Work and hardship in nursing homes... What if the solution could be "salutogenic" management?

La pénibilité au travail dans les EHPAD... Et si le management « salutogénique » était une solution ?

Christelle ROUTELOUS
Associate Professor – EHESP School of Health Management
Services and Health Management department – Arènes UMR 6051

Caroline RUILLER
Associate Professor – Graduate School of Management, University of Rennes 1 – CREM UMR CNRS 6211

Gulliver LUX
Associate Professor – ESG UQAM – Departement of Accounting – UQAM University, Montréal

ABSTRACT

The intensification of work in the health and the social sectors is recognized to deteriorate the working conditions, in recent years. With this assumption, this article aims at understanding the relationship existing between the quality perceived by user's support and the quality of life perceived by employees in the workplace. What are the best management practices to create the conditions of well-being in the workplace in regards to the constraints these organizations have to cope with? This is the research question we seek answers to. Based on an abductive research (4 cases studies), we operationalize the SLAC modeling – Sense, Links, Activity & Comfort – (Abord de Chatillon et Richard, 2015) to put into the light the sound management practices that Governance, manager and caregivers execute. We use the methodology of Gioia *et al.* (2013) to manually analyze the thematics of 12 interviews (Governance, managers, caregivers) with a conceptualizing logical. Our results corroborate the SLAC model while they also nuance the dimension of sense-making that appears to be transversal (that is to say, not independent). In terms of management insights, we thus propose and discuss salutogenic management practices we classify by level of responsibilities with an organizational and multilevel approach: (1) governance, (2) managers and (3) caregivers.

Key-words

Sustainable management; Training & developement; Salutogenic practices; Drudgery; Well-being; Prevention

RÉSUMÉ

L'intensification du travail dans le secteur sanitaire et social a été une cause essentielle de la dégradation des conditions de travail ces dernières années. La question de l'articulation possible entre la qualité de l'accompagnement des usagers et la qualité de vie au travail se pose. Quelles sont les outils et les postures managériales clés pour construire les conditions du bien-être au travail dans ces organisations sous tensions ? Par une approche abductive et à partir de quatre monographies, nous mettons à l'épreuve du secteur médi-

co-social, la modélisation SLAC – Sens, Lien, Activité, Confort – (Abord de Chatillon et Richard, 2015) pour mettre en perspective, les périmètres d'action des directions, de l'encadrement et des soignants. Nous référant à la méthodologie de Gioia, Corlay et Hamilton (2013), les douze entretiens réalisés (directions, cadres, et soignants) sont analysés manuellement dans une logique conceptualisante. Les résultats corroborent la modélisation SLAC tout en nuançant la dimension du sens du travail telle que proposée par ses auteurs, dimension qui au prisme de notre analyse, se révèle transversale du modèle SLAC... Nous proposons des implications managériales salutogéniques, catégorisées par niveaux de responsabilités : les directions, l'encadrement de proximité et les soignants-référents bientraitance.

Mots-clés

Management salutogénique ; Étude de cas multi-niveaux ; Prévention des risques professionnels ; Responsabilité sociale

INTRODUCTION

The intensification of work in the health and social service sectors in recent years is one of the key causes of deteriorating working conditions as perceived by employees. The core of the nursing profession working in EHPADs (an acronym used in France for residences for dependent elderly persons) and the missions of professionals have gradually become more focused on care and nursing tasks, to the detriment, equally, of providing relational support and maintaining functional abilities. These same acts, carried out repeatedly, and the effort they require (lifting, carrying, etc.) due to residents' loss of mobility, lead to pronounced physical and psychological hardship (Marquier *et al.*, 2016; Ruiller, 2012). But intensification of work need not be equated with a general deterioration of the work or of one's relationship to work (Gollac, 2005): organizations can take action.

The connection between the quality of support provided to patients and quality of work life (QWL) is an issue affecting the performance and social responsibility of institutions (Bachelard, 2017). Our study seeks to go beyond common representations of residences for dependent elderly persons, which are abusive of both professionals and patients. By studying best practices, we will identify the human resource choices made by institutional leaders and managers to link quality of care and quality of work life.

Various authors have advocated a salutogenic approach to human resource management (Neveu, 2009; Richard, 2012; Abord de Chatillon *et al.*, 2015). A salutogenic workplace is defined by the development of quality activities that maintain the individual's power to act (Clot, 2008). This salutogenic positioning is a response to recent findings on unattractive work and retention issues in medical-social workplaces, indicating a need to reconsider the human resource practices supporting employee engagement (Petit and Zardet, 2017). It also echoes a recent DREES report (DREES is an acronym used in France for Directorate for Research, Studies, Evaluation and Statistics; Marquier *et al.*, 2016) on the physical and psychological hardship experienced in EHPADs, a phenomenon that institutions have a responsibility to prevent. Even though, according to this report, care teams are increasingly involved in institutional thought processes (mainly through their trade unions), the perceived impacts and benefits of risk prevention policies remain limited (Abord de Chatillon *et al.*, 2016).

Our study applies an abductive approach. It is based on four case studies of EHPADs derived from a series of twelve interviews[1] conducted with senior managers,

1 Thirty interviews were conducted to document these four case studies. We structured our analysis around two themes: (1) salutogenic management practices and (2) caregivers' perceptions of such practices. Our contribution presents the results of the first theme and proposes

local managers and care teams. We performed a detailed analysis of best practices in selected institutions whose actions help introduce salutogenic approaches in care organizations, where particular attention is paid to the quality of support provided to patients as well as to employees' QWL.

We will show that providing adequate support to teams requires strong organizational leadership in order to moderate the hardship inherent in the work. This support is grounded in the meaning of the activity, by learning techniques for maintaining residents' abilities. Professionals' emotional attachment to any organization is strengthened when support is provided to their commitment to providing care, delivering well-being and relieving suffering. Training provides skill development through a tacit contract of "individual, organization, patient" to drive action. This training implements the managerial tools required for professionals to become involved in their work and achieve satisfaction. Establishing a relationship of trust between an employee and the organization is one way to maintain the capacity for action and for "work well done", whose corollary is job satisfaction. This climate is reflected in the intra- and inter-departmental solidarity that can be built through these actions.

This article has three parts. The first section presents the specific nature of the work performed in an EHPAD, in order to describe just how arduous this work is. Drawing on this background information, we justify the basis of our theoretical approach and our use of the SLAC – Sense, Links, Activity, Comfort – model (Abord de Chatillon *et al.*, 2015). The second section outlines the methodology used, based on four case studies and twelve interviews that were analyzed manually, following the recommendations of Gioïa *et al.* (2013). The third section presents our results, which are structured around the four themes of the SLAC model. A discussion of the results follows in the fourth section. Our results corroborate the SLAC model, but they also highlight how when well-being is managed in an EHPAD, the meaning of work is transversal in nature. We also propose a set of salutogenic managerial actions classified according to the responsibilities of senior management, managers and well-being resource persons (see the table in Appendix 2).

1. CONCEPTUAL FRAMEWORK

1.1. Arduous work and the healthcare and medical-social sector

According to the DREES report issued in September 2016, there are approximately 8,000 EHPADs in France housing 574,000 people (figures for late 2011, DREES). The care is provided by 361,000 healthcare, administrative and technical professionals (in full-time equivalents). Whether an EHPAD is in a hospital or non-hospital setting, is private for-profit or not-for-profit, this organizational form comprises a diversity of operations that one common denominator: a strong professional identity, built around professions whose arduous work is clearly evident but often overcome through individual commitment and multiple rewards (resulting from professionals' privileged relationships with patients, their families and friends, colleagues, and the facility) (Marquier *et al.*, 2016).

EHPADs have undergone profound change since 1997, with the gradual medicalization of facilities through tripartite agreements and fee convergence. These changes are reflected in the terminology used: EHPAD, an acronym used for residences for dependent elderly persons, replaced the former term, "retirement home". The gradual medicalization of this institution was experienced by its actors as an application of the health management model to medical-social care. In other words, the reluctance to accept this change may have taken the form of a professional disenchantment, given a certain fear that an organizational climate traditionally characterized as a "family" environment would become colder, or due to professional demands that the vision of care in the medical-social sector should not be replaced by the hospital care vision (Marquier *et al.*, 2016).

Caregivers' work is planned and carried out in the same way in all the facilities: "*it involves responding to the primary needs of residents through human assistance and the provision of care, assisting them in activities of daily living: sleep, getting dressed,*

a salutogenic management plan, categorized by perimeters of responsibility: (I) senior management; (II) local management and (III) welfare resource persons.

eating, eliminating, washing, moving about, caring for themselves, etc."[2] (*Idem*, 2016). These tasks are not without consequences in terms of the health of the staff working with patients. The latest results from the health insurance claims survey rank personal services as the most dangerous occupation for workplace injuries, with an average of 47.8 injuries per 1,000 employees (an average of 38 for all activities). The most frequent claims are for musculoskeletal disorders associated with moving and mobilizing dependent persons, the uncomfortable postures adopted to carry out tasks, and repetitive movements. The mental workload of professionals in EHPADs is also significant (Marquier el al., 2016). The stress is due in particular to unforeseen events, including those of a vital nature, fall management, feelings of powerlessness and guilt, and the risk of verbal and physical violence. But the stress is also due to conflicts with patients, their family members and friends, and dealing with painful or trying situations such as end-of-life. Working conditions may also suffer from a highly rigid institutional framework, which in turn accentuates value conflicts between the individual and the institution and fosters work overloads, contradictory demands, work that cannot be completed in the time given, and work in understaffed situations. There is also a risk of projecting problems onto one's friends and family and oneself, in one's exposure to ageing, loss of autonomy and death. The psychosocial risks are very high.

This activity of providing individualized support is part of life in communities where informal work has historically played an important role, and this seeps into human resource management practices. Although the content of caregivers' work is formalized in job descriptions, the individualized nature of care produces considerable autonomy and flexibility, enabling professionals to respond as best they can to residents' needs and unforeseen events. The aforementioned policies aimed at modernizing management are associated with additional stress placed on work, and this comes in cycles. This generates an increase in occupational health problems and, in extreme cases, burnout (Raveyre and Ughetto, 2003; Loriol, 2003). The caregiving, administrative and technical professionals working in EHPADs have to juggle three different types of ordinances that can be contradictory (Detchessahar and Grévin, 2009). First, industry ordinances may result in stricter procedures (such as more demanding accreditations and certifications, or reporting to trustees) (Lenay and Moisdon, 2003). Second, the need to compete in the market may lead to an increase in the number of residents becoming more dependent or in demands from families, who are increasingly involved in the co-production of care by specifying residents' needs in their files (Volant, 2014). Lastly, the organizational logic reveals a wide variety of realities that depend on the facility's policies and the way in which EHPAD senior managers understand facility management and the roles played by supervisors, who may or may not work at regulating local activities with the care teams. Detchessahar and Grévin (*Ibid.*, in reference to De Terssac, 1992) remark that this organizational work is fundamental to the performance of healthcare facilities, where managers often improvise what constitutes "know-how" beyond the expectations set forth in the job description (Dumas and Ruiller, 2013). The influence exercised by institutional policies, the "managerial project" and managers can therefore either facilitate or hinder the staff's activities, which may result in employees feeling that they are going against professional and personal values (Marquier *et al.*, 2016). If the institution's policies do not support day-to-day coordination activities – the invisible dimension of the managers' work (Minvielle, 2000; Bourret, 2006) – the individual and collective mobilization cannot be effective.

The present contribution focuses specifically on studying four EHPADs. In line with Richard (2012), the article seeks to identify the managerial, organizational and institutional logics underlying the appearance and handling of problems of suffering in the workplace, as well as the emergence of a new model for managing well-being at work. Richard (2012) points out that "*this critical and scientific analysis of the functioning of modern organizations is part of a broader project that questions traditional management and renews the practice of Human Resources Management*" (Aktouf, 2006). This model represents a renewed vision of human resource management.

Empirically, use of the SLAC model is therefore operationalized to rethink the foundations of sustainable management, connecting – to paraphrase Richard

2 Unless otherwise noted, the citations in this article, including quotes from the interviews, have been translated from French.

(*Ibid.*, 2012) – strategically distributed decision making, information sharing, the battle against incivility and providing feedback on performance.

1.2. Salutogenic management that creates conditions for well-being? The SLAC[3] model: sense, links, activity and comfort

The search for conditions conducive to well-being at work should not be reduced to the idea that an absence of pathological symptoms represents occupational health. The World Health Organization's 1946 definition of health states that "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*"[4]. In other words, well-being is not just about prevention related to occupational health and safety. The salutogenic approach to occupational health is based on a more integrative model.

A need has emerged to consider suffering and well-being at work at the same time (Bachelard, 2017; Bietry and Creusier, 2013; Lachmann *et al.*, 2010). One avenue of research has recently been developed in which the two approaches are integrated (Abord de Chatillon and Richard, 2015; Richard, 2012; Neveu, 2012; Detchessahar, 2011). These researchers include the management of well-being at work within the domain of human resource management by qualifying practices related to the management of occupational health. However, even though how we conceptualize suffering at work is well documented, the conceptualization of well-being is more recent, and is still in flux (Gollac, 2009; Biétry and Creusier, *Ibid.*).

Historically, four different approaches have been used, featuring different and complementary conceptions of well-being at work.

According to the hedonic school of thought, well-being at work is a state of subjective pleasure or happiness experienced at work as a result of processes that foster harmonious work relationships. For Cowen (1994), theorizing well-being should not be limited to an absence of psychopathology. Rather, it involves understanding the presence of positive manifestations of good functioning. Well-being at work does not consist of a simplistic evaluation of feelings of pleasure. Instead, it is the result of practices that create: (1) relationships of attachment, (2) the acquisition of skills that are appropriate to one's job, (3) the construction of harmonious interpersonal relationships, and (4) a setting that is favourable to mastering one's professional environment.

The personal expressiveness approach (eudaimonia) (Waterman, 1993) implies conceptualizing well-being at work on six dimensions: (1) work must allow an individual to thrive by developing his or her talents; (2) the individual must be able to act on his or her environment and confront the challenges it poses; (3) the individual must be able to act autonomously, taking initiatives in his or her work, while benefiting from a protective framework and flexibility and being able to make decisions and enjoy self-determination; (4) this leads to self-acceptance and a feeling of self-efficacy; (5) satisfaction is then provided by the feeling that the individual is a good fit with the work performed (an understanding of the work's meaning); and (6) this enables the individual to establish connections and positive relationships with others, support, and mutual enrichment.

Structural approaches distinguish between bottom-up and top-down models (Rolland, 2000). The bottom-up theories look for objective working conditions that are favourable to well-being. Top-down theories defend the idea of an individual's stable predisposition toward the work experience. They indicate that one's subjective view of the work determines a level of well-being that goes beyond its objective conditions. It would appear relevant to draw on both models, due to the constant inter-relationships between one's personality and one's work situation. This is the basis of interactional and transactional models for understanding occupational stress (Karasek, 1979; Siegrist, 1996).

Collective and psycho-sociological approaches present the work environment as ensuring that the conditions for well-being at work are maintained. A salutogenic

3 Salutogenic management that creates conditions for well-being? The SLAC model: sense, links, activity and comfort.

4 [URL: https://www.who.int/about/who-we-are/constitution].

social environment is defined as one that allows quality activities to develop and that serves as the source of one's power to act (Clot and Litim, 2008). This line of thinking is primarily concerned with the subjective and collective appropriation of the social world of work, of psychosocial resources and of the impediments that can affect it (Clot and Litim, 2008). This approach implies proposing a focus on activity, which creates intersubjective relationships. In this framework, work must be discussed in its objective, subjective and collective dimensions (Gomez, 2013), and discussion must be allowed of the quality of work within the work group.

Abord de Chatillon and Richard (2015) propose a synthetic model, integrating individual and subjective dimensions as well as collective and work organization dimensions. They identify four dimensions of well-being at work: (1) meaning, (2) connection, (3) activity, and (4) comfort.

First, sense or meaning is the subjective representation of work, the direction that guides actions, and coherence between values and actions (Morin and Cherré, 1999). This concept questions the objectification and purpose of the act of production. The construction of meaning and its actualization requires talking within a discussion space (Detchessahar, 2013), a space for dialogue to analyze the activity (Clot, 2008), and an ability to address real problems and keep work fresh (Desjours, 2009).

Second, links or connection includes support, recognition from one's colleagues, inclusion in a work group and the management of work spaces where one's social connections at work are developed and renewed (Thuderoz, 1995). Social connections refers to every form of social support and the quality of our interpersonal relations (Ruiller et Van Der Heijden, 2016). Relationships appear to play a central role in the construction and maintenance of well-being at work. The connection to oneself and to others is also achieved through exchanges, in discussion forums, on our actual experience of the activity.

Third, the activity is focused on what the individual does. Taking up the work of Clot (2010), Abord de Chatillon and Richard (*Ibid.*) associate work that is "well done" with well-being in the workplace. Achieving well-being at work depends on one's ability to act on oneself and on the work situation (Clot, 2010) in order to cope with the challenges faced (Zimmermann, 2011). Here again, spaces for discussion about the actual work performed play an important role, because they make the actual work visible and make it possible to produce arrangements and build quality in the work experience.

Fourth, comfort refers to the conditions under which this activity is carried out. It refers to a feeling of well-being that is at once physical, functional and psychological, ensuring quality of production as well as productivity. This feeling of comfort also includes meeting one's needs for autonomy, competence and being in relationships with others (Riou *et al.*, 2013). In this sense, a salutogenic workspace must be conceived as a place for communication, discussion, learning and group experiences, which employees appropriate and integrate into a cognitive and affective universe.

Name of the EHPAD	Duties of the persons interviewed
Le Château	Director, healthcare executive, and Welfare psychologist resource
Le Salut	Director, coordinating nurse, and Humanitude psychologist resource
Les Marches	General Manager, healthcare executive, and Humanitude nurse resource
Le Saint	Human Resources Manager, healthcare executive, and Humanitude nurse resource

Table 1 – Persons interviewed

Summarizing, Abord de Chatillon and Richard (2015) have modelled managerial, organizational and institutional logics that favour the emergence of a new model for managing well-being at work. This model respects people and takes their needs (physical, psychological and social) into account.

2. METHODOLOGY

The analyses are based on four case studies conducted to understand QWL practices. Twelve semi-structured interviews were held with EHPAD managers as well as 30 semi-structured interviews with employees. This contribution focuses on the interviews with managers. The interviewees were selected for their relevance to our topic of salutogenic management practices. This analysis empirically tested Abord de Chatillon and Richard's (2016) model.

Each of the four institutions was the site of a case study, and they were selected on the basis of two groups of data. The first was a list of facilities that had previously been identified by the regional health authority as innovative and proactive on QWL issues. The second data source was a comparison of a number of social indicators that are partially representative of QWL (Routelous and Ollivier, 2017) and regularly studied in the sector (Lux, 2015; 2019): the absenteeism rate and the turnover rate (see the table in Appendix 1.

PRESENTATION OF THE FOUR CASE STUDIES

LE SAINT

Le Saint is a public EHPAD associated with a local hospital. It has 148 residents and 99 employees (FTEs). The facility was rebuilt in 2011. It is located in a rural area, in a town with under 3,000 inhabitants. The facility was structured around the Humanitude approach and considers the promotion of QWL as another priority objective. Personalized care and service quality assessments are very much part of the facility's culture. The external assessment found that: "*Practices are constantly reviewed and improved.* [...] *Satisfaction surveys are conducted annually to assess the impact of changes in practices on satisfaction levels among both residents and professionals.* [...] *A concerted training plan, based on shared professional practices and 'Welfare,' has made it possible to open up areas of expertise, foster social interactions and encourage a common, interprofessional dynamic.* [...] *The facility has a policy of peer-to-peer training based on appointing resource persons in several areas of expertise*". Le Saint has two Humanitude resources, a steering committee, and an operational unit that were set up to support the Humanitude approach.

LES MARCHES

Les Marches is a public EHPAD associated with a local hospital. It has 150 residents and 103 employees (FTE). The facility was rebuilt in 2004. It is located in a rural area in a town of 1,300 inhabitants. One notable feature of Les Marches is that 76% of its residents have been diagnosed with a psychiatric illness and/or dementia. A shift in resident profiles toward more serious psychiatric and disruptive pathologies has required special support for the facility's staff. Much work is done to prevent psychosocial risks. To prevent burnout, senior management assigns improvement actions to improve working conditions. Staff members are regularly evaluated, and the facility organizes support for its professionals. The facility conducts satisfaction surveys. It seeks to manage through quality, and management has made a strong commitment to this goal. When the assistant manager responsible for quality arrived in January 2014, she began an overhaul of the approach used. In 2014 all staff members, in all the professions,

were trained on how to apply the continuous quality improvement approach. In support of the quality approach, the concept of the Humanitude project was made part of the deployment of the facility's overall project. More than 99% of the staff received this training, and since 2007 this project has made it possible to give meaning to everyone's actions and to regularly re-examine practices. The facility drafted a "Welfare" charter. Humanitude resource persons were designated, and they work with their colleagues to analyze practices, provide training in specific care practices and give support when problems arise in providing care to the facility's residents.

LE CHÂTEAU

Le Château is an autonomous public EHPAD that houses 127 patients and 81 employees (FTE). It is located in a town of 7,500 inhabitants approximately 15 kilometres from a regional city. "*The facility's project applies an approach that was voluntary, participative and collective. Residents were placed at the heart of the thought process of various actors in the structure.* [...] *The facility seeks to provide holistic, multidisciplinary support to each person*" (taken from the Le Château facility's project statement). The culture of promoting autonomy is supported by nurse resource persons in each department, ensuring a proactive approach. Times are set aside every day for consulting these resources. The facility has trained all its staff in non-medication patient support techniques (Humanitude, Naomi Feil, Snoezelen, etc.), and has set aside time for the professionals to discuss the residents' individual life plans. A continuous quality improvement process has been in place for many years and continues to be used. The facility is recognized for its institutional environment as a regional showcase project, in particular for how it supports people with psychological/ behavioural disorders. The facility serves as a training centre, and is well known as a good place to complete an internship. Psychosocial risks are prevented through annual professional evaluation interviews, meetings that are held to support professionals when problems arise, a QWL survey, a telephone number for psychological support, and the signing of local contracts to improve working conditions (implemented with CARSAT, the French national health insurance fund).

LE SALUT

Le Salut is an EHPAD owned by a private non-profit organization. It relies on an association that manages more than 122 French facilities and services. Le Salut, which opened in 2010, has 84 residents and 49 employees (FTE). It is located in a town of 47,000 inhabitants. The facility is developing a staff management system based on participatory management by objectives, and the project was drafted with the staff. The project emphasizes: "*a shared desire is that all residents should feel at home and be treated with humanity, which requires an unrelenting concern for good treatment of both residents and staff.* [...] *Our primary goal is to provide good treatment. It is a culture that inspires individual action and collective relations*" (excerpt from the Le Salut facility's project statement). According to an external evaluation, the facility's objectives underscore a desire to provide quality support. A personalized support project has been implemented in line with the facility's mission. Support is organized in accordance with the ebb and flow of residents' needs. The external evaluation found "*a strong mobilization of employees in a process of providing support to residents in a constructive spirit and above-average professional awareness*". The teams have integrated the concept of welfare into their practices. The goal is to allow for some adaptability in patient support. To this end, the teams are mobile within the structure, and task transfers have been institutionalized, particularly in terms of activities, so that everyone participates in overall patient support.

Using the social management control indicators, the four cases can be positioned as performing relatively well socially (in the first or second quartile). The absenteeism rate at each facility (restated after excluding absenteeism for training) is lower than the national median (9.8%)[5] and the regional median (10.1%) of each facility's administrative region. The finding for turnover rates is more or less the same, since they are relatively low compared to the national median (9.1%) and the regional median (6.9%).

The method used to analyze the qualitative data evolved over the course of the study. Initially our analytical approach was abductive and based on Eisenhardt's (1989) framework, which is considered particularly relevant for case studies (Langley, Abdallah, 2011). However, as the interviews progressed and we began analyzing the data, we moved toward a conceptual approach (Gioia *et al.*, 2013), applying the work of d'Abord de Chatillon and Richard (2015).

The purpose of this data analysis was to distinguish between the practices and tools implemented, based on the situations mentioned, in order to identify second-order themes in the form of a construct of "quality of life" oriented practices (Figure 1). In a second step, we tested the appropriateness of the Abord de Chatillon and Richard (2015) analysis grid by seeing whether it was possible to aggregate these second-order themes into dimensions that would correspond to the four aspects of quality of life developed by the authors: connections and the relational dimension of work, the activity performed, the meaning of work, comfort, and the conditions under which the work is carried out.

We also followed Wacheux's (1996) recommendations on the criteria for scientific case studies: the validity of the method (provides an effective and real account of the study's subject), internal acceptance (the proposed explanations must be submitted to the actors for discussion and validation), completeness or internal consistency (the proposed explanations must not contain internal contradictions nor contradict the facts), and saturation (the collection of additional data no longer adds any significant information to the established frame of reference). We submitted our results to the interviewees to ensure their accuracy. Lastly, the results reveal differences on several dimensions (the meaning of work is a dimension that cuts across the SLAC model, and we hypothesize that Humanitude is a factor that helps explain its transversal nature). The results make it possible to describe a salutogenic management plan that is broken down into areas of responsibility.

These steps were carried out after initially implementing an abductive approach (Eisenhardt, 1989) and then, based on the principles of grounded theory (as mentioned by Gioia *et al.* (2013)), the analysis was based on three major steps identified in the literature (Pratt, Rockmann and Kaufmann, 2006): (1) classifying verbatim transcripts of the interviews into a series of empirical themes, (2) abstracting these themes into conceptual categories that make sense in terms of the problem, and (3) connecting these categories in a theoretical model that can be used to identify practices and tools. The interviews were analyzed "manually" by parsing through the texts in search of concepts.

Step 1: Identifying empirical concepts, first-order analysis. We began by developing first-level codes (Strauss and Corbin, 1998) to simply describe the thoughts and meanings of the interview transcripts. These codes served as the basis for the tools and management practices that emerged from the study.

Step 2: Construction of conceptual themes, second-order analysis. In this second step we followed the recommendations of Strauss and Corbin (1998), carrying out axial coding to transform empirical concepts into conceptual categories through a process of abstraction. This construction involved going "back

5 Source: 2017 Medical-Social Dashboard, Bretagne regional health agency. [URL: https://www.bretagne.ars.sante.fr/sites/default/files/2017-03/Tableau%20de%20bord%20med-soc%202017%20VDEF.pdf].

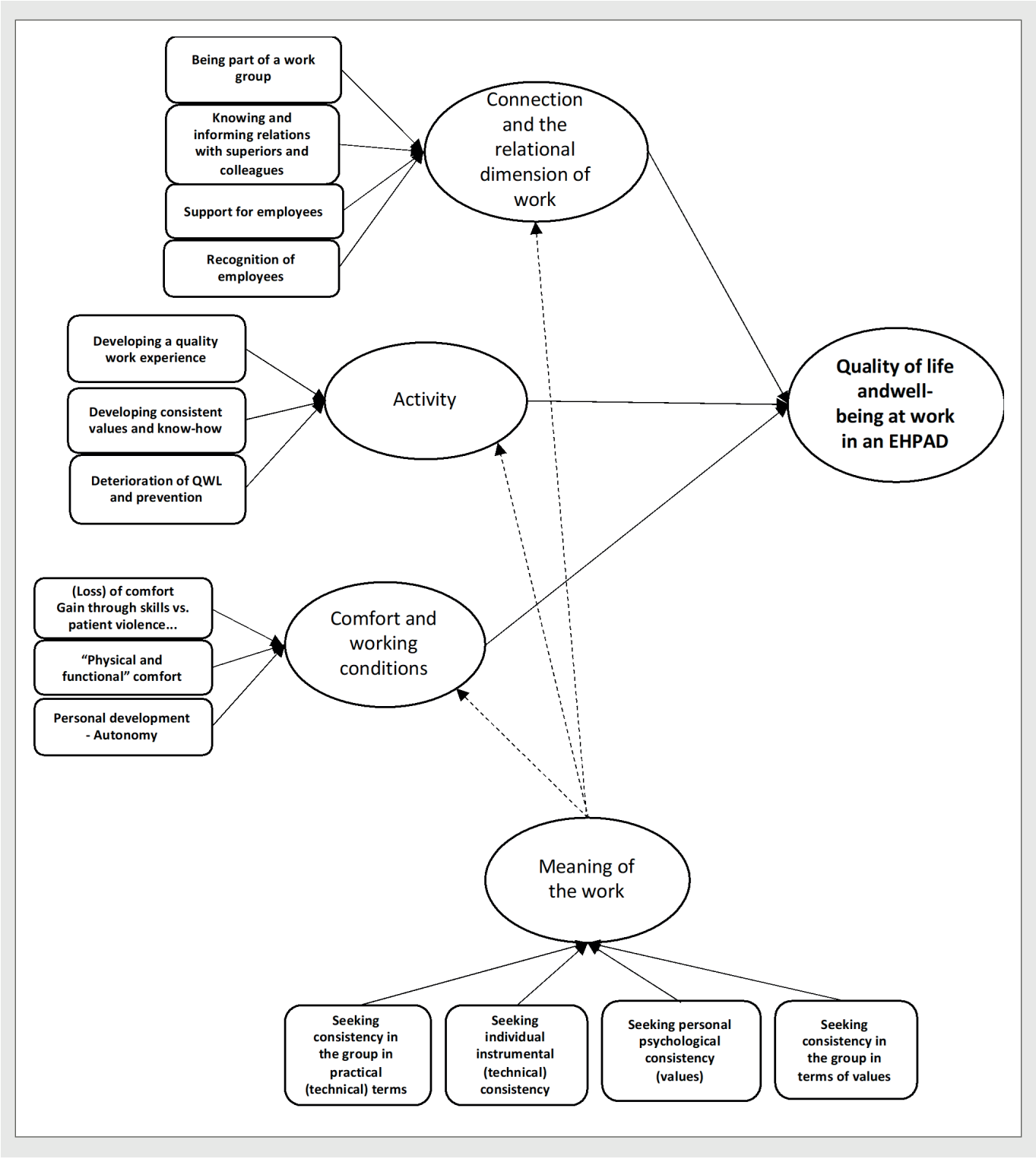

Figure 1 – Conceptual analysis according to the Gioia methodology

and forth" between the conceptual categories under construction and past academic works (in particular, the study by Abord de Chatillon and Richard – 2015).

Stage 3: Development of an explanatory and predictive model of the uses of management tools and design of the aggregated dimensions. The last step of the analysis consisted of aggregating and reconciling conceptual categories within the theoretical framework proposed by Abord de Chatillon and Richard (2015).

3. RESULTS: Testing the SLAC model in four EHPADs

3.1. Sense in work

Our results identify four subsets of meaning: (1) the meaning of action is shown through the facility's project as proposed by senior management and has a strong focus on the quality of support and care; (2) the meaning of action is supported and co-constructed by the Humanitude philosophy and care techniques, which promote an ethics of care and a global approach to patients; (3) meaning is also evident in the subjective representations of the employees and in its fit into their missions and the practices and values that have fostered their commitment to the health sector, and (4) meaning is debated and constructed collectively, through training sessions and discussion spaces, around the purpose and quality of their work.

An institutional will to value the meaning of work

The approaches adopted by all the facilities and spelled out in each of their projects is reflected in the comments made by senior and middle managers. The management teams consider dialogue around the missions a powerful lever for developing a culture of belonging. In all the cases, the facility's project benefits from a participatory and collective approach.

> "*We try to explain the objectives, meaning, method and commitments whenever we can. What are we asking them to do? What is the meaning of the work? Where are we going?*" – Manager, Le Saint.

The resident has been placed at the centre of the thought processes of the various actors in the structure. For example, Le Salut's project states: "*The common desire is that all residents feel at home and treated with humanity. This requires a constant concern for good treatment of residents and staff alike.* [...] *Our primary mission is to ensure their welfare. It is a culture that inspires individual action and collective relations. Treating people well is based on a culture of respect for the individual, for his or her background, dignity and uniqueness*". (Excerpt from Le Salut institutional project, 2015). The institutional project is therefore based on promoting the welfare of residents and staff alike.

> "*There are two key sentences that stand out in the facility's project. The first is 'to treat the residents well, you have to start by treating employees well.' And the other is: 'Would I want to grow old where I work now, and would I want someone like me to take care of me?' This is the conclusion of our facility's project. That's it. If your answer is no, then you need to ask yourself some questions!*" – Senior manager, Le Salut.

All four groups of senior managers share this desire to return to the foundations of "care", and they have chosen to mobilize training that is focused on good treatment and techniques for relational care.

Training-action that reflects the ethics of care

The Gineste-Marescotti® care methodology, known as Humanitude, repositions geriatric care in its caring dimension. The specific care techniques (based on sensory stimulation and techniques that are similar to physiotherapy) are intended to prevent the passive abuse associated with care without consent. The techniques give meaning to caregiver's actions as they acquire specific skills in supporting people who have lost physical and psychological autonomy or in managing periods of agitation and opposition from an elderly person. Humanitude goes beyond the usual tasks of nursing, promoting interventions aimed at improving patients' remaining abilities, behaviour and affect and adjusting the environment to suit the person's needs.

Fit between the aims behind the action and the advocated values

Consistency between the person providing care and the work carried out, between his or her desire to engage in a relationship, values, and desire to be involved in a comprehensive approach to support, is possible on a day-to-day basis in the caregiver's work

environment through the changes made to practices through this approach, which focuses on rendering support personal.

> "*It's much better and easier to set objectives for the resident with a holistic approach. And that is achieved through Humanitude, with the support project. I think it's great. And for this reason, I like my work even more than before. First of all, it's more rewarding for the caregiver. At least you have the impression that you're useful.*" – Humanitude nurse resource, Le Saint.

Many spaces to talk about the essence of one's profession

Training, practice analysis groups, in-house training on techniques, audits carried out by Humanitude respondents, etc., will help facilities move away from a hospital-centered culture, with limited personalization, toward more personalized support. The humanist values of the approach will then reflect the staff's commitment.

> "*We aren't in a routine, meaning that we do not apply the same method to all residents or to all the patients, as they do in the health sector. Here, each resident has his own individual care, which means that our work does not follow the same schedules. We will write care reports. We will analyze the request made by the person, the resident, and try to respect it, that's the important thing.* [...] *Our objective is to renew the person's sense of their life, to give them an image, respect for who they are, how they present themselves, etc. The objective is to make them live it.*" – Manager, Le Château.

The approach taken by senior managers and supported by the Humanitude training program encourages employees to stop often and take some time to think, collectively, about their facilities' missions and about good practices in relation to their values. As we will see below, this involves reflecting on the meaning of work and of what it means to do one's job well, and this takes time. It is connected to both the continuous quality improvement process and to the provisions governing the welfare approach. We should emphasize that collective work on sharing humanist values is a prerequisite and a catalyst for the approach taken.

3.2. Links in the workplace

Our results present three subsets of the relational dimension of work. First, creating a work group involved in the Humanitude project involves disseminating the Humanitude approach to all the organization's actors (caregivers and non-caregivers) through training and an analysis of practices. In addition to Humanitude, development of the group is encouraged through participative management, inter-departmental and inter-professional solidarity, and collective intelligence around project management (the individual patient's project, in particular). Second, management practices are built around developing trust in professional relationships and are reflected in a system for analyzing social data (satisfaction surveys, the role of shared human resources management and local management). Third, individual and group support and recognition practices are organized (through a training policy and a culture of systematic listening and recognition) and are subject to local and institutional regulations.

Creating a work group around the Humanitude project

In the four cases studied, all the staff were trained in the Humanitude philosophy, which constitutes a shared frame of reference. One of the objectives of this frame of reference (although not the main one, which is the care project) contributes to the work group's development. In one case, the collective around the Humanitude project is supported by a resource group dedicated to knowledge management (generating ideas and improving practices) and to preventing a dilution or loss of momentum in the well-being approach that is being applied by the teams. Local regulations may also be proposed through collegial meetings (Humanitude workshops) or additional training. One thing that the four facilities have in common is

that interprofessional cooperation is placed at the heart of the care project. This daily interdisciplinary approach around the patient encourages the meeting of professional worlds that, traditionally, do not necessarily meet. It is supported by multiple discussion forums on transmission, staff and meetings (within or between departments) when new or complex situations arise. The key role played by psychologists is brought to the fore to catalyze an inter-professional approach and disseminate it within the institution, but also to identify local real-world situations.

> "*So the psychologist will go and work on these things, and then we will meet with the psychologist, the coordinating physician, the manager and the local team on which this resident depends.*" – Nurse Humanitude resource, Le Saint.

Management practices aimed at incorporating, developing and maintaining relationships of trust at work

In all four facilities, management practices are organized in such a way as to foster interpersonal trust, but also to protect colleagues by preventing psychosocial risks (burnout). Beginning with the recruitment and integration of new resources, particular attention is paid to projecting the newcomer into the work environment to measure his or her ability to fit into the facility's project.

> "*New colleagues and employees are already welcomed through an interview with the manager. This interview already gives us a first impression, a feeling based on how things are expressed, of how things feel in relation to the self. Already at this stage we have a primary criterion. In fact, during this interview, we talk a lot about Humanitude.*" – Manager, Le Château

The annual evaluation interview then becomes a valuable tool as part of a proactive approach to activity design, but also to take stock of the colleague's experience in his or her relational environment and activity. It can then be used to adapt decision-making to support achievement of the latter (through a project for a job transfer, development within the institution, or employability through training). In one of the facilities, the annual interview is considered a powerful form of leverage for building a training policy that is consistent with the manager's vision. The manager assumes responsibility for it, using the interview as a determinant of perceived trust and of the credibility of his or her activism.

> "*In fact, starting in the first year I performed all the assessment interviews. I thought that afterwards I would delegate them to the health managers, especially for the care staff: orderlies, nursing aids and medical-psychological assistants. Then I realized that the professionals really needed them, and that they were important to them. I realized that for the professionals, the interviews were also a sign of recognition, that the manager would meet with them one-on-one, even if it was only for half an hour or twenty minutes.*" – Senior Manager, Le Château.

In all four facilities, training is seen not only as a tool but also as a time and place for discussing problems faced in the workplace. This questioning of the meaning of the work allows for the homogenization of work practices. Training is mainly focused on Humanitude practices, which are delivered through workshops in two of the facilities, where an analysis of practices on subjects targeted by the Humanitude resources facilitates the work by auditing care practices, from a "win-win" perspective for the patient and the caregiver.

At the same time, in three of the facilities a system for analyzing social data makes it possible to take the pulse of the work teams. Satisfaction surveys and undesirable event reports are used to identify and, ultimately, prevent incidents that may cause inter-professional relations to deteriorate.

> "*And we had – I think it was last year – several files from members of the cleaning staff who said that they didn't feel recognized at all by their colleagues.*" – Manager, Les Marches.

In addition to these tools for organizational audits, in two of the facilities internal communication is supported by tools aimed at more remote connections.

> "*The intranet system is not bad, because we can communicate – of course we can communicate orally – but we also have this communication through the intranet that allows us to use questions and answers. It's clear: there's a question, and there's an answer.*" – Senior Manager, Le Château.

Internal communications through electronic channels can be seen as a means to maintain a sense of closeness when the members of the institution are "out of sync" (variable work schedules, split schedules, misalignment in the work schedules of caregivers and their supervisors). It is also noteworthy that over the last year one facility has been experimenting with a toll-free number (provided under the insurance taken out by the facility) that employees can call for psychological support 24 hours a day if they experience suffering at work or personal problems.

Individual and collective support and recognition practices

In the four facilities studied, support and recognition practices are highlighted through the prism of a management style unanimously described as "participatory". All four EHPADs have systematized a culture of listening to and thanking others.

> "*For example, last weekend there was an epidemic of gastroenteritis. Both staff and residents took sick. We didn't have any replacements because they couldn't find any, so the staff worked it out amongst themselves. I asked that a note be put in the care software to thank everyone. It's the least we can do.*" – Senior manager, Les Marches.

The key role of local managers is thus highlighted in their local oversight and regulating role, relaying information within the departments, to think of organizational support practices at the level of the institution and to prevent risks, particularly psychosocial risks. Internal collaboration in the four facilities takes the form of companionship practices (registered nurse – nursing aid; nursing aid – orderly pairs), through a culture of listening and holding meetings, and through the role played by Humanitude resources and psychologists trying to enhance individual and collective performance and organizing workshops to analyze practices with a view to continuous improvement.

> "*If they want to, they can. The objective is that the employee – and they know this – takes whatever point of entry they prefer. Either they will take the psychologist, or the supervisor, or the Humanitude nurse resource. Or they can go to their manager directly.*" – Manager, Le Château.

3.3. Activity: developing the quality of work content

One of the sources of well-being at work is being able to do one's job well. An analysis of the transcripts of managers, supervisors and functions that serve as salutogenic practice resources allowed us to identify two dimensions that favour a job "well done". Work that is well done is defined first and foremost by the development of the quality of the work's content. This reflects a system of shared values, newly acquired skills, professional practices that make greater use of autonomy and accountability, and feedback from management. And a job well done is also made possible when the administration is attentive to human resources management and the organization of work.

Here we clearly see the dimensions revealed by the literature on motivation at work. Management is focused on the content of work. It gives individuals more fulfilling and rewarding tasks, and supervisors provide feedback and support employees. The work then becomes less mechanical, allowing people to deploy more of their competencies and not become demotivated because of routine work, which professionals find pointless and for which they receive no feedback.

Thinking collectively about the quality of work

Working on "well-being" as the guiding principle of the facility's project and with the Humanitude method makes room for discussions of humanist values, the meaning of the mission and work "well done".

> "*I would say that for the residents, I have seen a notable improvement over my 20 years here. It is enormous. I find a much more holistic approach is taken with residents, unlike before. We have the impression that we are bringing something positive to them. As a result, it has allowed us to ask some questions… other questions, and the right ones. Now the focus is not on ourselves, but on the residents.*" – Humanitude nurse resource, Les Marches.

The approach allows time for real collective thinking about good practice guidelines, to reflect on actual situations identified in the facility. The regular analysis of practices and audits carried out by the Humanitude resources, psychologists and managers allow for greater consideration of individuals and their needs, and to "refocus" the facility's project and daily practices on personalizing patient care. It is a collective learning process that occurs over time and as part of professional practices, related to the continuous quality improvement process.

> "*The audit mobilizes a considerable amount of energy, a lot of people, a lot of time. It occurs from time to time and it's related to the work of the Quality Office. Lately, the subject was clothing: were we respecting people's choices? Were we taking the time to ask them how they wanted to dress? Because that too is part of the Humanitude framework. The individual must be given choices in all areas of their lives, as long as they are still capable of choosing, as long as they can still decide. That is also how we respect the person.*" – Humanitude nurse resource, Le Saint.

In the longer term, it is important is to avoid returning to routines that could be focused on the organization at the expense of people. To this end, the facilities implement numerous mechanisms by which peers and the hierarchy audit and analyze practices. These mechanisms require a significant amount of time and resources. They require a strong commitment from management and enough time to provide personalized support to new arrivals, in order to support Humanitude practices by monitoring routines, the time set aside for discussion and time spent in training for a personalized project, etc. The Humanitude resource persons have time for this. There are resource groups in three of the facilities, and all the facilities hold workshops to analyze practices, mentor new professionals and provide in-house training. Time is also set aside for nurses to allow for grooming assessments or grooming with two staff members. As much as possible, "personalized" time – for more relational purposes – is also set aside in the afternoon to encourage a focus on residents' expectations, in particular for those who are no longer able to participate actively in group activities.

Developing the competencies needed to meet new support challenges

Management is attentive to the problems faced by professionals. Management pays particular attention to: feedback received from the institution representing the facility's staff; the DUERP (a mandatory document on work-related risks); records documenting undesirable events (such as violent behaviour by patients or their family or friends); annual interviews; and all information that reveals problems in the actual work performed. This information is used to set short-term objectives for staff training or external party interventions designed to support the facility's personnel. When unprecedented situations arise, the annual training plan is redirected to address the limits of the professionals' competencies.

Senior managers at all the facilities have shown a willingness to use the training plan to their caregivers' benefit, above and beyond what is required by regulation. Three of the facilities dedicate more funds to training than what is required by regulation. All four facilities emphasize the training policy as a means to support and recognize the problems encountered by staff in their work.

Enriching tasks by enhancing the relational component of support

In addition to the skills that enable the staff to manage defensive behaviour and other problems related to dementia or refusal of care, training on grooming assessments within the framework of Humanitude gives caregivers a better understanding of residents' remaining abilities and enables them to define objectives for dependency prevention. This enhances the content of their mission and opens up a field of expertise that is not mobilized by the institution's attending physicians. This training represents leadership in preventing loss of autonomy, it enhances employees' mission as EHPAD caregivers, and it redefines "gerontological" expertise, which tends to be denigrated in the hospital sector.

> "*It's much more worthwhile, and you can set goals for the resident when we take a holistic approach. And that's much better. That's through Humanitude, with the support project. I think it's great.*" – Humanitude nurse resource, Les Marches.

In this context, all tasks, whether related to care, support, logistics, etc., are valued because they help personalize the support provided.

> "*Humanitude is not just about the caregivers, it's also about the kitchen, because the kitchen will pay attention to the meals. It's also about housekeeping, maintenance, and linen services. And about the administration. It's also about how we speak to people, it's how we communicate.*" – Senior Manager, Le Salut.

There is less hierarchy implicit in the tasks, since the relational component is the core of the value system. Consideration for the person, holistically and individually, drives a multidisciplinary approach that contributes to better cooperation between the professions. New prerogatives backed up by new competencies enrich the tasks performed by the professionals who are in contact with residents. Beyond the tasks themselves, it is also the organization of these tasks that is evolving, as this is mediated by the professionals, individually, to meet the need for personalized care.

Enabling greater staff empowerment and accountability

The personalization of support projects renders the organization of work more complex, but it also gives the caregiver much more autonomy. The personalized project incorporates a great deal of flexibility in terms of when the care will be provided, making the individual caregiver responsible for ensuring that the practices correspond to the patient's needs and expectations. While this work requires a considerable ability to adapt and anticipate, this responsibility for personalization also gives caregivers a great deal of autonomy in carrying out their tasks.

> "*The role of the Humanitude resource is also about interest in the work. It's about responsibilities.* [...] *In any case, everything that has a project dimension, everything that gives meaning, everything that makes things dynamic, actually helps prevent problems... It isn't burnout, it's boredom, I think. It's part of one's personal recognition. It's that, plus many other little things too, that enable them to escape the day-to-day... and see themselves involved in something else. That's important.*" – Senior Manager, Les Marches.

The risk of this empowerment and the increase in skills lies in a higher density of tasks during one's work hours and a potential conflict between roles, given the difficulty of doing everything that one knows can and should be done for the good of the patient, given the workload and the amount of time available.

> "*Often we only remember the negative stuff, what we would have liked to do more of, but can't.*" – Humanitude nurse resource, Le Saint.

Giving feedback on the work performed and recognizing commitment

Recognition is given for work well done when the management team thanks groups and individuals. The administration values the teams for the progress they have made and the excellence of practices as recognized by the outside world.

> "*The external evaluations were rather positive, because we received compliments. What I liked was that it allowed us to highlight everything we could accomplish. Since many things have just become part of our working habits, we didn't necessarily realize how much had changed, especially since the introduction of the Humanitude approach. This has enabled us to highlight all the positive things we can do.*" – Humanitude nurse resource, Le Saint.

The satisfaction linked to feedback recalls the individual's need to be informed about the consequences of his or her achievements and the results for the organization. The approach is primarily participatory when decisions are made that affect employees' QWL.

> "*When we worked on the cost savings plan, we gave them choices on several issues, in particular whether to increase the split schedules or to reduce the number of days off. For them, the choice was clear: they preferred to eliminate days off rather than add more split schedules. The additional split schedules make it possible to cut costs more, but on the other hand, it's true that split schedules represent a considerable deterioration in QWL, because they mean that you spend your day at work.*" – Senior Manager, Les Marches.

The work of showing consideration for employees is also evident when management recognizes their involvement in the work. This turns the Humanitude resources' missions into opportunities to value individual investments. The Humanitude resource role promotes the employee's personal investment and his or her skills in something of strategic value to the organization.

As a result, there is a real effort to develop quality content in the work itself, which involves: (1) working on skills, (2) working on enriching current tasks, (3) achieving greater autonomy and responsibility with regard to the tasks to be carried out, and (4) greater appreciation of tasks that support organizational performance, in relation to (5) feedback and recognition of the work performed and its difficulties.

Here we find the points made by Abord de Chatillon *et al.* regarding the need to: (1) enable individuals to take action and have the ability to take up the activity and face the challenges posed by the work experience; (2) allow individuals to contribute to the development of their well-being in the workplace through responsible action; and (3) enhance the quality of the work experience and the conditions of wellbeing at work by addressing the problems of real work as a group.

However, we feel it is important to stress two points at this stage. First, the focus on humanist values was an important factor in getting individuals to subscribe to the management approach, and feedback and attention from management also represents crucial leverage in the process of enriching the work's content and in being able to do a job well. These actions focused on the content of the work are also part of the practices that require real attention from senior management, with regard to the staff and their well-being at work. This is particularly true because of the risk of role tensions between what is "possible" in the work, as enriched by training and autonomy, and the limits to which the work can be made more dense and institutional resources capped over the long term.

3.4. Comfort

One of the sources of well-being at work is "*comfort and the conditions under which the work is performed*". An analysis of the comments made by senior managers, supervisors and Humanitude resource functions enables us to identify: (1) two types of "practices" that foster this comfort, but also (2) one area that highlights the strong constraints on implementing these practices within the sector's tight budgets, both for the facilities and for certain employees.

Physical comfort and personal development as a determining factor of the conditions in which work is performed

The comments collected in our case studies tend to confirm the importance of physical comfort and personal development as factors in well-being at work, confirming work by others on the subject.

Physical and functional comfort appears to be the primary focus of work by organizations seeking to improve QWL, with several practices appearing repeatedly in the transcripts. First, technical training is often mentioned by senior managers and supervisors. In practical terms, this refers to skill maintenance training (technical training) to prevent musculoskeletal disorders, but it also refers to training on interpersonal relations to prevent mental distress and, more generally, psychosocial risks. All of these skills appear to be essential to maintaining one's position, so they are identified as necessary to achieving well-being at work.

> "*So, in 2011 or 2012 there was a call for projects for local contracts to improve working conditions, so we submitted a project and we got, I think, €35,000, maybe more. We got equipment, as well as training on how to prevent risks related to physical activity. Such training covers musculoskeletal disorders, and we also had occupational health and safety training.*" – Senior Manager, Le Château.
>
> "*We move the person without pain, or at least we keep the pain to a minimum, but at the same time it's useful to protect the caregiver's back, it's good for both of them. We did what we call a sliding transfer. They were pleased because, as they said, it required less exertion than usual, and the person didn't feel any pain.*" – Humanitude nurse resource, Le Salut.

In all four EHPADs, this training is accompanied by the purchase of specific equipment and technical adjustments to workstations to limit musculoskeletal problems.

> "*So we have proposed three tracks on the Verger floor. We are trying to see if this way of completing transfers could be good for residents. It turns out that, at the start I was apprehensive, because I thought that a resident is fragile and already in pain during a transfer from a wheelchair. And the resident is sometimes apprehensive. We realized that the residents are very satisfied with this kind of transfer.*" – Manager, Le Château.

These choices were almost all made by the organization's senior managers who, in addition to acquiring tools to improve QWL, see them as practices for better human resource management (reducing occupational accidents, absenteeism, complaints of problems in day-to-day work). The occupational health and safety committee is regularly cited as a "tool" for such management, as is the ergonomist.

In addition to these practices—some of which are legal obligations or whose use is strongly encouraged by public authorities —, the organizations demonstrate flexibility and innovate in order to provide their employees with physical and functional comfort. Some organizations will sometimes offer employees a new position within the organization or, more frequently, a choice of arrangements: a fixed or mobile position.

> "*The manager asked to know what each person wanted, whether they preferred a rotation or to stay on a specific floor or unit* [...]. *From there, Humanitude resource persons were appointed. They were also identified for better continuity of care, to allow for the best communication possible.*" – Welfare resource psychologist, Le Salut.
>
> "*So this person did not want to return to her department. She was offered another department at another site. And now she's even got a permanent position. It's going well. So, it's on a voluntary basis or as required. Not always in cases like this, as this was an extreme case, but when managers point out that someone is not doing well, is not working out, is no longer adjusting to the situation, or that something is wrong, attempts are made to move that person to another department. And often it works out well.*" – Manager, Les Marches.

Beyond strictly technical or functional approaches, some departments pay particular attention to the personal development of individuals, developing practices that promote psychological comfort. This includes a real career development policy as well as practices to support mobility, designed to help employees develop to their full potential.

More generally, psychological conditions are improved by supervisory practices.

> "*I think it's obvious: the teams that are hurting, the teams that are suffering. There is a something that is constant, or at least frequent – it's just an impression, it can't be measured objectively – between the presence of management, how the teams are managed, how they are supported and how they work. Teams whose supervision is inconsistent... Afterwards, there are several types of instability, we'll say... But when there is a manager who is not stable, who is very moody, it doesn't help the teams feel secure...*" – Manager, Le Château.

The work of studying positions by mission or work interest is also considered a practice that fosters personal development. In all four case studies, all of these practices are almost exclusively carried out by the facility's leadership.

Tense care context that limits these practices

While our respondents' remarks make it possible to very clearly identify certain practices that favour better physical, functional and psychological conditions for work, it also becomes clear that these practices are very stressful, and subject to the organizations' budget limitations (which affects replacements of absent staff, in particular, and equipment purchases), the care staff ratio (present and trained) and the residents' level of dependence (which has increased considerably in recent years). This situation is such that certain practices may be impossible to implement, or even negative for an organization that does not have the required financial and human means to achieve them. For example, setting aside time for building a relationship with a resident (which makes the work more interesting) "consumes" time, and the organization may have compensate by limiting transmission time (the Le Salut case), which is nevertheless necessary for quality operations and services. Similarly, allowing too much versatility in the organization, to make the positions more interesting, can be detrimental to quality, as illustrated by the following citation.

> "*So we worked at reorganizing the positions, so that the employees do more than just clean. The problem is that this affected quality, because today it's one employee and tomorrow it's another, and the quality of the work suffers.*" – Senior manager, Le Château.

The search for a better work-life balance may also lead to the elimination of split schedules, which may result in a shortage of human resources at certain times.

> "*That's what it's all about: avoiding fatigue and having a life. When you're on a split, if you can't go home at lunchtime, you end up staying here for twelve, thirteen hours... If you spend your salary, slightly above the minimum wage, on gas, that's it! There's no point to it.*" – Senior manager, Le Salut.

On the other hand, it appears that certain practices that make it possible to improve one aspect of working conditions may, at the same time, harm another. For example, training and machines that allow for better technical execution of care are so easy that they may sometimes harm relational time with residents.

Also, in a bottom-up approach to well-being at work, we identify concrete practices that can be developed within medical-social structures. The goal is to improve working conditions and therefore QWL, but also to remove obstacles to these practices. The practices in this area are based on investments at several levels of the organization.

4. DISCUSSION

This contribution has sought to produce actionable knowledge for practitioners by shedding light on something in the construction of well-being in the workplace that is not well known to human resource management practitioners. The objective was to provide an understanding of well-being in the workplace and the processes by which it occurs, from the perspective of human resources management as well as sustainable organization management. By taking this approach, we are following in the footsteps of Hatchuel (2000), who places management sciences in relation to ethical considerations of the usefulness of the knowledge provided. As an extension of these analyses, we wish to shed light on the managerial and organizational dimensions of salutogenic human resource management in a sector stigmatized for both its working conditions and the lack of quality work in employees' contacts with patients.

Our results can be divided into two parts. First, they corroborate the SLAC model while describing more fully the independence of the sense / meaning dimension, which is inseparable from the activity. We assume that this diffusion of meaning in the relational dimension of work, in the activity itself and in comfort is linked to the ethics of care in the four facilities' projects. This is reflected in particular in the care methods focused on "welfare" supported by the Humanitude care methodology. The fit managers seek between the values advocated and the outcome of action is reflected pragmatically in an individualization of practices, at the level of both care and management. The focus on the quality of the support provided comes with an emphasis on the employees' quality of life.

The managerial approach is based first and foremost on providing training in new skills that reflect values related to caring for employees (1). The approach also involves various forums for discussing problems faced in the work and the quality of the work with patients (2). In this context, middle managers and Humanitude resource persons, as per management's concerns, provide considerable support to the work teams, both in general and to their individual members (3). This work supports the continuous quality improvement process (4). Management therefore has four complementary mechanisms that support each other in a virtuous circle.

On the other hand, our results suggest a plan for managing well-being at work along the dimensions of the SLAC model. They lead us to propose a classification of salutogenic managerial practices, based on the categories of the SLAC model and presented by areas of responsibility (see the table in Appendix 2).

First, although management's responsibility for the meaning of work is based on the investment plan, the facility's project or the training policy, it is reflected at the operational level by managers' facilitating position and by the proactive role played by Humanitude resources, who analyze the work and guarantee dialogue.

Second, with regard to connection, senior management's responsibility refers to a policy for recognizing colleagues and the relational dimension of the work, and aims to achieve inter-professional collaboration. For the supervisors, this means playing the role of "transmission belt" between senior management and the care teams. The resource caregivers take part in organizational support by actively monitoring the problems encountered in the support work and providing specific knowledge to the members of all professional groups.

Third, senior management's responsibility in terms of activity involves organizing working hours and training time according to the demands of the care units to ensure quality work. Managers position themselves as serving a "bottom-up" approach in order to translate caregivers' demands, and they manage in response to the employees' needs. As for the caregivers, they are free to decide how they organize work in response to everyday problems and to personalize the care they provide.

Fourth, senior management's responsibility for comfort takes the form of the organization's willingness to show an interest in the well-being of its employees, in terms of both their physical comfort and their personal development. Many actions go beyond the regulatory expectations. Senior management maintains a strategic watch on funding opportunities that could support well-being at work. Managers are supported in their work of relaying information, and are positioned to support the teams in the field.

The fact remains that salutogenic working conditions are threatened by an imbalance between the time

dedicated to nursing and the time spent in a more relational approach and in mobilizing the residents' remaining abilities. With the limits on their resources, organizations have to deal with a higher level of dependency (levels of dependency and levels of required care have continued to rise in EHPADs, particularly in the private sector and in public sector EHPADs associated with a health facility). A broad mix of patient profiles (GIR profiles 1 to 4) has been replaced by a population that is concentrated in the most dependent profiles (GIR profiles 1 and 2). In this context, the level of support provided by nurses jeopardizes the availability of caregivers for times when more non-technical care is required. The development of a life plan and more relational support methods, as well as the time spent discussing good practices and support, must be achieved with whatever time is left over. This raises issues about the limits of a salutogenic management model in a work context, where the work is increasingly intense and manpower shortages are getting worse (Bazin and Muller, 2018).

Another issue that will require attention is the challenge presented by management's proximity to the work teams. The deployment of multi-annual contracts of objectives and means and the impact on budgets of fee reforms may encourage actors to group together, placing limits on the single-site EHPAD model. In small structures, this would mean creating multi-site manager positions, individuals who are only present at each site on a "part-time" basis. This change is currently taking place without the role of middle management and without the need for a subsidiary on site having been defined.

The fact remains that institutional policy, which is expressed in the leadership of a director, appears to be central. The director's humanist vision of management policy, his or her ability to achieve a personal managerial vision internally and develop inter-organization relations (to find funding, to develop a strategic concept, to exchange practices, etc.) are all things that can serve as either levers or obstacles to operationalizing the tools and practices identified in this study.

Finally, our study has several limitations. First, our work does not incorporate the points of view of the other organizational stakeholders, i.e. the employees and the residents. Second, our study is based on an approach that is centered on the organization and does not take into account interactions with the fee-setting authorities (local, regional and national), nor the work of national agencies such as the scientific health authority (HAS) and the national performance support authority (ANAP), nor even future reforms. In the future, it will undoubtedly be useful to examine the disability sector as well, to see if the ratio of staff per patient is a determining factor in the model's applicability, since the ratio is significantly higher in this sector. It would also be useful to see, in the context of a return to financial equilibrium, whether the facilities are able to undertake an ambitious policy on training and discussion time within their currently available means. Second, we have not performed an inter-case analysis. In the future, a comparison of good practices among the four case studies will allow us to gain some perspective on employees' perceptions of the management practices discussed in this contribution.

CONCLUSION

This contribution has sought to identify the key managerial tools and postures for constructing the conditions of well-being based on four EHPAD case studies through an empirical implementation of the SLAC model (Abord de Chatillon and Richard, 2015). Our results have various theoretical and managerial implications. We show that the sense / meaning of work is a cross-cutting dimension of SLAC, which we will seek to verify through a future operationalization.

Our results suggest a multilevel classification of the key managerial tools and postures for a salutogenic organization. They also open a discussion on the contingency factors that either foster or hinder the conditions necessary for such an organization. The recent experience with COVID-19 may shed additional light on this issue.

The mobilization of all stakeholders in the four cases studied would depend significantly on these contingency factors. Our conclusions open up numerous avenues for future research, particularly on the issue of prevention practices in occupational health and safety.

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APPENDIX 1
Table of Absenteeism and Turnover Rates at the Surveyed Facilities

	ABSENTEEISM RATE	TURNOVER RATE
Le Château	8,2% (excluding training)	1,9% (excluding retirement departures*)
Le Salut	9,6% (excluding training)	3,4% (hexcluding retirement departures)
Les Marches	9% (excluding training)	(2,5%) (excluding retirement departures)
Le Saint	8,9% (excluding training)	(1,2%) (excluding retirement departures)

*Note that this rate may, at times, be significantly affected by the age distribution of employees (retirement departures).

APPENDIX 2

Table Presenting Salutogenic Management Practices and Tools by EHPAD Hierarchical Level

	Senior managers	Managers	Humanitude resources
Meaning	Investment plan Facility project Continuous improvement and quality initiatives Training policy	Facilitator Key player and position in interprofessional coordination Training and getting the activity started	Analysis of the work Participation in training sessions and interactions – discussions of Humanitude
Connection	Recognition policy Interprofessional approaches (project management, joint tasks, etc.) Investments in resources (e.g. psychologist) Exemplarity Internal audits (e.g. satisfaction, feedback on undesirable events) "External" recognition: inter-institutional relations Permanence of connection and listening = 24-hour hotline	Create interprofessional relations and spaces for dialogue Connection, transmission belt with senior management and Humanitude resources Analysis of practices	Active listening and peer support Empathetic attitude
Activity	Training plan and responsiveness = matching the plan to institutional needs Benchmarking in relation to calls for projects from the supervisory authorities Search for resources and funding to support the teams (equipment purchases, psychological support)	Reporting and escalating adverse events (bottom-up) Social support for the team Strategist for staff mobility and replacements Recognition of the relational dimension of nursing Delegation and empowerment Recognition and support = reassurance for colleagues	Free discussion of how missions/tasks are organized Spreading good practices Satisfaction with work well done Feeling of being recognized for one's commitment Residents' satisfaction with relational aspects Recognition of the resident and his or her family

	Senior managers	Managers	Humanitude resources
Comfort	Occupational health and safety committee Physical and psychological ergonomics training plan Proposals for organizational flexibility (positions, mobility) Investment plan (machines, work) Professional promotion (psychological comfort)	Proposals for flexibility in the care service Annual assessment interview = study of the tasks and the interest of the work for employees Support for employees' desire for mobility and job enrichment	Position studies Active listening