family/volunteer wellness, music medicine, music care training and music care research. Historically in long term care settings, common domains of music care include programming, music therapy and community music.

10. I have heard the term “music care” before. (Y/N)
11. I think music care is the same as music therapy. (Y/N)
12. In your opinion, who, in long term care, ought to be engaging in music care? (Circle all that apply)
   - Program Staff
   - Care Staff
   - Families, volunteers, community groups
   - Everyone
   - I don’t know
   - Other ________________________________

13. The leadership team at my LTC home perceives the value of using music in care to be:

<table>
<thead>
<tr>
<th>Very low</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Very high</th>
</tr>
</thead>
</table>

14. The residents at my LTC home perceive the value of using music in care to be:

<table>
<thead>
<tr>
<th>Very low</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Very high</th>
</tr>
</thead>
</table>

15. The staff in my LTC home perceives the value of using music in care to be:

<table>
<thead>
<tr>
<th>Very low</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Very high</th>
</tr>
</thead>
</table>

16. The families of residents in my LTC home perceive the value of using music in care to be:

<table>
<thead>
<tr>
<th>Very low</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Very high</th>
</tr>
</thead>
</table>

17. I think music is beneficial to residents in my LTC home:

<table>
<thead>
<tr>
<th>Never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>All the time</th>
</tr>
</thead>
</table>

   - If you answered “3” “4” or “5”, please list 3 ways you think music benefits residents in your LTC home.
18. I think music can affect residents in my LTC home adversely.
   Never 1 2 3 4 5 All the time
   ○ If you answered “3” “4” or “5”, please describe why you think music can have an adverse effect on people.

19. I think music can enhance culture change in my LTC home.
   Never 1 2 3 4 5 All the time

20. I think music should be prioritized in our programming.
   Strongly disagree 1 2 3 4 5 Strongly Agree

21. How confident do you feel using music in your practice of care?
   Not at all 1 2 3 4 5 Very much

22. How motivated would you be to receive music care training?
   Not at all 1 2 3 4 5 Very much

23. My comfortability with using digital technology to deliver music care is:
   Weak 1 2 3 4 5 Very Strong

Section IV – MUSIC CARE DELIVERY IN LONG TERM CARE

24. Music is used in my LTC home. (Y/N)
   ○ If yes, list 3 ways music is used in your LTC home.

25. Who does deliver music care in your LTC home? (Circle all that apply)
   ○ Program Staff
   ○ Care Staff
   ○ Families, Volunteers, Community groups
   ○ Other ____________________________

26. Is there a music therapist on staff at my LTC home? (Y/N)
   ○ If yes, how many hours of music therapy is there per week at your LTC home?
     ○ 1-2 days a week
     ○ 3 or more days a week

27. Music care training is conducted in my LTC home:
   Never 1 2 3 4 5 All the time

28. There is someone in my LTC home (staff, volunteer, or resident) who has technical expertise and would help me or other staff learn to deliver music care via technology. (Y/N)

29. How readily available are music resources for staff or volunteers in my LTC home who wish to use music in delivering care?
   Not at all 1 2 3 4 5 Very much

30. How readily available are music resources for residents who wish to make or use music in a non-programmed (non-structured) way?
   Not at all 1 2 3 4 5 Very much

31. Residents in your LTC home are allowed to play music in their rooms. (Y/N)
32. There are dedicated areas in my LTC home for music-making. (Y/N)
33. There are dedicated areas in my LTC home for music listening. (Y/N)
34. There are dedicated areas in my LTC home for staff to listen to music. (Y/N)
35. Residents are given the opportunity to attend musical events outside of my LTC home:
   o Once a month
   o Once a year
   o 2-3 times per year
   o Never
36. My LTC home has a music care plan. (Y/N)
37. My LTC home has a music care budget. (Y/N)
   o If yes, please check the allocation that is budgeted for all aspects of music care in your LTC home, including resources, personnel, entertainment.
      o Under $2,000
      o $2001-10,000
      o More than $10,000
38. Residents or families of residents are asked about individual residents’ previous musical experience or musical preferences when assessed for LTC placement. (Y/N)
39. Residents or families of residents are asked about individual residents’ previous musical experience or musical preferences upon entering my LTC home. (Y/N)
40. The style of music that best describes the musical preferences of residents at my LTC home is:
   o Classical/Traditional
   o Country/Folk
   o Jazz
   o Pop/Rock
   o Religious
   o Other __________________________________
41. Is technology used to deliver music in your LTC? (Y/N)
   o If yes, please circle the technology used to deliver music care in your LTC home.
      o Radio/television
      o Stereo systems/CD players
      o Mp3 players/iPods/blue tooth
      o iPads/streaming
      o Other ________________________________
42. Is there anything else you’d like to say about music care delivery in your LTC home?
Appendix 8 – Phase Two – REB Consent Letter

PROTOCOL REFERENCE # 30095

March 25, 2014

Dr. Lee Bartel
FACULTY OF MUSIC

Mrs. Bev Foster
FACULTY OF MUSIC

Dear Dr. Bartel and Mrs. Bev Foster,

Re:  Your research protocol entitled, "Understanding music care and music care delivery in residential long term care"

ETHICS APPROVAL

Original Approval Date: March 25, 2014
Expiry Date: March 24, 2015
Continuing Review Level: 1

We are writing to advise you that the Social Sciences, Humanities, and Education Research Ethics Board (REB) has granted approval to the above-named research protocol under the REB’s delegated review process. Your protocol has been approved for a period of one year and ongoing research under this protocol must be renewed prior to the expiry date.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.

If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Sarah Wakefield, Ph.D.
REB Chair

Dean Sharpe
REB Manager

OFFICE OF RESEARCH ETHICS
McMurrich Building, 12 Queen’s Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada
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Music care is an approach that believes all of us can use music for health and well-being in our own lives and in those we care for. Music care is about using music with intention, knowing that therapeutic principles of sound and music affect us and can have specific outcomes. Music care integrates sound, silence and music into life, paying close attention to how interpersonal connection and human contact is enhanced through musical associations. Music care aims to enhance well-being and quality of life for all people. Music care delivery is comprised of informed and intentional musical implementation and music integration in a health care setting. Ten domains of music care delivery include:

- **Community Music**: individuals or organizations that partner with the healthcare team to provide musical services or entertainment in the facility
  - Arts-in-Health partnerships, piano performer for the lobby at Christmas, blues band for summer barbeque in the courtyard

- **Music Care Specialties**: individuals that bring their training and experience in music care to a healthcare setting
  - Harp Therapist, Music Thanatologist, Bedside Singers

- **Music Therapy**: a specific scope of music care practice that uses music and musical tools to address clinical goals and objectives within a therapeutic relationship
  - Examples of client populations: mental health, rehabilitation, palliative

- **Musicking**: formal or spontaneous music-making, within person-centered care of patients, families of patients, facility staff and volunteers, and is specific to the interest, ability and personal relationship to music of each care partner
  - Playing instruments, singing

- **Music Programming**: staff or volunteers within the facility who plan for and employ the use of music into recreational or therapeutic programs that are delivered to individuals or groups
  - Formal – Recreation Therapist using music within program i.e. Sing-along, listening groups
  - Integrated – Occupational Therapist using music in rehabilitating gait performance, Speech Therapist using music to regain verbal ability

- **Music Technology**: the intentional use of technology and staff training to use technology to suit patients’ musical needs or staff’s treatment goals
  - Bedside music terminals, iPod programs for sleep assistance or pain management

- **Environmental Sound**: intentionally setting ambient healing sounds in the facility
  - Recording of Tibetan bowls in prayer room, sounds to accompany labyrinth experience

- **Music Medicine**: the prescriptive use of music strategies in healthcare for medical-related outcomes
  - Research examples: neurobiological processing of music, pain management

- **Music Care Training**: educating care providers, caregivers and other stakeholders (i.e. teachers) in the integration and implementation of music in care
  - In-services, training programs, webinars, certificate program

- **Music Care Research**: the use of systematic evidence for music and its use in healthcare
  - Neurobiological processing, music psychology, stroke rehabilitation