RESEARCH

How Residents' Quality of Life are Represented in Long-Term Care Policy: A Novel Method to Support Policy Analysis

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Context: In one's final years, quality of life (QoL) is a fundamental desire. In Canada, a publicly-funded long-term care (LTC) system is governed provincially through multiple policies about housing and care provision. A pan-Canadian research team investigated federal and provincial policies' influence on the QoL of older people living in residential LTC in four provinces: British Columbia, Alberta, Ontario, and Nova Scotia.
Objective(s): This paper describes a novel method of policy analysis developed by the authors to analyse the inclusion of QoL domains within these LTC policies, and assess implications for residents, their families, and staff.
Method(s): Within the novel method mentioned there were four stages in the method that consisted of an iterative and collaborative approach to understanding the relationships between LTC regulations and resident QoL domains through four perspectives (resident, staff, family, volunteer). At first, inclusion/exclusion criteria were applied to select appropriate policies, and secondly, policy texts were to coded according to Kane's (2001) QoL domains. The third stage involved assigning a level of regulatory power, with the final stage interrogating the policy categorisation data from four perspectives: residents, families, volunteers and workers.
Findings: The outcome revealed a dominant discourse of safety, security, and order over other domains such as dignity, privacy, and spirituality.
Limitations: Policies dictate regulatory and guiding principles, and are only one part of the story. *How* these policies are implemented is beyond the scope of our research, but we recognize that understanding these implementation practices are essential to fully capture the experiences of residents, their families, and staff.
Implications: This novel method is useful in exploring how QoL is supported across a high number of complex cross-jurisdictional policies. We conclude that our approach to policy analysis enables a re-examination of policies affecting LTC and assesses whether these policies reflect the values of the residents and society at large.

Keywords: Long-term care policy; Quality of Life; policy analysis; nursing homes; late life; Canada

Introduction

Internationally, there have been several decades of discussions about the best approaches to improve quality of life (QoL) for residents in long-term care (LTC) facilities. In Canada, each province has jurisdiction over its publicly-funded LTC system, which results in multiple rules and policies about the provision of housing and care for those who need it. The many levels of policies produce confusing and sometimes conflicting documents that fail to clarify how policies can better work together to support residents' QoL. Our research team worked towards understanding how multiple policies in each province

interacted with each other to achieve QoL for residents (Keefe, Taylor and Cook, 2020).

Quality of life is a human interest that becomes more profound as we age, no matter where we live. In one's final years, QoL is a fundamental desire, yet often policies focus on quality of care, typically measured by clinical outcomes rather than residents' and/or their families' perspectives (Spilsbury *et al.*, 2011). The policies that instruct on quality of care also instruct, explicitly or implicitly, on QoL. Policy researchers have emphasised the need to explore how policy supports older LTC residents' QoL given the desire for a rich QoL at the end of life (Johs-Artisensi, Hansen and Olson, 2020). For decades there has been a dominant social discourse that often emphasises quality of care over QoL, and as such, reduces residents' options for a meaningful QoL preferences (Daly and Szebehely, 2012). Our study team worked towards understanding

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how we may raise the profile of QoL by examining how multiple policies in each province work together, or not, to achieve QoL. This paper describes a novel method to specifically assess policies for their recognition, and support of, directives that contribute to LTC residents' QoL.

Background

The provision of health care in Canada falls under both federal and provincial jurisdictions, with the federal government largely responsible for funding and oversight, and provincial and territorial governments administering and delivering care (Health Canada, 2019a). Although some of these jurisdictions overlap, "the provision of long-term care relies on a mix of public and private funding and varies in the way it is structured, organised, and delivered across every province and territory" (National Institute on Ageing, 2019, p. 9). Nonetheless, there is broad agreement about the need for quality of care (Canadian Institute for Health Information, 2020), and an increasing emphasis on person-centred models of LTC provision (Brownie and Nancarrow, 2013; Kitson *et al.*, 2013; Koren, 2010; National Institute on Aging, 2019; Sharma, Bamford and Dodman, 2015); in essence, a shift towards QoL.

The World Health Organization (Orley and Saxena, 1996) defines QoL as a multidimensional concept that rests on an individual's subjective appraisal of physical, psychological, social, environmental, and spiritual influences on their life. This research contributes to this literature by asking, "What policies support or offer barriers for promising approaches to quality of late life in long term care?" (Keefe *et al.*, 2020).

Policy Analysis Approach

Policy analysis aims to understand the effectiveness of policies to achieve their desired goals, such as exploring the reasons why policies are enacted or rejected (Browne *et al.*, 2019). However, fulfilling this aim presented a significant challenge for our policy team in aligning a diverse array of LTC-related policies at different levels across multiple provinces, compounded by the conceptual indeterminacy of QoL (Bangerter *et al.*, 2017; Lehnert *et al.*, 2019). The initial research plan was to use the National Collaborating Centre for Healthy Public Policy (NCCHPP) (2020) framework. As the project advanced, it was recognised that this logic model, while admirable in many policy analyses, did not easily bridge the LTC/QoL nexus because it did not adequately represent the multi-directional complexities that were difficult to clearly layout in a logic model format.

Interpretive policy analysis provided a viable solution for the desired policy analysis. With others (L'Espérance, 2013; Mann and Schweiger, 2009; Venturato, Moyle and Steel, 2011; Yanow, 2007), Brown *et al.* (2019) suggest that an interpretive approach addresses "how policy problems are defined or constructed" (p. 1934) and "how problem framing shapes the array of possible policy responses" (p. 1038); thus, this framework was the most salient for the specific goals of this research. It also enables assessment of each policy's emphasis on particular QoL domains.

Methodological Framework

We chose a hermeneutic approach in order to narrow our analytic focus on the written words in each policy. We did this intentionally to avoid making analytic decisions using peripheral contextual information, such as what the policy says versus what may happen in reality in LTC. The hermeneutic approach also provided a way to analyse policy content in its purest state, as distinct from how policy plays out in reality with respect to a variety of influences. This approach enabled the team to see new possibilities in how existing policy, when considered in multiple texts and in multiple regions, could support or inhibit QoL for residents. Previous studies show that theory-informed policy analysis is an effective research method for investigating healthcare systems (Bosch-Capblanch *et al.*, 2012; Koon, Hawkins and Mayhew, 2016), in which combining two frameworks can expand policy horizons and strengthen research outcomes (Roth, Dunsby and Bero, 2003; Venturato, Moyle and Steel, 2011). Correspondingly, we selected two intersecting frameworks to underpin our analytical approach: broadly, a modified hermeneutics method to understand and interpret policies (Balfour and Mesaros, 1994; Browne *et al.*, 2019; Mann and Schweiger, 2009; Yanow, 2007) and content analysis to describe and categorise text (Bowen, 2009; Daw *et al.*, 2014; Elo and Kyngas, 2007; Schreier, 2014).

In addition, we used the 11 QoL domains described by Kane et al. (Kane, 2001; Kane *et al.*, 2003) to ensure that our analysis was grounded in QoL perspectives specific to older people living in LTC. We found Kane's domains–sense of safety, security and order; physical comfort; enjoyment; meaningful activity; relationships; functional competence; dignity; privacy; individuality; autonomy/choice; and spiritual well-being–most relevant for our policy analysis. These domains allowed the team to sort very complex QoL perspectives according to evidenced-based named categories. More recent literature on QoL in LTC were not suitable to use in an analysis of policy excerpts. For example, Kehyayan *et al.* (2015), Shippee *et al.* (2005) and Morris *et al.* (2018) underpin their exploration of QoL in LTC on the international Resident Assessment Instrument (interRAI). LTC residents' QoL priorities in Canada and the United States were ranked (Kehyayan *et al.*, 2015; Shippee *et al.*, 2005) and QoL homeness for LTC residents were evaluated in a development setting (Morris *et al.*, 2018). In contrast, Van Haitsma *et al.* (2019) created a new theoretical model of preference-based care grounded in resident's daily preferences. Policies, however, do not lend themselves solely to resident's choice and autonomy but address multiple, and sometimes competing, objectives. Kane's (2001; Kane *et al.*, 2003) domains had the most utility for applying a comprehensive analysis of how QoL is represented in policy for this research.

Method

Hermeneutic content analysis (Viera and de Queiroz, 2017) provided a cohesive method for deconstructing policy through a circular process of systematisation, coding, interpretation, understanding, and reflection. In this con-

text, hermeneutic interpretation examines written text in a reflective cycle of understanding (Mann and Schweiger, 2009), and qualitative content analysis involves word for word text interpretation, consistent and sequential steps, and flexible data-driven categorisation. We used a modified version of Mann and Schweiger's (2009) objective hermeneutics method to interpret and code policies according to Kane's (2001) QoL domain definitions. While some hermeneutics approaches to policy analysis involve interpreting policy intent and possible outcomes, Mann and Schweiger (2009) explain that the objective hermeneutics method focuses only on what can be interpreted from text itself.

Using this approach, we enacted three procedural levels in analysing and interpreting the content of policy documents: at first, a minimum of two researchers independently reviewed, identified, interpreted, coded, and categorised policy excerpts according to their relevance for LTC and QoL. Because "inter-coder reliability…is of particular significance" in content analysis (Mayring, 2014, p. 42), the researchers formed consensus through multiple review meetings. A second level of confirmatory analysis was then conducted by the principal investigators following similar steps, and in the final instance, the findings were presented to senior policy makers for their feedback. This in turn, informed our final decisions regarding policy document inclusion and policy interpretation.

This research had favourable ethical opinion from the Mount Saint Vincent University Research Ethics Board (2019–021) and the Interior Health Research Ethics Board (2019-20-034-I).

Analytical Framework

Van Hulst and Yarnow's (2016) analytic framework also informed the analytic process. Closely aligned with the hermeneutic interpretative orientation, policy framing represents a dynamically responsive and engaged approach to policy analysis (refer to Koon, Hawkins and Mayhew, 2016 for a comprehensive review) via a series of phases (sense-making, categorising, selecting, naming, framing, story-telling). To explain these stages briefly, (recursive) sense-making is an interactive *conversation with a situation*, whereby details and generalities interrelate to create greater clarity and emergent meaning/s; categorising, selecting, and naming relate to interpretive data reduction; framing builds on a prior knowledge and provides an organising scaffold to guide further action; and, story-telling weaves together these elements to form a coherent model of the analytic process (Van Hulst and Yarnow, 2016). Earlier work (Capoccia and Kelemen, 2007; L'Espérance, 2013; Van Hulst and Yarnow, 2016) indicate that transitions between these phased *circles of understanding* can be triggered through tipping points leading to *re-framing,* or alternatively, by a longer, deliberative period of *frame reflection.*

Analytical Process
Systematic Process
Overall, the analytical process developed by the authors was an intensive, iterative, evolving, and collaborative experience: it sought interpretive understanding through

a hermeneutic analytic approach (Viera and de Queiroz, 2017) characterised by deliberative stages (Van Hulst and Yarnow, 2016) and punctuated with critical decision and transition points (L'Espérance, 2013).

It is important to note here that there were no substantial time lapses between each cycle of the analysis. For example, during the first year, the research team met weekly for two to four hours to discuss and form consensus on elements of the analysis. Maintaining this temporal momentum allowed us to respond to the volume of policies under review (as new policies were added), construct the first phases of categorising the policy extracts, and continue to re/focus the analysis on QoL.

Monitoring and Evaluation
Monitoring and evaluation embedded throughout the systematic process were integral in strengthening this new method. This occurred in two ways: firstly, frequent team-based consultations were conducted to enable systematic policy coordination and cross-referencing, facilitate interpretive processes, and promote common bases of understanding. By testing and re-testing the interpretive outputs, we enhanced the rigour of coding and categorisation activities, while ensuring that they retained the link between policy text and QoL domain. Secondly, feedback on progress occurred through selected dissemination events, including joint meetings, conference presentations, and workshops.

This paper is part of a larger project entitled Seniors Adding Live to Years (SALTY) that aims to improve the quality of life of older people living in long-term care. The research team's governance model exemplifies their commitment to integrated knowledge translation (iKT) with decision and policy makers, clinicians and end users of the research (Keefe *et al.*, 2020). For example, the SALTY Advisory Committee consisted of persons living with dementia, LTC residents, family caregivers, LTC volunteers and direct care staff who were consulted regularly throughout the four-year project. Clinicians, decision and policy makers representing all four provinces comprised the Knowledge Translation Advisory Committee and it was these stakeholders who recommended that in the interests of parsimony, only documents relating to the highest regulatory power be analysed (see Hande *et al.*, 2021). After the policy data were coded and analysed, the authors shared jurisdiction-specific findings and interviewed two key informants in each province to assess any missing documents, validate the findings and understand contextual factors that might help explain our findings. Decision and policy makers (e.g. senior directors of Long Term Care at provincial and regional health authority levels) were essential to weaving real-world interpretation into the analysis, ensuring that appropriate and relevant policies were included and grounding our analysis in practical reality.

Four Stages of applying the method
There were four stages in the method. The first focused on which policies to include in the overall analysis, setting the boundaries of inclusion and exclusion criteria.

The second stage allowed for a more in-depth probe of each policy text to determine its category according to Kane's (2001) QoL domains. At this stage, the included policies were reviewed by decision and policy makers for their input. The third stage involved assigning a level of regulatory power based on the authorship of each policy. This helped to identify the likelihood of a policy interpretation perceived as a directive/rule versus a suggestion/guideline within the context of the QoL (Kane, 2001) analytic framework. It also served to construct provincial policy profiles that outlined how policies were supporting QoL in an aggregate or overarching perspective. The fourth stage involved interrogating the policy categorisation data from four perspectives: residents, families, volunteers and workers. This provided a way to consider how these policies supported aspects of QoL (Kane, 2001) from those who live, visit, support, and work in LTC in these four provinces. Each of these stages are described in detail as follows.

Stage 1: Policy Collection (Criteria)

Identifying and deciphering policy interactions is a highly complex task and requires long and deep interactive re-readings at multiple levels to uncover, understand, and interpret meaning (Keefe *et al.*, 2020).

At first, we examined publicly available federal and provincial repositories in British Columbia, Alberta, Ontario, and Nova Scotia to locate and identify potentially relevant policy documents related to residential, long-term, and end-of-life care. The ensuing collection of 350 data sources represented significant jurisdictional differences by numerous authors with varying goals, resulting in a diverse range of candidate policies. To facilitate sense-making, we entered all documents in an Excel matrix, and iteratively cross-checked and synchronised their recording criteria, while re/screening and re/interpreting policies for their LTC intent and applicability. Policies were initially collated according to province, with 139 forming a baseline policy library (see **Figure 1**).

Policies were excluded in progressive stages: firstly, policies or influential documents concerning LTC facility residents aged 65 years and over were eligible for inclusion, thus eliminating policies related to residential facilities for younger age groups. Secondly, documents were included if identified as influential by key stakeholders, or referenced in later strategic planning guidelines, provincial reports, or policies, and federally or provincially authored strategic plans or statements. In an effort to reduce the number of eligible Ontario policies to both a manageable volume for analysis and to reflect a pattern of referencing policies repeatedly in the data (for example to avoid duplication of data), we decided that documents from Ontario must meet the first two criteria, whereas other provinces were required to align only with one. Third, any policies created or released after July 2017 were excluded because by their nature policies are continually changing and the research team needed to establish a hard deadline in order to complete the analysis within the grant timelines. Later we re-evaluated this timeframe in order to accommodate two key policies: the federal *Palliative Care in Canada Act* (Health Canada, 2018), and the *Resident and Family Councils Act* in Alberta (Government of Alberta, 2018) following input from our decision-maker advisors who indicated that these two seminal acts should be included. One Hundred and ninety-two documents were excluded due to these criteria; a later decision to omit best practice documents from non-governmental sources (such as LTC organizations and health charities) resulted in a further 19 documents being omitted (see **Figure 1**).

We agreed to maintain our focus on policy interactions within and between provinces rather than account for individual examples of implementation–effectively conforming to "what a policy says rather than what it does" (Mann and Schweiger, 2009, p. 447), and to retain multiple codes if a policy related to more than one QoL domain. Authors and staff completed another round of time-intensive, iterative, and collaborative discussions to refine the policy/QoL matrix.

As indicated earlier, the delivery of LTC in Canada is the responsibility of provinces and territories rather than the federal government. This decentralisation has resulted in a high level of regulation and a myriad of frequently conflicting policies. Similarly, QoL is a complex, multi-layered concept (Kane, 2001; Kane *et al.*, 2013; Kehyayan *et al.*, 2015; Morris *et al.*, 2018; Orley and Saxena, 1996; Shippee *et al.*, 2005; Van Haitsma *et al.*, 2019). Together with input from key advisory groups, described above, we aligned selected policies directly with QoL domain categories to advance our understanding of these key inter-relationships.

Stage 2: Policy Categorising

This stage, policy categorisation, juxtaposed types of policy with Kane's QoL domains. This was an exhaustive process, involving in-depth, line-by-line interpretive coding, and thorough oversight by policy leads and consultants. As anticipated, the policies were found to be in tension with each other, creating multiple complex algorithms of care direction.

Two indicative examples illustrate these underlying tensions. For instance, building code regulations mandate optimal environmental design for LTC residences (National Research Council of Canada, 2015): expressed in terms of the QoL domains as accessible spaces that facilitate resident safety, security, and order, and promote functional capacity and autonomy, but also restrict resident privacy (see Fancey *et al.*, 2012 for a comprehensive review of parallel literature). Similarly, the Canada Food Guide and concomitant provincial food regulation and safety standards prescribe quality nutrition in residential care facilities, without necessarily specifying a corresponding requirement to accommodate individual and cultural dietary preferences (Health Canada, 2019b). Ontario's *Long-Term Care Homes Act* (Government of Ontario, 2007) exemplifies this interpretive mismatch, whereby the mandated provision of food alternatives does not guarantee (valid) dietary choices available to individual residents. These tensions are explored in greater detail (Armstrong and Lowndes, 2018; Banerjee and Armstrong, 2015), but it is clear that relating policies to QoL domains is a

complicated and convoluted process, and as such, signified another intensive, iterative, interpretive circle of understanding for the team.

Further refinement of policy inclusion criteria was accomplished through consultation with a group of decision-makers that raised some contentious questions, such as: Which policies are most influential? And under what circumstances? After debating some coterminous issues–prescriptive policies versus directive policies, policy levers versus legal levers, enforceable rules versus spheres of influence –we devised a ranking system to classify the degree of regulatory power–a process described next. This collaboration with decision-makers, as part of our integrative knowledge translation approach (Keefe *et al.*, 2020), was an initiative that we believe subsequently enhanced the overall rigour of our analysis.

Stage 3: Assigning Regulatory Policy Rankings

Our ranking system classified the degree of regulatory power (obligatory "bindingness") accorded to various policies impacting LTC in Canada (**Figure 1**). This framing process involved connecting the type of policy document (non/LTC specific policies, programs/endorsed recommendations, best practices) to the authority prescribed by the policy (federal and provincial governments, government or government-supported agency) to create four levels of regulatory authority.

Regulatory binding documents: High degree of obligation; representative federal and provincial policies examples include LTC oriented licensing legislation and regulations, program requirements, (such as LTC acts) and federal or provincial legislation encompassing LTC (fire and building codes, occupational health and safety, freedom of information and protection of privacy).

Government authored or endorsed documents: Medium degree of obligation; representative LTC oriented programmes or government endorsed/supported agency recommendations include the British Columbia Ombudsman report, reports from Provincial Auditor Generals, as well as government/government supported

agencies and endorsed recommendations encompassing, but not specific to LTC residents, such as the Dementia Strategy of the Public Health Agency of Canada.

To minimise complexity and strengthen the utility of this frame, the research project's knowledge translation advisory group then recommended that we anchor the policy/QoL frame on the highest regulatory powers, the *must comply* categories. Further re-framing addressed an outstanding objective: to apply differential funnels or policy perspectives to ascertain which policies support and/or limit perspectives from residents, staff, family/friend caregivers, and volunteers in residential LTC facilities across the four provinces (British Columbia, Alberta, Ontario, and Nova Scotia).

Stage 4: Policy Selection Lenses

It is suggested that a resident circle of care allows stakeholders to adopt a person-centred approach to care and identify gaps and areas for improvement (Price, 2016). This approach informed the four perspectives "named" by the team: resident preferences for comfort, autonomy, and security; staff flexibility to provide quality care within the regulatory environment; family/friend caregiver involvement in care contributing to residents' QoL; and volunteer contributions to informal care for persons at late life.

A keyword search re-screened policies to discover and iteratively build an understanding of regulations enabling and/or inhibiting resident, staff, family/friend caregiver, and volunteer LTC involvement, and to identify gaps in care practice. Key terms used to search policies are found in **Table 1**. Papers reporting the detailed analysis of each perspective by province are available (staff perspective – Hande, Keefe and Taylor, 2021; volunteer perspective-Hande, Taylor and Keefe in press) or are under review (family perspective– Keefe *et al.*, under review and resident perspective- Irwin, Taylor and Keefe under review).

A detailed examination of the results is outside the aim of this paper, namely, to detail the novel method approach to complex policy analysis. However, a summative description of QoL domains according to each province is
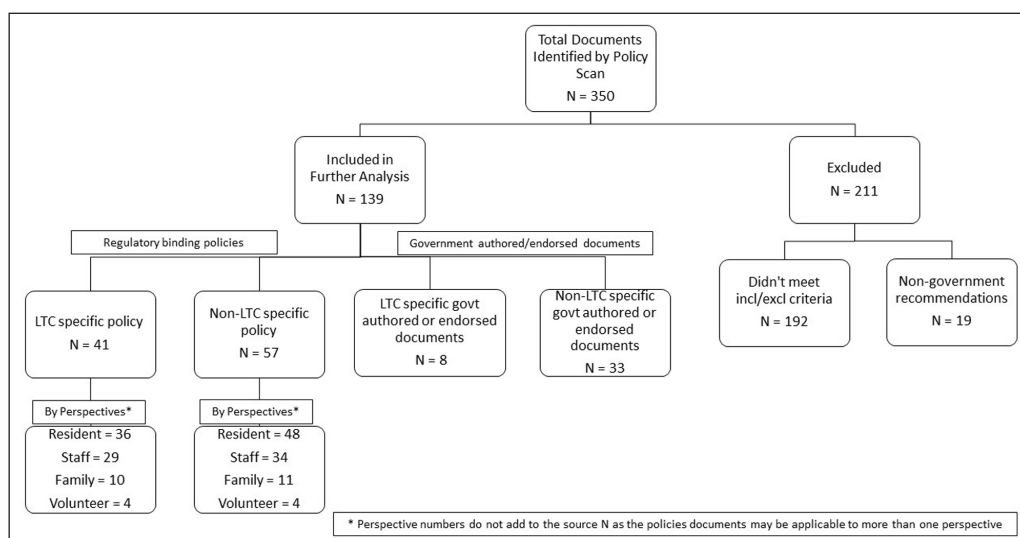

Figure 1: Policy Inclusion Process and Classification for Long-Term Care.

Table 1: Keyword Search Terms Used in Policy Analysis for Each Perspective.

Perspective	Keyword Search Terms
Resident	person; client; patient; resident
Staff	service provider; care aid; physician; doctor; nurse; worker; staff; employ
Family/Friend Caregiver	family; families; significant other, spouse
Volunteer	volunteer
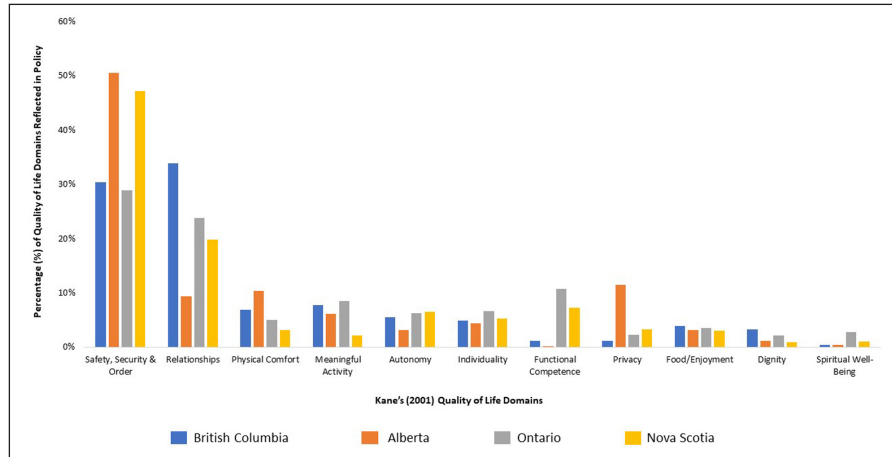
Figure 2: Proportion of Long-term Care Policy Excerpts by 11 Quality of Life Domains and Province.
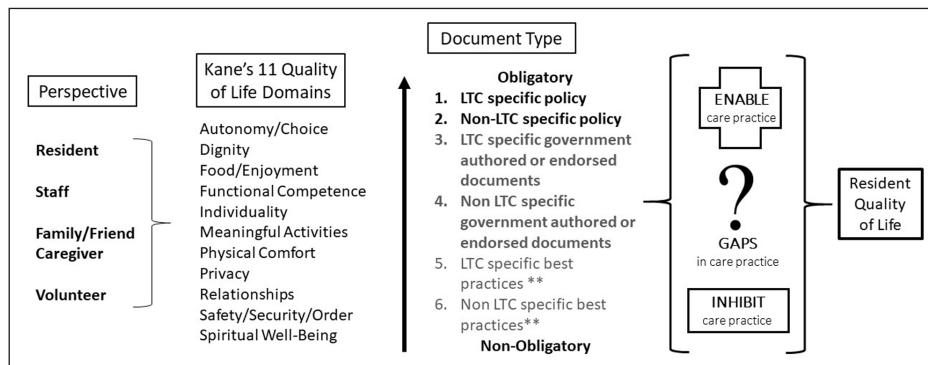
Figure 3: Analytical Model for Assessing Quality of Life in Long-term Care Policies.

captured in **Figure 2**, and clearly indicates the predominance of the safety, security, and order QoL domain for the four perspectives and across all provinces, especially in Alberta and Nova Scotia where over 50 percent of the policy excerpts were coded as addressing this domain. In addition, there are proportionally far fewer texts describing QoL domains such as dignity and spirituality (less than 5 percent), or autonomy and individuality domains (less than 10 percent) across all perspectives and the four provinces. Provinces though, differ in certain areas. For instance, Alberta has fewer policy excerpts reflecting relationships but a higher proportion of policy excerpt denoting privacy (see **Figure 2**).

A Novel Approach to QoL Policy Analysis Method for Residential LTC

Browne *et al.* (2019) claim that "analyzing policy is far from straightforward because there is little agreement about what public policy is and how it can be investigated

and understood, with different approaches based upon diverse theoretical and methodological assumptions" (p. 1033). Our method of policy analysis (see **Figure 3**) provides a novel way to reduce this complexity. It details an evidence-based, iterative, and collaborative approach to understanding the relationships between LTC oriented regulatory policies and resident QoL domains across four Canadian provinces (British Columbia, Alberta, Ontario, and Nova Scotia), and through four perspectives (resident, staff, family/friend caregiver, and volunteer). The developmental process was informed throughout by monitoring and evaluative feedback from stakeholder groups.

Discussion

In addition to bridging policy and QoL domains, this new method afforded an opportunity to unpack how QoL is considered in policy. Comparisons within and across provinces were produced for each policy lens and QoL domain,

confirming the dominance of safety, security, and order for QoL in all provinces, and across four perspectives (resident, staff, family/friend caregiver, and volunteer). Furthermore, this method provides substantive confirmation of previous research indicating that policies and regulations in Canadian LTC facilities focus on risk mitigation and strategies to limit liability (Tufford *et al.*, 2018).

The approach also allowed us to consider which polices enable and/or inhibit residents' QoL in LTC facilities. Here, the role of the physical environment in facilitating or hindering residents' QoL provides an example. In Nova Scotia, the provision of private spaces for residents to visit with family members and friends is an explicit requirement of new LTC facility builds (Nova Scotia Department of Health and Wellness, 2019). Consequently, all new LTC residential facilities constructed in Nova Scotia must now include a minimum of one family room per facility, with sleeping accommodations, a small kitchenette, and a three-piece en-suite bathroom. Similarly, the *Ontario Long-Term Care Act* (Government of Ontario, 2007) makes mention of residents' rights; a facility must "ensure" that residents have options and opportunities to make choices and fulfill their individual needs and preferences in their instrumental/activities of daily living. Alternatively, policies relating to the role of the physical environment in LTC in Alberta are more directed towards safety, security, and order, with limited emphasis on creating physical spaces that support socialisation with family and friends (such as creating home-like surroundings through furnishings, finishes, and so forth).

Policy gaps were also evident; in particular, the dearth of policies related to long-term/residential care volunteers. This omission was especially noteworthy with respect to volunteer contribution to QoL for residents, staff, and family/friend caregivers in LTC.

The policy analysis also underscored the prominence of person-centered philosophy of care in LTC contexts. This paradigm shift affirms movement away from the prevailing institutionalised, regimented, and biomedical care model, but its degree of uptake varies according to jurisdictional priorities.

Furthermore, our analysis signifies the volatility of Canada's LTC policy landscape, and the types and levels of policies differing across provinces (Daly, 2015). Many of these policies are historical artifacts, amended over time in response to changing political, economic, social, and cultural imperatives. As observed in an earlier section, each province adds its own perspective and preferences to the mix, with implications for how LTC policies are interpreted, and concomitantly, how care is impacted.

Overall, finding a methodological path through this policy/QoL juncture was a difficult and challenging task. This remit was amplified by the lack of a workable analytical framework, and compounded by long data collection, incubation, and interpretative phases. These problems were moderated by the team's rigorous, theory driven, and collaborative developmental process, and this new method of policy analysis succeeded in meeting the research mandate. Nevertheless, we recognize that our model has some limitations and we will turn to these next.

Limitations
Transferability
Like all qualitative and interpretive approaches to research, generalisability is problematic (Mann and Schweiger, 2009), especially for a nascent method. To enhance methodological reproducibility and transferability, we ensured that all processes were systematically documented, and continually subjected to monitoring and evaluative oversight by knowledge users, key stakeholders, and advisory groups (Hande, Keefe and Taylor, 2021; Keefe *et al.*, 2020).

"Outlier" Policies
Some policies are created as a "one-off" directive to address pressing, often local, contexts, as in a recent Ministerial Order in Alberta (Pon, 2019) designating primary and secondary funded items for older residents: "Long-term care (LTC) residents may apply for benefits toward the purchase of a television." The presumption is that this item contributes to residents' leisure enjoyment, and hence, benefits their QoL. Because of their specificity, these orders do not readily integrate with a composite provincial policy profile and were not included in the analysis.

Level of Analysis
From the outset, we determined that analysis would be located within provincial policies' licensing and regulatory levels, rather than directed towards provider agencies or implementation of the policies contributing to individual experiences (see Hunter *et al.*, 2020). Although this approach enables a powerful decomposition of the interplay between policies and QoL, it does not permit a fine-grained analysis of every QoL domain, such as the 'dignity' domain. Kane (2001) defines dignity as "the *perception* [emphasis added] that one's dignity is respected rather than the important but different notion that each person is treated with dignity, regardless of whether he or she can perceive indignities" (p. 298). Therefore, relevant dignity enabling policies that are in place and respected by staff, family/friend caregivers, and volunteers still may not accord with residents' perceptions of dignity. For example, policies related to person-centered care may be at odds with those prescribing the delivery of personal care assistance in limited staffing situations. With respect to dignity, policy is an enabler to achieve the circumstances that support necessary, but not sufficient, fulfilment of the anticipated purpose.

Again, it is important to recognise that while policies dictate regulatory and guiding principles, the "how they are represented" is not presented in this analysis. We acknowledge that policies are only one part of the story. How these policies are implemented in specific areas of focus is beyond the aim of our research, but we recognize the criticality of these implementation practices to understand the experiences of residents, their families, and staff.

Further Research
A related issue for additional research is the congruence between the analytical framework and other QoL measures. Is this new method Kane domain-specific? Or, is it

elastic enough to accommodate other QoL measures, and/or adaptable to other concepts, such as wellbeing?

The tensions around "objective" (hard) instrumental QoL domains and "subjective" (soft) person-centred care are a rich resource for further analysis. An analogous review could relate QoL domains with isolated (silo) and/or integrated policies in terms of enhancing or hindering the development of person-centered LTC. Following Daly *et al.* (2017), a comparative analysis of prescriptive or interpretive policies across Canada would strengthen the policy map. There are also policies directed towards health authorities and service delivery facilities that we have not reviewed in this analysis. These are substantial sources of further research.

Moreover, a re-analysis of the policy library will uncover unused rules: policies that exist but are not implemented, thereby improving the efficacy of existing legislation.

Conclusion

There are multiple ways to conduct a policy analysis; yet few approaches provide a comprehensive method to study multiple policies across multiple jurisdictions. In addition, there are no published methods that offer a rigorous approach to complex policy analysis that incorporates a QoL lens across different perspectives. We contend that this novel method provides a rigorous foundation for undertaking QoL policy analyses across broad geographies using large data sets. It is also an important reminder to policy-makers and health system leaders to ask questions about how policy may be interpreted in the context of specific QoL domains such as privacy, dignity and spirituality.

There are also important practical implications to understanding the way in which resident QoL is represented in policy. If managers and administrators look to policy and their subsequent regulations and guidelines to determine direction in particular situations, assurances of basic values need to be represented. For example, our simple illustration of the proportion of policy excerpts that support safety, security and order compared to QoL domains around autonomy, dignity and individuality demonstrate what is valued in LTC. We conclude that our approach provides a foundation for policy analysis that enables policy makers to re-examine the confusing, and sometimes conflicting, policies that have developed over time and assess whether they reflect the values of the residents themselves and society at large.

Acknowledgements

Competing Interests

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