Full-Length Article

Understanding Music Care in Canadian Facility-Based Long Term Care

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Abstract

Music has been used in Canadian long term care (LTC) facilities which, for decades, have relied on programs, technology and music therapy to deliver live music through a variety of forums. Current confluences in long term care (LTC), in particular, a change in demographic and a shift in philosophy towards person-centered care, call for a renewed understanding of music in LTC and specifically how it is delivered. In this mixed method study, 7 emergent factors influence music care delivery from a phase 1 qualitative study in 5 Ontario LTC homes and form the basis of phase 2, a pan-Canadian survey in 50 LTC homes. Results illustrate several key aspects of understanding music care in Canadian LTC facilities as well as illuminate some of the incongruencies of music care delivery in the Canadian LTC context. Recommendations to LTC leadership for imminent next steps are posited.

Keywords: ***long term care, culture change, quality of care, quality of life, music care***

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Introduction

Music has been implemented in Canadian long term care (LTC) facilities for decades and has been linked to improved quality of life (QoL) for the aging population [1-6]. Resident experience while living in LTC are often enhanced with music, providing opportunities for enjoyment, meaning, social engagement and agency. In LTC practice in Canada, music has historically been understood and delivered through programs, technology and music therapy. Certain confluences in Canadian LTC, discussed below, call for an assessment of how music is understood and delivered, not just in the form of music therapy, formal music programming or community entertainers, but as an intentional and informed co-modal agent of care, which can be delivered by all care partners, regardless of their musical training. This wider approach to *intentionally* use music for wellbeing is a developing paradigm of care called, by the authors, "music care".[1] In the face of these new realities in LTC, music as a means of care becomes a viable and vital way to improve quality of care and resident experience.

The *culture change movement* in LTC seeks to change residents from a medical model of care that emphasizes survival to a social construct of care which focuses on the necessities of living [7,8]. *Person-centred care* is at the heart of culture change and refers to a collaborative and respectful partnership between the resident and the caregiving staff where each resident is honored and not lost in the daily tasks of caring [9]. Resident-preferred interests drive daily activities and programs. The opportunity to provide individualized music [10,11] is more realistic in these contexts. Music is valued for its *social agency.* It strengthens community by reducing isolation and depression in residents. Its social value also includes meaningful music-making or music-based activities [12]. The majority of LTC residents in Canada have some form of *dementia*, many of them with difficult behaviours. Music can reduce responsive behaviors [13-17] and activity disturbances [18] in people living with dementia. This makes music a non- pharmacological option in dementia care. [1]

These realities raise questions about music in long term care. How is music being used and delivered, and how does it impact care? It is these questions that have provided a

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[1] Music care is an umbrella term for care that integrates the use of music into care goals and has been defined by the Room 217 Foundation, a Canadian entity dedicated to care through music. Music care seeks to address the gap between the proven value of music in care circles and the paucity of available resources, knowledge and training for music to actually be delivered effectively in care contexts. Since 2005, Room 217 has been developing music care resources and programs. Room 217 participates in collaborative research and has developed the *Ten Domains of Music Care*.

rationale for, and driven the development of, the concept of music care as an approach to care.

Music care is comprised of informed and intentional music implementation and music integration throughout care delivery in any health care setting. The theoretical framework used for understanding music care in this report is *10 Domains of Music Care, a taxonomy* which provides a general classification for understanding the dimensions of how music is used in health care settings. The 10 domains present ways in which music can be delivered in care contexts and can be used to map actual use and provide possibilities for optimization.

This paper focuses on where the gaps and perceived needs may be identifiable particularly in Canadian LTC. The purpose of this research is to provide a clearer understanding of what music care is, in order to improve and optimize its delivery, integration and implementation in Canadian residential LTC. This research addresses the following questions:

How is music care understood in Canadian LTC facilities?

What are the perceived factors of music care delivery in facility-based Canadian LTC?

Methods

An exploratory sequential design was chosen to conduct this research. The premise of this mixed method 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. 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.

In phase 1, 5 LTC homes in Ontario, all operated by the same owner, were purposefully sampled. Ethics approval was obtained from the LTC national office and executive director (ED) of each individual home, as well as from the university through which the research was affiliated. Informed consent was obtained by program managers in each home. 24, 30-minute interviews were conducted amongst the home leaders including 5 executive directors, 5 directors of care, 5 program managers, 3 music therapists and 6 residents (including 4 women and 2 men, 2 in their fifties, 1 in seventies, 3 in eighties). Homes were selected with the guidance of the LTC national office to reflect diversity in a set of criteria: regional representation, whether they had a music therapist or not onsite, size (number of beds), and homogeneity of residents. Participating LTC sites including information about the type of service offered, number of programs and nursing staff as well as whether or not there is a music therapist on staff are shown in Table 1.

Site Setting	Type of service	# of program staff	# of nursing staff	Music Therapist
Rural	LTC	4 FT	76 FT/casual	Yes – 5 hours/wk
Remote	LTC	4 FT/PT	40 FT/casual	No
Suburban	LTC/secure unit	12 FT/PT/casual	90 FT/PT/casual	No
Suburban	LTC/secure unit	5 FT/PT	123	Yes – 1 day/wk
Downtown	LTC/secure unit/Trans	11 FT/PT/stud/Rehab	185 FT/PT/casual	Yes – 2 sessions/wk

Table 1. Phase 1 participating LTC sites

Data was collected by structured in-person interviews that were conducted to obtain participants' perceptions and experiences. Interviews were recorded and transcribed. Data collection also included observation of music care programs. Data validation included question triangulation and method checking with participants. The data was then analyzed by developing familiarity with the data, coding, and thematic analysis.

Phase 2 was a pilot study of 50 LTC homes in Canada. Data was collected through an electronic survey in a stratified sample. Ethics approvals were obtained from the university and the individual homes. The characteristics of study participants were noted, indicating the respondent role (executive director ED, the director of care DOC, director of programs, DOP or other), the philosophical working model (medical or social), the number of LTC beds, age of residents, and the facility's geographical location in Canada.

The survey was pilot tested and was comprised of 42 questions (multiple choice, Likert ratings, listing and open-ended questions) which emerged from phase 1, and was designed in 4 parts, including demographic information of participants, information about the LTC home, defining music care, and music care delivery. Analysis included factors of variability such as roles, provinces, number of beds, philosophy of care, age of residents served, and the length of time respondent had worked in the LTC home.

Results

In phase 1, 7 factors, each with sub-factors that influence music care delivery, emerged as follows:

1. Attitudes about music care (dual track thinking – music as program vs. care, preconceptions about music's scope)
2. The nature of music (preferences, meaning, musical effects)

3. Facility location and design (geographical location, building design)
4. LTC community culture (demographics, staff culture, family and community involvement)
5. Planning and sustainability (funding and resources, role, music care plan, balancing needs of residents)
6. Music care education and awareness (understanding of music care, musical skills and knowledge)
7. Gaps between theory and practice (medical vs social approach, LTC vs nursing home approach, music therapy identity)

Findings indicated that these factors were either enablers or barriers to music care delivery. The salient factor that enabled or disabled music care delivery was how the LTC leadership felt about music care belonging in health care.

Phase 2 probed more deeply into music care understanding by LTC leadership as well gaining more insight into the other 6 delivery factors. The results were organized into 2 categories: conceptual data and status data.

Conceptual data (how music care is perceived and understood by leadership in Canadian LTC)

Key aspects of understanding included leadership's perceptions, attitudes, beliefs and values regarding music care. Understanding of music care varied. 52 percent of respondents had heard the term "music care". Role did not seem to impact this: 55% percent of EDs, 44% of DOCs, 52% of DOPs and 57% "other" had heard the term "music care". LTC homes identifying themselves as using the medical model of care reported 39% having heard the term while those adopting the social model was 64%. Two-thirds of leaders with 1-5 years of experience had heard the term "music care" compared to one third of those with less than a year's experience or more than 6 years of experience. Findings indicate that the term music care is familiar in 70% of rural LTC homes compared to 41% urban homes.

All 74 study participants except one thought that music benefits residents in Canadian LTC by improving quality of life and quality of care. Table 2 summarizes the collective results and perceived benefits.

90% of participants thought that everyone - program staff, care staff, family and volunteers - should be engaging in music care. 74% of participants felt very confident using music. Those with more than six years of experience felt the most confident. EDs felt the least confident. 75% of participants were motivated to embrace music care education and training measures that would empower staff to integrate music into regular care practice. Perceptions around the value of music were measured. Each respondent was asked to rate his or her perceptions of how the leadership team, residents, staff and families valued music in care. 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.

Area of Benefit	Perceived benefits of music by LTC leaders
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 2. Perceived benefits of music care for QoL and QoC

Findings showed that 78% of respondents believe music can enhance culture change. Those facilities 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%. 80% believed strongly that music should be prioritized in programming.

Status data (how music care is delivered and implemented in Canadian LTC)

Key aspects of music care delivery include who does it, how it is done, where it is done, and resident preferences toward delivery. Music was delivered in 96% of LTC homes while 4% claimed music was not used. Those who deliver music included program staff (98%), care staff (42%), family/volunteers (74%). Music therapists were 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. All LTC homes reported using technology to deliver music care. Methods of technological music care delivery included radio/television (94%), stereo/CD (96%),

mp3/iPod (59%), iPads/streaming (31%). Country music was the preferred style in Canadian LTC while specific cultural music i.e. Chinese opera, Italian pop was the least preferred generally. Religious, classical, pop/rock and jazz were also preferred in that order. Style preferences varied by Canadian province.

In each phase of the study, uses of music in LTC were mapped against the 10 domains of music care as shown in Table 3.

Domain	Use
Community music	Community groups doing entertainment Community access – residents going on musical outings
Music Care specialties	NONE REPORTED
Music therapy	1:1 visits Small groups
Musicking	Drumming Karaoke Residents informally playing music
Music programming	Choir, Glee Club Singalongs, Hymn Sings Handbell choir Dances, Pub nights, Happy Hour Music games i.e. bingo, trivia Celebrations i.e. birthdays, anniversaries Special events i.e. Valentine's Day Time filler Java Music Club Recreation or exercise programs i.e. WII Religious services Chaplain visits Remembrance Services
Technology	YouTube videos iPod/CD/radio/TV/computer for music listening Music libraries with CDs or iTunes library
Environmental sound	Ambiance for common areas i.e. dining room, front entrance, lobby, spa, nursing stations Cuing for transitions Background music
Music medicine	Sensory stimulation i.e. Snoezelen Rehab and restorative programs Palliative and end of life care
Music care training	Reported in less than 4% of homes
Music care research	NONE REPORTED other than participation in this study

Table 3. Use of music in LTC mapped against 10 Domains of music care

In 98% of LTC homes, music was allowed to be played in residents' rooms. Music listening areas for staff existed in only about one quarter of the homes. Access for residents to participate in musical events outside of the LTC home varied with the strongest variables being the number of beds, care model and geography. LTC homes who describe themselves operating in the medical model never took residents on musical outings whereas those who valued a more social approach to care were more consistent in opportunities for musical outings for their residents. Mid-size LTC i.e. 61-200 beds also indicated more consistency in community access than smaller or mega-homes.

84% of respondents reported having no music care plan for their LTC home. 36% of respondents reported having a music care budget (6% budget under $2K, 28% between $2.1-10K and 6% $10K and over). 60% of participants reported they didn't have a budget for music care.

The availability of music resources for staff or volunteers to use for music care happened 40% of the time. For residents, music resources to use in a non-structured (non-programmed) way were readily available 32% of the time.

Residents or families of residents were asked about the individual resident's previous musical experience or musical preferences when assessed for LTC placement by Canadian Community Access to Care or family doctors in 50% of situations. That number increased to 76% when residents or families of residents were asked about the individual resident's previous musical experience or musical preferences once they became residents in a specific LTC home.

Limitations

There were several limitations in this study. Data was recorded from facility leadership and residents, and did not include input from staff, family and volunteers as well as boards of directors or LTC operators. 9 provinces were represented in phase 2 findings, not including Newfoundland or the 3 Territories. The number of homes from participating provinces did not represent the ratio of homes per province against the national total.

Discussion

For some LTC residents in Canada, music may be one of the most important activities in their lives. For many, music helps them engage socially and provides meaning and constancy amidst transitions, changes and losses, while enhancing human connection and contact. How LTC leadership and staff think, feel and behave about music and how they value music will determine far more than residents' musical experiences in the LTC home. Music has the ability to reorient a resident's entire experience living in LTC. Prioritizing music through daily implementation and integration into all aspects of care, whether it is in programming, rehabilitation, the activities of

daily living, personal hygiene tasks, transfers, or mealtimes, improves resident experience and satisfaction in most cases.

However, music does not always work. Leadership strongly believed in the benefits of music and were not as aware about the adverse effects of music. Only 24% of study participants believed music could have adverse effects. Few studies report music's adverse impact on residents in LTC. Popular culture documentaries that highlight the positive effects of music on residents in LTC are helpful in promoting the use of music in LTC. However, they do not tell the whole story about music in care. Music can be irritating, escalate behaviours, increase sadness and loneliness and may not always be a panacea.

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. Music care may be 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 a "job", with tasks to be done. For music care to be delivered in LTC, staff buy-in to the value of music is essential, especially for staff that relate to residents on a daily basis. As primary gatekeepers of music care, staff need to value music if that's what the resident values. To maintain a person-centered approach, staff must be primarily concerned with the preferences and needs of the resident.

In this regard, staff training in music care becomes essential. What other intervention in healthcare is used so pervasively without baseline training? Lack of training could be a reflection on the relative newness of music care as a concept. Or it may be that leadership assumes caregivers are cognizant of the impact music has on residents. The universality and accessibility of music generally creates the illusion that caregivers are equipped to use music in care. By training LTC staff how to use music effectively and conscientiously, music care may be optimized in the facility.

This study illuminates incongruencies in music care delivery across Canada. Valuing music in care and music care delivery readiness are not the same thing. The fact that less than half of the homes have music care resources readily available for staff, volunteers and residents to use 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. It may also be due to a lack of available music care resources.

Disparities in music care sustainability are evident. Planning was the second most salient factor in music care delivery from phase 1. Interestingly, 60% of survey respondents in phase 2 do not account for their lack of financial investment in music care. This could mean that leadership does not want to own the discrepancy between belief that music is essential in LTC and a lack of financial commitment to ensure sustainable music care. Or it may indicate the ambiguity around where financial allocation of highly-regulated government funds need to be made. 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. This is one of the reasons why music care looks different across Canada.

Other inconsistencies exist in music care delivery in Canada. Technology use in LTC is not standardized. Some places are firewalled, others will not allow staff personal devices to be used at the facility while others are outfitted with the latest devices. Dedicated music spaces are disparate. Community access for musical outings is not a program expectation across the country. There is no consistent assessment practice for a residents' musical background, preferences or interest prior to or during LTC resident intake.

Recommendations

6 imminent areas of need are identified as a result of this study. Recommendations from these areas can be incorporated into both corporate management and facility strategic planning.

1. Provide LTC staff, volunteers, families and stakeholders with music care education and training. Baseline music care training and education needs to become standard practice.
2. Optimize music care by intentionally locating existing efforts using the *10 Domains of Music Care,* and developing new endeavours. Map current music initiatives against the *10 Domains* and identify where efforts can be made to enhance music.
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.
4. Invest in music care as an accountable and sustainable component of LTC. Give music care a budget line and grow it to account for targeted music care resources as well as human resources who will bring skill and vision for extending the goodness of music to each resident.
5. Appoint a music care point person who will provide leadership and advocacy in music care. The point person needs to appreciate and understand music's therapeutic value, have excellent networking and communication skills, be passionate about the potential of music care for purposes of well-being, and genuinely care for people.
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 need to

be deliberate and robust. Research centres need to develop relationships with LTC providers for potential further inquiry.

Conclusion

Music is essential in Canadian LTC and impacts social engagement and agency, human connection and resident orientation. Although there are gaps and incongruencies in music's present integration to LTC, this study demonstrates motivation by leadership to deliver music care and to learn to use it more effectively. These results should encourage further research and direction for the use of music care within the Canadian LTC community and beyond.

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