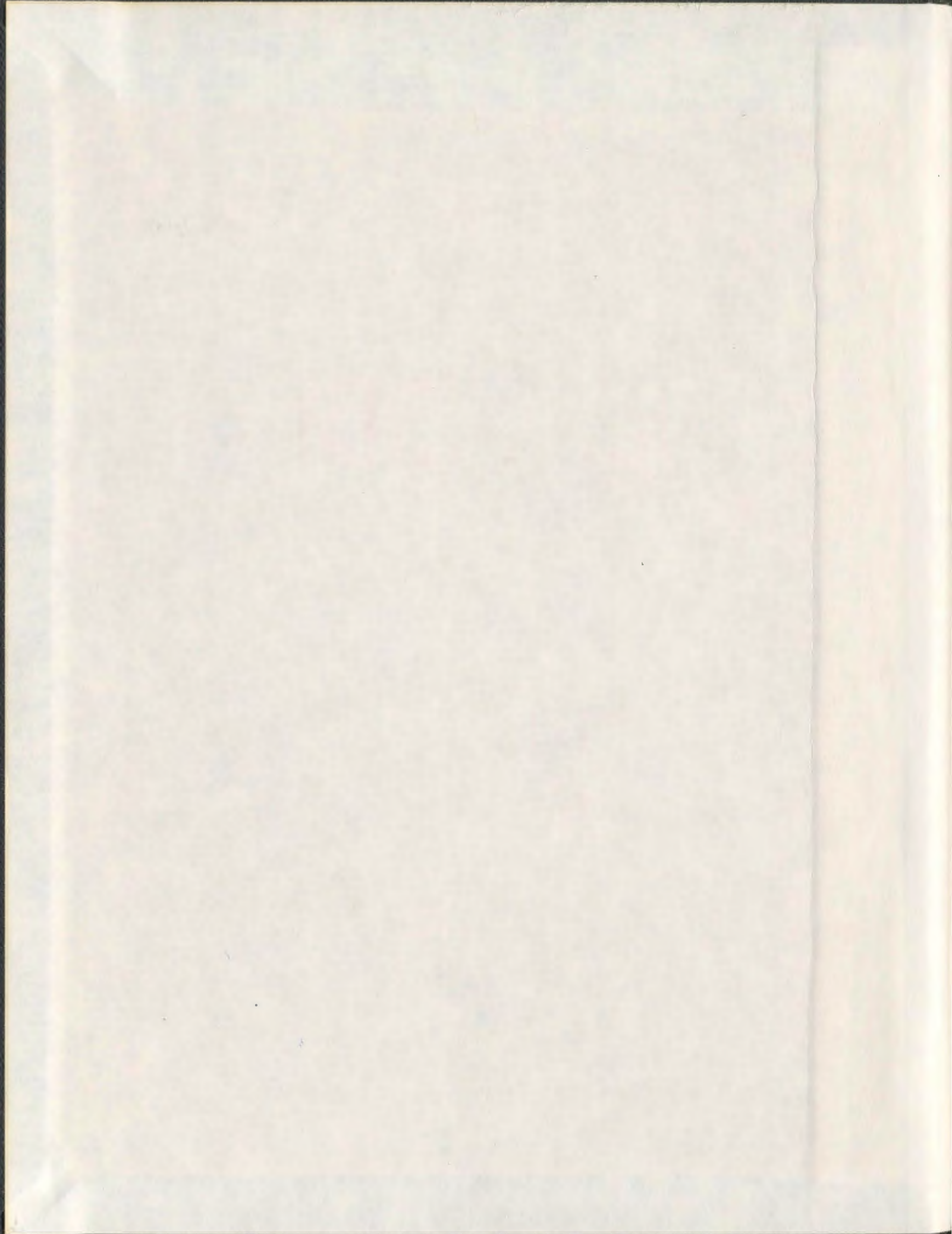


MAPPING SOCIAL RELATIONS OF OLDER WORKERS'
EMPLOYMENT: USING INSTITUTIONAL ETHNOGRAPHY
TO EXPLORE THE MEANING AND ORGANIZATION OF
WORK, HEALTH, AND SAFETY OF AGING WORKERS
IN THE HOME SUPPORT SECTOR

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Mapping social relations of older workers' employment: using institutional ethnography to explore the meaning and organization of work, health, and safety of aging workers in the home support sector

by

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Abstract

Demographic trends both provincially and nationally indicate increasing life expectancy and growing numbers of older adults living with chronic disease and disability. Human resource projections predict that Canada will need to double the number of formal home care workers in order to meet future demands. This demographic change has also resulted in increasing numbers of older adults choosing to remain engaged in the workforce past the traditional age time of retirement. Research on supportive services in the community has identified the issues and challenges of homecare but little has addressed the complex interplay of economic, political, and social factors that have resulted in the health and safety challenges associated with the work provided by home support workers. Using a method of inquiry called Institutional Ethnography, this research explored the meaning of work and health and safety considerations of workers over 50 years old who are providing home support services in Newfoundland. This exploration of health and safety needs and practices, work environments, as well as policies and government systems regulating the employment of workers can be summarized into three threads that describe the everyday work of these aging home support workers: Crossing Boundaries - More Than Just a Job; Making it Work in Unhealthy and Unsafe Work Environments; and Becoming a Home Support Worker: Experience, Orientation, and Training Necessary to do the Work. The findings suggest that decision making practices to engage in risk taking behaviour that impact health and safety in the workplace are influenced by the meaning of work as well as the emotional connections and close, personal

relationships with clients. It is anticipated that this research may positively influence the health and safety of aging workers in this sector. This will be achieved through the recommendations for policy and practice that emerged from this research including the development and implementation of a risk assessment tool for home support workers, clear standards on education, orientation, and training , wage parity with the acute care sector, and more clarity on title, roles, and responsibilities of home support workers.

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List of Acronyms

HRLE	Human Resources Labour and Employment
IE	Institutional Ethnography
MOW	Meaning of Work
NAPE	Newfoundland and Labrador Association of Public and Private Employees
OH&S	Occupational Health and Safety
RIHA	Regional Integrated Health Authority

Chapter 1

Introduction

Projections indicate that the demand for community health care services will exceed the supply of human resources in the very near future (Canadian Home Care Association, 2003; Keefe & Légaré, 2008). Home care has become an important part of our health care system, since many Canadians are choosing to remain at home as they age and/or manage chronic disease and disability. The aging population, the growing numbers of disabled seniors, earlier discharge from acute care for those with complex care needs, and the de-institutionalization of younger, disabled clients mean that more people will require some degree of community-based supportive services.

Concerns exist about the number of workers who will be available to provide this care (Canadian Home Care Association, 2008a; Keefe, & Légaré, 2008; Keefe, Knight, Martin-Matthews, & Légaré, 2011). The aging population has led to a shortage of health care workers, and the home support sector is no exception. Shifting demographics and the changing organization of the workplace are leading to an aging home care workforce. Increasing numbers of older adults are continuing to remain engaged in the work force and, therefore, protection of their health and safety is imperative. Additional research on the health and safety needs of aging workers has the potential to improve health and safety as well as the recruitment and retention of aging and experienced workers in this area of health care.

Background

The large number of seniors in the Canadian population can be attributed to several factors: declining birth rates, the aging of the baby boomer generation, and increased longevity. The aging of the baby boom generation has accelerated the growth not only in the number of older Canadians but also in the number of older people with chronic illness and disabilities, resulting in an expanding need for supportive home care services.

Home care has been defined as “the full array of services offered at home and in the community to support those who need help to remain in the home and those who care for them” (Canadian Healthcare Association, 2009, p. 22). The home care sector is an important part of our health care system and is a key factor in primary health care and chronic disease management. Home support incorporates a variety of services that facilitate individuals remaining in their own homes. These services include personal and behavioural supports, household management, respite services, and home maintenance. This care is provided by family and/ or by workers who may be untrained or who may have some degree of formal training through an approved college offering a home support worker/personal care attendant training program.

Home care costs in Canada had doubled over the ten year period from 1994-2004 ten years (from the period 1994-2004) from 1.6 billion to 3.4 billion dollars (Canadian Institute for Health Information, 2007). During this same ten-year period, the number of home care recipients had increased by 24 percent. More recently, it has been noted that at any given time, 1 million Canadians are receiving home care (Canadian Homecare Association, 2008) with the majority (82%) being older than 65 (CIHI, 2011). High

turnover rates and fewer workers choosing to enter the home support sector are resulting in an inadequate number of workers to provide care to these clients. Nationally, concerns exist in relation to the quality of care provided—issues like breaks in continuity of care, families having to adapt to changing workers, and alterations in the way that care is coordinated (Denton, Zeytinoglu, Davies, & Hunter, 2005).

The delivery of health services to individuals living in the community is a fast-growing sector within the health care system in Canada. Statistics Canada (2011a) indicated that 14.8% of Canadian citizens are over 65 years of age, a figure which has increased from 13.7% in 2006. This percentage is expected to increase to 23-25% by 2036. Based on their projections for home support services Keefe and Légaré (2008) and Keefe, Knight, Martin-Matthews and Légaré (2011) predicted that the population of seniors aged 65 and older requiring assistance in the home is expected to more than double between 2006 and 2031. Home care programs nationally have increased their number of home care recipients by 51% (Canadian Home Care Association, 2008a). One reason for this growth can be attributed to increasing numbers of individuals choosing to remain in their own homes and to receive care there. Other factors include an aging population, increasing numbers of Canadians suffering from chronic disease and disability, and earlier discharges from the hospital setting necessitating more home-based supportive care. Family and friends—informal care providers—remain the greatest contributors to the support of older people in the community (Keefe & Légaré). However, the proportion of formal support services required is projected to grow at a much faster rate than in previous years. The provision of supportive home care services is key to maintaining the

security of individuals in their home environment, thus reducing the number and length of hospital stays and delaying institutionalization (Keefe & Légaré).

As the number of aging and disabled people grows and the resulting need for home care increases, the gap between supply and demand widens. Shifting demographics indicate that the workforce in Canada is also changing; consequently, there is increasing concern about labour shortages. Statistics Canada (2009) reported that in 2005 there were an estimated 2.3 million Canadian workers over the age of 55, a number that represented 14% of the total workforce. The majority (60%) of that 14% were men, and most (84%) were between the ages of 55 and 64. They were working in sales and service; business, finance and administration; and trades, transport, and equipment operation. By 2020, it is anticipated that workers over age 64 will comprise 26% of the working age population (Human Resources Labour and Employment [HRLE], 2011). More recently, Statistics Canada (2011a) projected that by 2036 the number of employed seniors over age 65 will rise from 20 for every 100 people in the workforce to 39 for every 100 people in the workforce.

The Canadian Home Care Association estimated that in 2003 there were over 32,000 home support workers working across Canada. Fifty to 70% of this workforce at the time of the study was 40 years and older, indicating that very few younger adults were entering this field of work. Recruitment initiatives of many home support agencies are competing with those of hospitals and long-term care facilities that offer better salaries and regular schedules.

How one defines older workers varies across provinces, within provincial departments, and from one jurisdiction to another. The literature has various definitions

(applied in different contexts) of “older workers,” with ages ranging anywhere from 40+ to 65+. For example, an older worker is defined by the Age, Employment and Discrimination Act as a worker of 40+ years of age, by Human Resources and Employment Development Canada (HRDC) (2007) as 45+, and by various studies conducted by Statistics Canada as over 50.

It is difficult to obtain accurate statistics to determine the number of home support workers in Canada and, more specifically, older workers in home care, because of the variation in job descriptions and classifications. In Newfoundland and Labrador, British Columbia, New Brunswick, the Yukon, and the Northwest Territories, the term “home support worker” identifies the provider of care in the home. Other terms used by the Canadian Research Network for Care in the Community (2010) include “personal support worker” (Ontario), “resident care worker” (Prince Edward Island), and health care aide (Quebec & Alberta). In this dissertation, I will use the term “home support worker,” to be consistent with the title used in Newfoundland and Labrador.

Home Care Nationally and Provincially

Health care reform involving hospital and home-based health systems has focused on reducing health care expenditures (Denton, Zeytinoglu, Kusch, & Davies, 2007). Health care reform was initiated when provincial and federal governments sought out efficient and cost-effective alternatives to care provided in hospitals and institutions. In 1986, the federal government began reducing its contributions to provincial health budgets, and most provinces responded by cutting acute care expenditures and shifting care to the community (Deber et al., 1998). This reform involved the home and hospital health care systems shifting their focus from expensive acute care institutions to

community-based/home-based settings as a cost-efficient health care model. Care became more focused in the community setting with the services of home support workers. This care was believed to reduce health care costs for two reasons. First, people were being discharged sooner from hospital, so fewer patients occupied acute care beds. Second, home care was often provided by less skilled workers, who were paid lower wages (Denton, Zeytinoglu, Davies, & Hunter, 2005).

The market-modelled home care approach resulted in increased “casualized employment.” This term has been defined by Zeytinoglu, Denton, Davies, and Plenderleith (2009) as non-permanent employment; it refers to part-time hours, on call work, split shifts, pay-per-visit work hours, and hourly pay with variable hours. Casualized employment in home care was a result of health system reform in the 1990s that greatly affected work environments, the management of human resources, union management, and employee attitudes (Zeytinoglu et al., 2009). The majority of home care workers are, increasingly, employed on a part-time and casual basis. This shift to the market-modelled competitive home care system, with the resultant casualization of workers, has had detrimental health and safety consequences for front line workers and therefore made the recruitment and retention of qualified workers in this field a challenge (Denton et al., 2005; Zeytinoglu & Denton, 2006).

The Ontario Community Support Association (2000) estimated that the turnover rate for home support workers was double to triple that of other health care workers across Canada. The undervalued work and the reportedly poor working conditions have posed many challenges for the recruitment and retention of qualified workers. Job-specific factors such as high travel costs, health and safety concerns in people’s homes,

low wages, work-related stress, and professional isolation lead to job dissatisfaction (Denton et al., 2005). If these issues are not addressed, the current home care sector will be unable to meet the increasing demands of the aging population. This deficit may result in seniors having to access their required health care needs in acute care and long-term care settings, as they will not be able to remain in their own homes without support.

Factors affecting satisfaction and retention in this sector include a lack of resources, increased work intensity, budget cuts, dissatisfaction with the hours of work, and wage benefit inequalities compared to hospital and nursing home sectors (Zeytinoglu & Denton, 2006). Home support workers have a wide range of responsibilities, including the provision of personal care, patient transfers (e.g., from bed to chair), housekeeping services, and medication dispensing; as well, they may be responsible for performing more complex tasks such as ileostomy and colostomy care and the testing of blood glucose levels. Some of these responsibilities may place the home care worker at risk for health and safety. Furthermore, the health and safety of workers are believed to be jeopardized by long shifts, split shifts, a lack of orientation and training, low wages, and poor working environments.

Significance of This Research in Newfoundland and Labrador

The Canada Health Act, which governs Canada's publicly funded and insured health care system does not include home care as an insured service. Unlike medically necessary hospital and physician services that are publically funded, home care is defined as an extended service and therefore, the federal government is not required to provide funding for it (Canadian Healthcare Association, 2009). Provincial governments provide some public funding for home support services; however, no defined standards or policy

exist to ensure the amount of services funded. Policies vary by province in terms of access to delivery of home care services. In Newfoundland Labrador, funds are provided to the Regional Integrated Health Authority (RIHA) from the provincial budget. Provincial governments have each developed individualized home care arrangements, and each province is responsible for managing a budget that includes a mix of health promotion; disease prevention; and primary, acute, and long-term care services (Sharkey, Larsen, & Mildon, 2003).

Home care programs were introduced in 1975 in the province of Newfoundland and Labrador (Newfoundland and Labrador Association of Public and Private Employees [NAPE]), where they are now delivered as a provincial program with policies and services implemented through a coordinated system of assessment, planning, and service delivery by the RIHA. Home care recipients are eligible to receive publically funded coverage for short-term support services (up to two weeks), as well as palliative care (if the person is deemed to have less than four weeks to live). Some clients may require longer term home support services. In that case, the provision of services depends on a financial assessment. As a result, some individuals have to pay for home support services out of their own earnings or savings while others may be eligible if they can demonstrate that they have exhausted all other sources of financial support.

The Government of Newfoundland and Labrador (2007) in recognition of the aging population of Newfoundland, made healthy aging a priority area for future policy development. In 2006, the government developed the Provincial Healthy Aging Implementation Plan after consultations with over 1000 people in 17 communities. Six priority directions to promote healthy aging were identified, and two of these priority

areas directly link with my research. The first is “Building Supportive Communities”; with one of its goals being the development of policies and programs related to provincial home support programs. The plan recommended the development and continuation of home care services to make these programs age-friendly and to ensure an adequate number of care providers for the aging population and, as well, to expand the home support. A second priority area, “Employment, Education and Research,” identified priority areas of program planning that included recognizing the need for human resource networks to plan for an aging workforce and implementation initiatives to recruit workers in the area of aging and seniors.

Research on supportive services in the community has identified the issues, challenges, and opportunities for home care, including some research on the health and safety of these workers, but few studies have addressed the complex interplay of economic, historical, political, and social factors that have resulted in the challenges faced by home support workers. Research on employment practices, the meaning of work, and the health needs of aging home support workers can contribute to the effective design of workplaces, which in this context are the clients’ homes. Research has demonstrated the demanding responsibilities of home support workers, yet little is known about how workers negotiate the policies and practicalities of their work every day to protect their own health and safety.

The Workplace Health, Safety, and Compensation Commission in Newfoundland and Labrador (2012) indicated the types of injuries reported by workers in the home support sector. According to the Commission, home support services are classified under Home Maker Services. These are defined by Workplace

Health, Safety, and Compensation Commission as “Establishments primarily engaged in providing physical care and emotional support and in carrying out daily household activities such as cleaning, meal preparation, laundering, shopping, and care of children etc.. to create or preserve a wholesome environment within the homes of clients who are incapacitated or cannot cope” (Workers Compensation Commission, 2012). According to their statistics, the top injury for workers in home maker services in the years 2005–2011 (for all age groups) were over-exertion in lifting; injuries from bending, climbing, crawling, reaching, and twisting; and falls to the floor, walkway or other surfaces. More specifically, in the 50+ age group, the top three reported injuries were sprains, strains and tears; traumatic injuries to muscles, tendons, ligaments, and joints; and back injuries. From 2005-2011 there were 308 injuries reported to the WHSCC for lost work time due to injury in the home maker industry (for all age groups) with 64 of those in the 50 and older age group. (WHSCC, 2012). However, the prevalence rates for injuries in the home support sector are difficult to track, mainly because many injuries are unreported and there may be a number of reasons that would account for underreporting. Many workers are working outside an agency setting and working without any compensation benefits that would protect them if they were injured. In addition, many workers fear reprisal from their employers if they reported an injury or don't think that their injuries are significant enough to report.

Purpose of Study

The purpose of my research was to use a method of inquiry called Institutional Ethnography (IE) to explore the work lives of home support service

workers over the age of 50. From the standpoint of these workers, I wanted to explore the meaning of work, health and safety needs and practices, and work environments, as well as policies and government systems regulating their employment. My research explores how these factors organize everyday processes for making decisions about the health and safety of aging home support workers. An understanding of the factors that impact both the recruitment and retention of older workers is significant considering we have an aging workforce and older workers may have different reasons for working as well as different experiences than younger workers.

A central aim of this study was to identify implications for program or policy change that may improve the health, safety, and working lives of these care providers. My research has enabled me to make recommendations to improve the everyday work and experiences of home support workers that I believe will improve recruitment and retention of qualified workers in this field.

This research investigated five broad areas:

1. The everyday experiences of aging workers in the home support sector and, more specifically, the work that they did.
2. Factors influencing aging home support workers' decision to remain working and the meaning of work for them.
3. The multiple social relations that generated these everyday experiences and gave meaning to the experience of work.

4. The ways in which their work was constructed and influenced by the work of others and coordinated with outside events, policies, and regulations; and
5. Workers' descriptions of their age as a factor that influenced their ability to do their job, to protect their health and safety in the workplace, and their decision to stay in the workforce.

Organization of Dissertation

This dissertation is organized into eight chapters. In this chapter I provided the background to my study, including statistics on the aging population and aging workers. I identified the increasing need for home support services and presented the broad areas to be investigated. The purpose of the study was explained, and I highlighted the context of home care in Newfoundland and Labrador.

Chapter 2 is the first of two literature review chapters that form the foundation of my study into the everyday experiences of aging workers in the home support sector. This chapter presents literature pertaining to the meaning of employment and examines the financial and non-financial incentives of employment.

Chapter 3 provides an extensive review of the literature concerning employment and safety practices in home support. This body of knowledge includes ideas about health and safety, recruitment and retention, and employment practices. The chapter highlights how these factors affect health and safety in the home support sector, with particular consideration of aging workers.

Chapter 4 outlines the theoretical and methodological perspectives of Institutional Ethnography that guided my study. I explain my own epistemological perspective, how

this viewpoint guided my choice of methodology, and how my research proceeded. I explain in detail the methods of data collection and analysis, as well as ethical considerations followed in accordance with the Tri-Council Policy Statement 1 governing research involving human subjects.

In chapters 5, 6, and 7, I present and discuss my research findings in the context of the relevant literature and show how my research adds to this available research. Each of these chapters is dedicated to one thread of information that explicates the everyday experiences of these aging home support workers. These three main threads are (1) Crossing Boundaries—More than Just a Job; (2) Making It Work in Unhealthy and Unsafe Work Environments; and (3) Becoming a Home Care Worker: Experience, Orientation, and Training Necessary to do the Work. In each chapter, I analyze the standardized texts or policies that organized the home support worker's day-to-day work and present excerpts from narratives generated by front line workers that affected decisions regarding health and safety practices. Some of these texts include the Newfoundland and Labrador Regional Health Authority Operational Standards, the Newfoundland and Labrador Association of Public and Private Employees (NAPE) union contract, discharge planning policies and processes as part of the Operational Standards, and the curriculum for the Home Support Worker/ Personal Care Attendant Training program.

In Chapter 8, I offer my concluding remarks and present the implications of my study. I argue that workers' decisions about the protection of their health and safety are largely determined by the meaning of work and their close and emotional relationships with their clients. I also provide four broad recommendations for practitioners in this area of health care. First, a safety risk assessment tool for home support workers to be

developed and implemented; second, clear guidelines on education, orientation, and training need to be developed and utilized by home support agencies and the broader organizing institutions of the RIHA; third, wage parity is necessary with the long-term care and acute care sectors; and fourth, clarification of the titles, roles, and responsibilities of home support workers should be implemented. I discuss how these recommendations will enhance the everyday work experiences for these aging workers. In addition, I suggest that implementation of these recommendations will improve both the quality and consistency of care for those in need of home support. I conclude the thesis with a reflection on the limitations of my study and recommendations for future research.

Chapter 2

The Meaning of Work

A comprehensive review of the literature including policy documents confirms that demographic changes are affecting the demographics of the workforce and, therefore, the structure of the labour market. As life expectancy increases, many aging workers are remaining in the workforce and it is important to understand the meaning of work for these workers and how this meaning constructs decisions to protect health and safety in the workplace. In this chapter, I provide an overview of the literature pertaining to aging and employment, with a focus on the meaning of work (MOW). A thorough review of the literature indicated that few studies have linked both the meaning of work and the health and safety considerations for aging workers in the home support sector.

The literature reviewed for this chapter was retrieved from a number of electronic databases including CINAHL, PubMed, and Academic Premier. The search terms used were “older worker,” “aging worker,” “work,” “meaning of work,” “health and safety”, “home care,” “home support,” “employment,” “significance of work,” “work motivators,” “homecare worker,” and “home support worker.” The terms “home support worker” and “home care worker” have been used interchangeably, depending on how the research defines home support worker, where the research has been conducted, and what terms are used in that area to define this type of employment.

Meaning of Work for Aging Workers

Work and the meaning of work have been the focus of researchers in many disciplines, including sociology and psychology, for many years. People often look for meaning in their work and this meaning can assist in valuing or ascribing the significance

of work to them. Work is a necessary aspect of many people's lives and may experience it as a source of joy and fulfillment or, perhaps, as an unhappy but necessary function of daily life. Work constitutes a major part of one's life, and workers' satisfaction varies among individuals (Howes, 2008; Rosso, Dekas & Wrzesniewski, 2010) and affects their quality of life (Chou, Fu, Kroger & Ru-yan, 2010).

Research on the meaning of work for older adults has been ongoing for many years. Early research from the 1950s included the work of Friedman and Havighurst (1954), who noted that work has great significance for older adults. Their study of five occupational groups of men over age 55 showed that one-third to two-thirds of workers wanted to continue to work past age 65. In their research, Friedman and Havighurst indicated that work can perform as many as five functions—it can provide income, provide for expenditure of time and activity (something to do), assist with the identification of the person in his group (job and role identity), fix patterns of association (for example, employee-employer relations, friendships), and provide a set of meaningful life experiences, including contacts with persons, objects, and ideas. Although work can perform the same functions for most workers, the meaning of work may differ among individuals or groups.

In the 1960s, a Canada Pension Plan (CPP) at age 65 and the Old Age Security (OAS) benefit at age 70 became available, however, some older workers opted for part-time or short-term work in order to remain involved in the workforce and earn more money. Changes in the labour market, including an increase in flexible, short-term, and part-time employment opportunities, as well as the elimination of mandatory retirement have facilitated older workers' continued

connection with the workforce and this trend has emphasized the importance of research about the meaning of work for older workers.

In defining the meaning of work, the Meaning of Work (MOW) International Research Team (1987) suggested that the meaning of work relates to the significance that people find in the work they do. Many older workers construct the meaning of work as a function of many factors, including work values, expectations, and norms. The MOW International Research Team considered the meaning of work to be a personal construct that contained three elements: work centrality (importance of working to the individual), social norms about working (societal beliefs and expectations), and valued work outcomes (the results of working, such as income or personal growth).

The available literature on the meaning of work is vast. Puplampu (2009) implied that the meaning of work is not clearly defined, and there has been much debate in the literature as to definitions. The term “meaning” has various conceptual definitions that may include concepts such as significance, cultural or social meaning. Puplampu suggested that the confusion maybe caused by the interchangeable use of terms such as work values, work ethics, work attitudes, and work motivation.

One perspective considers the meaning of work as part of an individual’s subjective interpretations and perceptions of work experiences and interactions (Baumeister, 1991; Shacklock & Brunetto, 2011; Wrzesniewski, 2003). This perspective attributes a sense of agency to individuals by providing definitions of the meaning of work that may include general beliefs, values, and attitudes about work,

as well as the personal experience and significance of work (MOW International Research Team, 1987; Wrzesniewski, Dutton, & Debebe, 2003).

Wrzesniewski, Dutton, and Debebe (2003) postulated a model of “interpersonal sensemaking” and explained how this sense making contributed to the meaning that employees make of their work. These authors considered the role of others in the construction of the meaning of work. Their model’s contribution lies in its ability to shift the focus of meaning of work from elements within the employee or the job to the social interplay between the employee and others on the job; it also addresses the social context in which work is carried out. This research offers a new perspective, in that much literature exploring the meaning of work concerns individual values, job characteristics, and work satisfaction, but little has addressed the role of others, such as co-workers, supervisors, clients, and customers. This model explores the role of employees and employers, and their part in creating meaning that constitutes interpersonal sensemaking.

Another perspective considered the meaning that people ascribe to aspects of their lives that reflect a system of social or cultural values (Rosso, Dekas, & Wrzesniewski, 2010). This perspective suggested the meaning of work may be strongly influenced by sociocultural forces, as when older workers derive their meaning of work from social expectations that require them to be productive members of society. This is evident when one considers the history of the theories of aging and social engagement. To illustrate this point I provide a brief overview of sociological theories such as the life course theory and the disengagement theory and show how these theories have shaped the meaning of work.

Many theories of aging are marked by a degenerative paradigm leading to a body of scientific and social knowledge and attitudes defining aging as an unavoidable and universal decrease in physical, cognitive, emotional, and social skills and abilities. These hegemonic discourses that are endorsed through powerful social institutions such as employment and work become embedded in our everyday lives and are central to the meaning of work and attitudes about work.

Sociological theories explain and predict changes in roles and relationships of older adults. One major focus of these sociological theories of aging is the adjustment to new roles and new transitions, such as employment and retirement. For example, the Life Course theoretical perspective explains an individual's progression through time with an expected pattern of change in biological, sociological, and psychological contexts (Chappell, McDonald, & Stones, 2008; Elder, 1992; Hagestad, 1990). These patterns are believed to be age-defined and socially acceptable patterns of change and transition throughout life, and society has expectations about when individuals take on or exit from expected social roles (Chappell et al.), such as when they retire or continue to work.

Some sociological theories of aging, such as Disengagement Theory, suggest that "aging is an inevitable, mutual withdrawal or disengagement; resulting in decreased interaction between the aging person and others in the social system he belongs to" (Cumming & Henry, 1961, p.2). This implies that the individual's withdrawal from society and the community as one ages is natural and acceptable. The basic tenet of this theory is that withdrawal occurs and is agreed upon by both the individual and society (Chappell et al., 2008; Touhy & Jett, 2010). This theory

however, is not without its critics, as many older adults are not opting for disengagement or withdrawal from society but remain active in their communities and maintain aspects of their previous lifestyles, such as unpaid volunteer work or active employment.

Other theories allow for a different and emerging view of the older adult in society and in the workplace to understand the meaning of work. The Theory of Productive Aging was first introduced by Dr. Robert Butler in 1982. He asked the important question: “will 69 million baby boomers suddenly drop out of the workforce when they turn 65? It is difficult to imagine this generation, with its talent, education, and experience, idling away the last thirty years of life” (Butler, 200, p. vii). Supporters of Butler’s theory challenge the myth of unproductivity (Hendricks, 1995). Butler and Gleason (1985) stated that productive aging is the “capacity of an individual or population to serve in the paid workforce; to serve in volunteer activities; to assist in the family; and to maintain, to varying degrees, autonomy and independence for as long as possible” (p. 39). Productive aging is becoming an increasingly important concept as the demographic shift of older adults continues. These theories help set the context for work and the meaning of work as many older adults remain active in the workforce to be productive and contributing members of society.

The Meaning of Work in the Home Support Sector

This following section will summarize relevant research conducted specifically on the meaning of work and then apply this research to the MOW in the home support sector, presenting both extrinsic and intrinsic work motivators.

Herzberg, Mausner, and Snyderman (1959) were the first to distinguish between extrinsic and intrinsic motivators for work. These motivators also have been referred to as the financial and non-financial rewards. Herzberg et al.'s early work identified intrinsic motivators that included opportunities for advancement, achievement, and recognition, with later research focusing on interest in work, creativity, and fulfillment. Extrinsic work factors included motivators such as pay, working conditions, and job security.

The wide range of literature reviewed for this chapter indicated that there is a diverse research base on the meaning of work, but few studies highlighting the meaning of work for older workers within the specific context of the home support sector. One body of literature emphasizes the financial incentive as an essential component of work. Another perspective centres on the emotional and personal values that workers gain from their employment. I argue that the meaning of work for home care workers is embedded somewhere between the laborious responsibilities that accompany this work as being required for the financial rewards of their work and the sense of personal fulfillment. These two notions are closely linked with the five functions of work defined by Friedman and Havighurst (1954). The rewards of income, expenditure of time, identification of person, patterns of association, and meaningful life experiences that were identified in the early 1950s are still identified in the current literature.

Extrinsic Rewards of Work

Research shows that those with financial needs focus more on the economic value of work (Kemper et al., 2008; Leana, Stiehl, & Mittal, 2009), and research on

the financial incentives for understanding motivations to work and the meaning of work has been widely noted in the literature (Brief, Brett, Futter, & Stein, 1997; Hursh, Lui, & Pransky, 2006; Silverstein, 2007; Vohs, Mead, & Goode, 2006). Like their younger counterparts, some older workers are still supporting families; some may be experiencing a change in marital status that affects their finances; others are still paying mortgages, or they have no private pension benefits and are, therefore, saving for retirement (Shacklock, Brunetto, & Nelson, 2009; Silverstein, 2008). Increasingly, older adults are choosing to work, or are working, beyond the traditional age of retirement due to the need for money caused by a decline in retirement savings and financial insecurity or mounting costs of health benefits.

In 2006, Newfoundland and Labrador had the second-highest poverty rate of all the Canadian provinces (Government of NL Poverty Reduction Strategy, 2006). One of the groups identified as being most vulnerable to poverty was the 55- to 64-year-old group (Department of Human Resources, Labour and Employment [HRLE], 2011). This vulnerability may be attributed to lower education, employment in lower paying jobs, or membership in a one-income family. The working poor constitute about 8.5% of all employed people earning the minimum wage. These workers have few, if any, benefits or job security. Statistics on income show that the situation improves somewhat after age 65, when seniors can access the Old Age Security (OAS) Program and the Canada Pension Plan (CPP) provided by the federal government.

With an emphasis on the extrinsic or financial rewards of work, Nugent (2007) surveyed home support workers in New Brunswick, examining the

demographic characteristics and working conditions of home support workers (aged 18-69) in that province. Of the returned surveys, 86.45% identified the need for change to their current work situation that included better wages, improved benefits (for example, paid vacation time, travel expense reimbursement, and medical insurance), a modified work schedule (for example, consistent schedules, rotating schedules, and scheduling of clients close to their homes) and more training. Other changes recommended by workers in this study included a more specific communication of the job description and more information about a client's case. However, a limitation of this study is that these 400 participants were not classified according to age; therefore, it is unknown whether older or younger workers suggested a need to change their work situation.

For women in particular, working into their senior years in a low-paying job is often a financial necessity. Many women have worked part time, had interrupted periods of work, or did not work outside the home and, therefore, did not pay into a pension plan or have retirement benefits (Wegman & McGee, 2004). In an early study, Astin (1984) identified sociological factors such as increased longevity, medical advances, increased divorce rates, and changes in the economy as just a few of the factors that influence women's commitment to continued paid employment. Statistics Canada (2011b) reported that in 2009, women accounted for 58.3% of the general work force in Canada, double the number of working women in 1976. In 2010, Canada's Labour Force Survey reported that 14.8% of workers worked in part-time jobs, and women represented 70.4% of these part-time workers. Women's paid work tends to be less valued than men's, and women in some sectors still earn

considerably less than men for work of the same value. However, in the home support sector in NL, both males and females earn the same hourly wage. In the home support sector, the majority of workers are midlife women of lower socio-economic status (Butler, 2009; Stacey, 2005; Yamanda, 2005).

Overall, women fare worse than men in terms of wages, however, between 1988 and 2008, the female-male wage gap closed by 16.2% among older workers aged 50 to 54 as women's wages grew 11.6% faster than men's (Statistics Canada, 2011b). One of the reasons for the lower average annual income among women is the impact of part-time employment in jobs that tend to have lower weekly wages (HRLE, 2011). Despite the arguments for the financial incentives for continued employment there are also workers who work for reasons other than for the financial rewards.

Intrinsic Rewards of Work

Another body of literature suggests that older workers may also find value in the non-financial or intrinsic rewards of their work (Eustis, Kane, & Fischer, 1993; Kanungo & Hartwick, 1987; Olsson & Ingvad, 2001; Smyer & Pitt-Catsouphes, 2007). As described by Freidman and Havighurst (1954) and Herzberg et al. (1959), some older adults work into their senior years for intrinsic rewards which may include the opportunity to be productive members of society, to socialize and interact with others, or to retain a sense of identity as an active member of the workforce.

A wealth of literature focuses on the non-financial meaning of work; however, limited recent research addresses the context of the home support sector (Butler, 2009; Delp, Wallace, Geiger-Brown, & Muntaner, 2010; Howes, 2008;

Sims-Gould, Byrne, Craven, Martin-Matthews, & Keefe, 2010; Stacey, 2005). These studies suggested that the meaning of older workers' employment in home care can be largely determined not by financial factors but by intrinsic rewards. Home support work is challenging, and workers frequently do not receive adequate recognition for the work they do. Despite these drawbacks, they continue to provide care in often stressful working conditions for lower pay with few opportunities for advancement.

In an early study on the meaning of work, Morse and Weiss (1955) examined the extent to which work serves non-monetary functions for both middle and working class occupational groups such as professional managers, sales workers, farmers, trades workers, machine operators, and service workers. They reported that in general 80% of male workers said they would continue to work even if they did not have to. Although a major reason for working was the monetary reward, the reasons for *wanting* to continue to work were non-monetary. These findings are consistent with more recent literature on the non-financial meaning of work within the home support sector (Butler, 2009; Delp, Wallace, Geiger-Brown, & Muntaner, 2010; Howes, 2008; Olsson & Ingvad, 2001; Sims-Gould et al., 2010; Stacey, 2005). According to these authors, many people reported that they would continue to work without pay if they did not need the salary (Morse & Weiss). This trend was believed to decrease in later decades (Vecchio, 1980); however, recent research demonstrates that financial incentives to work become less compelling as people realize that there are other more powerful motivators (Shacklock, Brunetto, & Nelson, 2009; Sims-Gould et al., 2010).

Studies of home health care aides have identified close relationships between clients and their home care workers (Aronson & Neysmith, 1996; Piercy, 2000). Positive relationships with clients give meaning to the work of home health aides and increase job satisfaction (Karner, 1998; Piercy & Woolley, 1999). Using interviews with home health aides and their clients, Piercy (2000) described most of the relationships between clients and workers as “friendly,” “friendships,” or “like one of the family.” The conditions that facilitated these friendly relationships included continuity of care (e.g., having received the care from the same workers), social isolation (e.g., those who were socially isolated or alone developed closer relationships with their workers), and homogeneity (e.g., the matching of gender with workers and clients facilitated positive experiences with care).

Another study, similar to Howes’ (2008) research that explored intrinsic rewards of work, highlighted multiple factors influencing the decision to choose employment in home support (Sims-Gould et al., 2010). Fifty-seven home support workers (predominately females ages 22-70) in three Canadian provinces were interviewed to explore factors that drew them to home support. It was suggested that the meaning of work for these workers was constructed by many factors, including the enjoyment of working with people, previous experience in caring for a relative or friend, and the financial necessity of work. These three factors were strong predictors for people choosing to work and find meaning in this field. In both Howes’ (2008) and Sims-Gould et al., studies the meaning of work for caregivers extended beyond financial reimbursement.

In an investigation on the meaning of work and intention to continue work, Shacklock and Brunetto (2011) extended the meaning of work theoretical model that was developed initially by the MOW International Research Team (1987) and further refined by Westwood and Lok (2003). The initial meaning of work model (MOW International Research Team) explained workers' intentions to continue with paid employment and measured the impact of work-related factors on the decision to work. Their research showed that older workers' intention to continue with employment is based not only on health and financial factors but also on four work-related variables: the importance of working to the individual, the flexibility of work arrangements, the workers' interests outside work, and management factors such as supervision, bureaucracy, and the work environment. The first theoretical model developed by the MOW International Research failed to explain how the meaning of work influenced intentions to continue working. Shacklock and Brunetto's research on older workers clearly defined the impact of work-related factors upon the meaning of work and, therefore, upon older workers' intentions to continue work. However, the study is limited in that it did not consider workplace policies or the larger organizing policies that influence decisions about the continuation of work.

Home support workers take pride in their work despite the fact that it is often undervalued. In exploring the meaning of work for home support workers, Stacey (2005) researched the constraints and rewards of low-wage home care labour and how workers experience and negotiate their everyday responsibilities. Her research investigated how home care workers assigned meaning to certain tasks described as both physically and emotionally demanding or as what Stacey referred to as "dirty

work” (p. 832). Stacey reported that being overworked, having increased responsibilities, experiencing increased risk on the job, and dealing with the emotional and physical strain of the work made home care difficult. At the same time, workers derived dignity and value from their work. Stacey reported three sources of dignity in home care: 1) autonomy on the job, 2) skill building (individual rewards or rewards that allowed the workers some control over their work), and 3) the pride in “dirty work.” Workers described the sense of meaning and dignity that they derived from providing care that improved the lives of others. She asserted that paradoxically, the difficult work that gave workers a sense of dignity was generally undervalued and invisible to the general public.

Considering organizational policies and the impact on work, Diamond (1992) conducted an institutional ethnographic study of the work of nursing home aides in the nursing home setting and used textual analysis to investigate how these workers managed their jobs in a bureaucratic and profit-driven workplace. He reported that nursing home aides often became distressed by their working conditions; however, they were able to collaborate, have close relationships with their clients, and find ways to maintain a sense of dignity in their work. This research closely links with research on the meaning of caregiving, as reported by Sims-Gould et al. (2010), Stacey (2005), and Howes (2008). Diamond’s research, although specifically focused on caregivers in an institutional setting, contributed to knowledge about the meaning of work for formal caregivers. The intrinsic rewards of work in this institutional context are applicable to the rewards of home support workers in a community setting.

Age and family support networks have been linked to job satisfaction and quality of life. Chou, Fu, Kroger, and Ru-yan (2011) suggested that older home care workers with a high level of family support reported higher job satisfaction than their younger counterparts. This research did support earlier findings that similarly found home care workers' age and social support were predictors of job satisfaction (Ejaz, Noelker, Menne, & Bagaka, 2008; Flemming & Taylor, 2006;). Although this study focused on home care workers who were simultaneously engaged in both formal and informal caregiving, the findings can be applied to the discussion on formal caregivers' job satisfaction.

With the exception of Diamond (1992), very little research discussed or analyzed the meaning of work in relation to institutional policies and the bureaucratic and organizational policies that organize home support work. However, in addressing this gap, Sims-Gould and Martin-Matthews (2010) conducted in-depth interviews with 118 unionized home support workers to consider the connections between the public and private spheres of home care in four areas: 1) social (for example, relationships with clients), 2) spatial (for example, a workplace in the private sphere of clients' homes), 3) temporal (for example, the stresses of compressed work time and time required to travel), and 4) organizational (for example, care plans or tools that determine their work). These researchers suggested that the delivery of support services goes beyond completing assigned tasks and includes negotiating relationships between workers and clients. Workers emphasized the importance of building relationships with their clients and described how quality relationships enhanced their satisfaction in their work.

Meaning of Work and Recruitment and Retention

Home care worker recruitment and retention has been and continues to be a challenge, largely because of the devaluing of home care work and the poor working conditions that have been documented across Canada and internationally (Armstrong & Armstrong 2003; Butler, 2009; Canadian Homecare Association, 2003).

Recruitment and retention are closely linked with workers' sense of fulfillment and research has indicated that high job satisfaction is associated with lower staff turnover (Ejaz et al., 2008; Zeytinoglu & Denton, 2006). A worker's propensity to enjoy work and find meaning and security is sometimes overshadowed by employment practices which are organized by the larger institutional policies in the home care sector. Working in isolation, difficulty with challenging client behaviours, harassment, difficult tasks for bedridden clients (Benjamin & Matthias, 2004; Feldman, 1997), as well as work overload and limited opportunities for promotion (Brannon, Barry, Kemper, Schreiner, & Vasey, 2007) were identified in the literature as challenges to recruitment and retention. The concept of meaning of work, job satisfaction, and recruitment and retention has been well elaborated in the literature. However, the theoretical links across these three concepts and the relationship to recruitment and retention within the context of home support has not been explored.

The Department of Human Resources Labour and Employment (HRLE) (2011) in Newfoundland and Labrador has emphasized the importance of retaining workers in the area of home support. Home support workers are among the 50 occupational groups that will experience the strongest recruitment pressures over the period from 2011 to 2020. It forecasted tremendous labour demands in the home

support sector as a result of new jobs, new job openings when older workers retire, and strong competition from other jurisdictions.

Labor force participation and recruitment and retention are closely related to job satisfaction as well as decisions about work participation. The meaning of work for older workers was factored into Hwalek, Straub, and Kosniewski's (2008) investigation into ways of improving supportive community services by expanding the labour force in both the long-term care sector. This research was conducted in 615 nursing homes and 410 home health agencies and included 1,091 low-income participants over age 40. The meaning of work for home support workers was closely linked with job satisfaction, and this influenced the recruitment and retention of workers. Researchers supported that low-income older workers may be utilized as direct, front line care workers, in the field of home health care. This recommendation supports the impetus for my research to focus on the meaning of work and the influence of this meaning on recruitment and retention of older workers in this field.

In some jurisdictions, full-time home support workers are eligible for health and pension benefits. Howes (2008) surveyed home support workers in eight counties in California to explore the impact of wages and benefits on recruitment and retention of home support workers and what motivates people to work in home care. In this study, of the 2260 participants surveyed, two-thirds (66%) of the respondents reported that commitment to their client was the most important reason for employment in this sector and only 25% of respondents reported that pay or benefits ranked in the top three most important reasons for working in this field. Howe's

evidence supports that regardless of the reasons why people take the job in home support, once they are in the job they often find greater meaning through their commitment to their clients regardless of the wages and benefits.

Butler (2009) identified challenges that influenced recruitment and retention of older women working in home support. The largest challenge was the difference in work from that of direct care workers in nursing homes. Butler's study sought to understand how society can best support older workers in their work to positively influence recruitment and retention. Six main themes described the workers' experiences: the job works for them (enjoyment working with older people, job autonomy); there are problems with the work (emotional work of watching client suffer, occupational hazards); money is a worry (having to work with more than one agency); being able to do the work despite physical limitations (reports of chronic conditions, decreased energy); being older helps (the value of experience and wisdom); and the fact that their work should be more highly valued (need for recognition and praise, close relationships with their clients). In general the findings suggested that the participants late to middle age garnered meaning and value from their work despite its undervalued and underpaid nature. Recommendations supported improvements in training, financial compensation, and recognition of the image of home care that may potentially influence recruitment and retention to address this workforce crisis.

Using the Job Demand Control/Support model developed by Karasek (1979), Delp, Wallace, Geiger-Brown, and Muntaner (2010) conducted interviews with primarily middle-aged women to investigate job satisfaction among 1,614 home care

workers in Los Angeles. Karasek identified three types of job-related stress: job demand, job control, and job support. In using these stress indicators, Delp et al. found that home care workers often experienced both job stress and job satisfaction. Factors identified as leading to job dissatisfaction included abuse from clients, unpaid hours, and job insecurity. Adequate benefits and reasonable hours of work minimized the stress of excess hours and job insecurity. Delp et al. recommended that to improve work relationships and workers' well-being, employer policies could reduce demands while improving worker control; they could increase support to increase job satisfaction and retention. This research highlighted the social, cultural, economic, and political factors that shape home care work, indicating the recognition that home care policies originate within larger social and political arenas and how this affects job satisfaction.

Similarly, Fleming and Taylor (2006) studied variables that affected recruitment and retention of home care workers in Northern Ireland. Commitment to their clients was noted as the primary reason these workers chose not to leave, and the level of satisfaction with work and pay were high despite the identified challenges. This research is consistent with other findings recognizing the stressors and work-related issues that penetrate the home support sector (Keefe, Knight, Martin-Matthews, & Legare, 2011). In a review of the literature, Keefe et al. identified four major human resource issues affecting the recruitment and retention of home support workers: compensation, education and training, quality assurance, and working conditions. Recommendations from Keefe et al. suggested improvements in marketing strategies for employers to learn what workers value in their work and

what attracts workers to home support work; this information would help them to improve the work environment.

Policy makers need to design public policies and management strategies to increase pay and improve working relationships (Kemper et al., 2008). As part of a national U.S. study across three settings (nursing homes, assisted living facilities, and home care agencies), direct care workers reported looking for two changes: increased compensation (including pay, benefits, and hours worked) and improved work relationships (being listened to, appreciated, and respected). These changes were suggested to enhance recruitment and retention of workers in this sector. The researchers recognized that because of the unique site of home care work (in the clients' homes), management have less control over workers' jobs. Therefore the workers were less likely to identify strategies for employers to improve their jobs. These workers suggested changes in financial compensation, hours worked, scheduling, and training to positively influence recruitment and retention.

Summary

Research on the meaning of work for older workers has been ongoing for over half a century. It began with the work of Friedman and Havighurst (1954) and was further developed by Herzberg, Mausner, and Snyderman (1959) and Westwood and Lok (2003) in their consideration of the intrinsic and extrinsic meanings of work. Several studies have addressed the meaning of work for workers in the home support sector, but little is known about the meaning of work for older home care workers and how this meaning is influenced by organizing institutional policies. My research study adds to a narrow body of literature that focuses on aging home support workers

with an emphasis on the meaning of work and how it relates to decision making around work, health, and safety. In the next chapter I will present the available literature on health and safety, with a focus on aging workers within the context of the home support sector.

Chapter 3

Employment Practices and Health and Safety in Home Support

In conducting a review of literature focused on health and safety in the home support sector, I located several studies that highlighted changing demographics, current employment practices, and the impact of these practices on the health and safety of home support workers. In this chapter, I will present a synthesis of the literature and show the connections between employment practices, the aging body, ability to work, and the maintenance of health and safety in the home support sector, while highlighting gaps in the current body of knowledge on this topic. It is noteworthy that much of the research on health and safety dates to the 1990s, followed by a lull in the literature before more recent contributions to the literature were evident.

One challenge in conducting this literature review was the recognition of varying terms for “home support worker” in jurisdictions in Canada and the United States. Several terms were used, including “home health aide” and “community health worker,” a title that includes community nurses, occupational therapists, and home support workers. It was necessary to ensure that the research was indeed referring to the same population and relevant to the home support workers that I was studying in Newfoundland Labrador. The literature review for this chapter was retrieved from databases including CINAHL, PubMed, Social Science databases, Google Scholar, the Canadian Centre for Occupational Health and Safety (CCOHS), and Embase. Key terms used in the search were “contingent employment,” “non-standard employment,” “risk,” “employment,”

“occupational health and safety,” “home support,” “home care,” “older worker,” “aging worker,” and “accident and injury.”

Employment Practices and Health and Safety

Work environments are changing in many sectors, and home support is no exception. Demographic changes in the aging population are influencing the composition of the workforce and the labour market. Current global economic trends have resulted in many changes, including the growth of “non-standard” (in Canada) or “contingent” (in the U.S.) employment (Vosko, Zukewich, & Cranford, 2003). The standard employment model has been defined as employment where a worker has one employer and works year round and full time on the employer’s premises while enjoying benefits and entitlements (Economic Council of Canada 1990; Fudge, 1997; Schellenberg & Clarke, 1996; Vosko, 1997). Vosko, Zukewich, and Cranford noted that the standard employment model is the model upon which labour laws, legislations, and policies are developed and implemented.

In Canada, non-standard work became more prevalent in the 1980s and grew in the 1990s but has since stabilized (Vosko, 2003) to a constant proportion of today’s employment. During this time, approximately half of all new jobs differed from the traditional model of full-time standard employment (Cranford, Vosko & Zukewich, 2003). The most common types of non-standard employment are part-time and temporary employment, including seasonal, casual (i.e., on call, split shifts, involuntary hours, pay-per-visit work hours), and contractual work; self-employment; and multiple job holding (Cranford et al.; Zeytinoglu et al., 2009). Non-standard work environments are considered flexible, and many workers

perceive this flexibility as positive; however, non-standard work can also increase problems with insurance coverage, information dissemination, and the identification of work-related injuries (Sullivan & Frank, 2000).

The term “precarious employment” describes specific characteristics of non-standard employment and highlights labour market insecurity (Vosko, 2003). Many workers in precarious employment “face constant uncertainty about their future employment prospects and the terms and conditions of their work” (Lewchuk, deWolff, King, & Polyani, 2003, p. 25). The term “precarious employment” may include atypical employment contracts, limited social benefits and statutory entitlements, job insecurity, low job tenure, low wages, and high risks of ill health (Fudge, 1997; Quinlan & Meyhew, 1999; Vosko).

Non-standard employment is a term that has been applied to workers in the home support sector. Many of these workers are engaged in part-time, contractual, and casual employment, as their weekly schedules depend upon agency and client need. Factors such as hospital admissions and discharges, death of a client, increased complexity of client care, and unexpected illnesses of a client’s family member or of a co-worker can influence both the number and scheduling of hours for these support workers. A worker’s schedule can change on an hourly, daily, and weekly basis, making full-time and continuous employment unlikely. As was discussed in the previous chapter, despite inconvenient scheduling and uncertain work arrangements, home support workers continue to work in this sector.

Concern is growing that the increase in precarious employment has augmented the risk of injury and disability in the workplace (Cummings & Kreiss,

2008; Quinlan & Mayhew, 1999). Research shows that some non-standard workers may receive minimal health and safety training in their jobs, lack appropriate safety equipment, be less likely to have specialized job knowledge, and work in more hazardous or generally poor conditions (Aronsson, 1999; Benach & Muntaner, 2007; Cummings & Kreiss; Fabiano, Curro, Reverberi, & Pastorino, 2008; Im et al., 2012; Sullivan, 2000).

Risks of occupational injury among temporary workers in various occupational groups (i.e., trades, plant workers, agricultural and fishery workers) are commonplace (Benavides, Benach, Delclos, Catot, & Amable, 2006). In this research, temporary workers were found to have higher rates of occupational injury than those workers with permanent work. Two main factors create the association between temporary employment and occupational injuries: exposure to more hazardous working conditions and/or lack of job experience. Similarly, Benach and Muntaner (2007) noted that temporary workers are often exposed to strenuous and tiring positions, have less information about the work environment, enjoy less job autonomy, and have fewer job skills and less experience than permanent employees. Benavide et al.'s research, however, did not consider the possible influence of an appropriate orientation and training program on the incidence of occupational injuries among temporary workers. Benavide et al.'s research is relevant to home support workers, as they work mostly in temporary positions, often fill in on short notice, and provide care for unfamiliar clients without adequate preparation time.

In relating employment practices to the organization of home support, the Canadian Home Care Association (2003) looked specifically at human resource

issues in the home care sector. This was a large-scale national study with 61 representatives of associations, ministries of education, employers, managers of home care organizations, and unions. Those surveyed were formal caregivers (home support workers, registered nurses, licensed practical nurses, physical and occupational therapists, and social workers) and informal caregivers. This study recognized that the home care sector does not attract or retain many young workers or men, mainly because of concerns about working conditions, specifically the lack of stability in employment. These conditions are disincentives for people entering and remaining in the sector. The findings revealed that approximately 10-20% of home support workers were planning to leave their current employer in the next 12 months because of low wages and lack of job stability and benefits. Major recommendations relating to home support resulted from this study; these included improving working conditions for formal and informal caregivers, defining and promoting the profile of the home care sector, re-examining the organization and funding of the home support sector, and promoting appropriate compensation for people providing home care.

Women and Work in Non-Standard Work Environments

This section provides a general overview of trends affecting women and work, with a specific focus on the gendered nature of non-standard employment practices. Specific studies relating to health and safety in the home support sector and recognition of the gendered nature of home care will be threaded throughout the remainder of the chapter. This section begins with the current trends affecting

women and employment practices and thus the impact of these trends on women's health and safety.

Non-standard work, as defined above by Vosko et al. (2003), has always been the norm for many working women. "Atypical" or "non-standard" work arrangements have been seen as gender-biased because women occupy the vast majority of these roles (Chappell, McDonald, & Stone, 2008; Duffy & Pupo, 1992; Fudge and Owens, 2006; Messing, 1998; Nugent, 2007; Quinlan & Mayhew, 1999). Gender can influence the types of jobs people hold, occupational exposures, and social roles, as well as income differential and the retirement experience (Wegman & McGee, 2004). Messing reported that "women are three times as likely as men to work part time and three times more likely to be temporary workers" (p. 2) and part-time employment can have a significant effect on the health and safety of female workers. Chappell et al. identified the existing "industrial segregation" with more women employed in a lower-paying "helping" job such as secretary, cashier, health care worker, and worker in certain technical occupations.

Given the nature of home support as being a caring and nurturing profession, women traditionally represent the majority of workers in this sector (Butler, 2009; Canadian Home Care Association, 2003; Chappell et al., 2008; Vosko, 2003). In 2008 the Newfoundland and Labrador Association of Public and Private Employees (NAPE), the union representing many home support workers in Newfoundland, suggested that home care, traditionally done by women, is "rooted in the exploitation of women's traditional role of caretakers" (p. 13).

Two main differences between the male and female workforces are in employment conditions (salaries, hours of work, length of contract) and the content or requirements of their jobs (Messing, 1998). Gender influences the nature and type of work of women, with women traditionally earning less money on average than men. In addition, unstable working conditions often leave women more vulnerable to adverse health and safety outcomes. Men are more likely to report hazardous work exposures than women, and women's occupations often have unrecognized health effects. Messing was critical of the conventional theory that suggested that "women have fewer compensated injuries and illnesses than men because their jobs are safer" (p. 13). She argued that "women have fewer compensated injuries and illnesses because the compensation system has been set up in response to problems in jobs traditionally held by men" (p. 13). Other research has shown that female-dominated jobs are more likely to have low pay, low levels of autonomy, high levels of routine work, low levels of complexity, and responsibility for providing care and support for others (Bulan, Erickson, & Wharton, 1997; Pugliesi, 1995).

Health and Safety of Aging Workers

This section presents a critical overview of the conflicting research on the relationship between age and work-related injuries that has complicated the debate on the protection of health and safety of older workers. There are two points of view: on the one hand, experts in the field argue that older workers have fewer injuries because of their experience and their awareness of health and safety concerns in their work (Costa & Sartori, 2007; Salminen, 2004). Research supporting this has suggested that occupational injuries were less frequent in older workers; however,

those that do occur tend to be more serious (Pransky et al., 2005a ; Root, 1981; Ross, 2010; Wegman & McGee, 1994). On the other hand, some research claims that older workers lose strength, stamina, and ability to work as they age (Laflamme & Menckel, 1995; Silverstein, 2007; Wegman & McGee, 1994). Therefore, the argument has been made that older workers have higher injury rates because of the normal physiological changes of aging that affect reflexes, muscle strength, and sensory losses. Some researchers also argue that older workers are more likely than their younger counterparts to become careless through familiarity with their work. In the following section, I will present the debate on the work ability of older adults, accident and injury, and the impact of the aging body on injuries and accidents.

Older Workers and Ability to Work

When considering the health and safety of older workers, specifically injury rates, some researchers have questioned older workers' physical capability to do their job safely. Discussions in the literature have complicated the debate about older workers' ability to continue employment and the implications for accidents and injuries.

A systematic review of the literature that focused on ability to work emphasized that the normal physical and cognitive changes associated with aging may affect individuals at work (Crawford, Graveling, Cowie, & Dixon, 2010). Age-related changes in aerobic capacity, physical strength and endurance, balance, thermoregulation, and sensory abilities were some of the elements investigated. Sprains and strains accounted for about one-third of all injuries and fractures, and bruises and cuts accounted for another 10%. Overexertion was a common cause of

injury, occurring in approximately 25% of cases, with falls accounting for about 20% of overexertion injuries. Crawford et al.'s review supported previous research suggesting that older workers have a lower accident risk than younger workers.

The requirements of a job determine what abilities a worker must have in order to effectively perform in that role. Costa and Sartori (2007) researched age and work ability with both males and females in various work settings, including health care workers (nurses, physicians, lab technicians, and biologists), chemical plant workers, and construction workers. Among this group of 1449 Italian workers, the relationship between age and work ability varied according to the type of job, the working conditions, and the worker's personal health status. These authors noted that job demands often do not follow the natural biological and functional changes experienced by older adults and, therefore, the workload may be more physically demanding for older workers. Conversely, aging also means professional growth in terms of experience, ability, shrewdness, and wisdom. Costa and Sartori's findings indicated that the most relevant decrease in work ability was found among blue-collar workers employed in jobs requiring heavy lifting, such as construction work and nursing. However, the work ability of older workers such as clerks and physicians, employed in lighter physical work, remained unchanged. The authors advanced one possible explanation for the lower level of work ability in women shift workers: that being additional family commitments (for example, physically demanding responsibilities at home or decreased sleep opportunity because of home and work responsibilities) that may affect women. This research concluded that work ability in older workers was largely a result of job demands.

Physical ability and balance are important factors in relation to safe and healthy work practices (Punakallio, 2003). Punakallio's research was conducted with groups of home care workers, firefighters, and construction workers all between the ages of 23 and 61. In each of the occupational groups, the younger and middle-aged workers were faster and made fewer assessment errors than the older workers, and there was a decline in functional and postural balance according to age among all three occupational groups. This research stressed the importance of considering work demands and the normal deterioration of age in the attempt to promote work ability and prevent injury. This recommendation applies to the home support sector and the close working relationships that workers have with their clients; it also supports the recommendation presented by Zwerling et al. (1996), who suggested the importance of negotiating a good match between worker capability and job demands.

Normal age-related alteration in sleep patterns is another factor that may affect workers' ability to perform safely in the workplace (Costa, 2005; Pires et al., 2009). Such normal changes include a reduced ability to fall asleep and an inability to stay asleep, as well as frequent and early awakenings that may affect one's ability to be productive, healthy, and safe while working. Reduced alertness in workers may be associated with increased risk of injury or accidents and decreased productivity. Normal physiological changes in sleep, coupled with long shifts, split shifts, or disruption in the biological and social routines of life, may affect health and safety. The critical age for intolerance to shift work and night work is estimated to be in the 40-50 year range (Costa & DiMillia, 2008). This intolerance is related to chronobiological factors, psycho-physical factors, and social conditions (Reinberg,

Ashkenzai, & Smolensky, 2007; Takahashi et al., 2006). Aging has been associated with intolerance to longer work hours and a more difficult adjustment to increased sleep disturbances (Reinberg et al., 2007; Wegman & McGee, 2004).

Research has suggested that older workers experience difficulty in coping with successive night shifts and may be less able to maintain their performance over the course of a night shift (Folkard, 2008). Folkard noted that prior to 2008 there were no other direct studies of the combined effects of shift work and age on safety. He suggested that there is clear evidence that injury rates are higher at night and increase over successive night shifts. Folkard proposed that older workers on the night shift might pose an increased risk in terms of injuries and accidents, most likely attributable to increased fatigue and decreased alertness over the course of a night shift or successive night shifts. Four overarching themes in incident rates emerged from this research: risks across different shifts with increased risk of injury as the day progressed, increased risk of injury over the course of the night shift, increased risk over successive (usually 4) shifts, and increased risk occurrence relative to 8-hour, 10-hour, and 12-hour shifts. These findings are relevant to my study because many home support workers are expected and often choose to work night shifts; many work several successive night shifts or multiple jobs, resulting in long periods of on-the-job responsibility.

Accident and Injury in Older Workers

While some researchers in the past reported an increased risk of work injury and possible disability due to age-associated changes in cognitive functioning, health, and ability to return to the pre-injury state others claim older workers are not at a

greater risk of occupational injuries and accidents (Root, 1981). This early research used data collected from the 1977 Bureau of Labour and Statistics that included the age distribution of injury comparative to exposure by industry and occupation and looked at injuries and costs associated with injury. These data revealed that occupational injuries occurred at a lower rate among older workers in various occupations, including mining, construction, retail trade, services, public administration, and wholesale trade. The most frequently reported injuries for all workers were sprains, strains, cuts, lacerations, contusions, and bruises, which together accounted for 75% of all injuries. However, falls were identified as a more serious concern for older workers, comprising nearly one-third of reported injuries.

Pransky, Benjamin, Savageau, Currivan, and Fletcher (2005) also noted that older workers fare better than younger workers after a work-related injury. Age was noted to be unrelated to poor outcomes. Although the researchers found older workers were likely to encounter more serious injuries, the outcomes of the older and younger workers with injuries were similar. A self-report survey about occupational health financial outcomes was conducted 2-8 weeks after injury with both older and younger workers. Overall, there were no significant age-related differences for the majority of outcomes examined, including changes in the ability to do one's job before and after the injury, injury-related pain, and concerns about future job capacity and job retention. Age was related to only one outcome, injury-related financial difficulties, where being older had a protective effect. Among those who lost time from their jobs, older workers were more content, with younger workers

reporting more economic problems and more negative impact of the injury on the quality of their work life.

In a systematic analysis of injuries of younger and older workers, a more recent analysis than Root (1981) by Salminen (2004) investigated whether older workers had higher occupational injuries than younger workers and if those injuries were more often fatal. Comparison between younger and older worker injuries published in peer-reviewed journals and reported in a number of countries showed that, in the majority of nonfatal studies (56%), younger workers had a higher injury rate than older workers. In only 17% of the studies, older workers had more injuries than the younger workers; 27% showed no difference. Salminen's analysis revealed higher rates of injury among younger workers but higher mortality among older workers. Some of these differences could be attributed to the fact that younger workers had fewer years of experience, which could have increased their risk of injury. This has been supported by other research (Pransky, Snyder, Dember, & Himmelstein, 1999; Root & Hoefler, 1979; Siskind, 1982; Sullivan, 2000). Salminen's review indicated that increased experience, safer behaviour, and less physically demanding jobs could account for the lower rate of occupational injuries among older workers.

Zwerling et al. (1996) analyzed data from the Health and Retirement Study of American adults aged 51 to 61 to investigate the potential risk factors of older workers for occupational injury in various sectors. The large study involved 9,756 participants aged 51-61, including service workers, machine operators, sales personnel, administrative support, labourers, and executives/managers. The study

showed that certain occupational groups were at an increased risk for occupational injuries: mechanics, service personnel, workers in jobs requiring heavy lifting, and workers with impaired hearing or vision. Additionally, after controlling for the occupation, heavy lifting was the factor most strongly associated with occupational injury among older workers in this study. The authors noted that this may be a problem for older workers who remain in physically demanding jobs during a time when their physical capabilities are starting to decline. This study is limited in its reporting of the severity and types of injuries for these older workers. These results are significant for further research into occupational health and safety for aging workers in the home support sector, as many of these workers are involved in heavy lifting and transferring of clients. This study emphasized the importance of negotiating a good match between worker capability and the demands of the job.

Breslin and Smith (2005) suggested several factors that contributed to increased injuries among a group of workers less than 35 years of age, as compared to workers over age 35. In this study, the younger workers reported twice as many burns, scalds, chemical burns, scrapes, and bruises than the older workers. However, the older workers reported more serious injuries such as dislocation, sprains, and strains. They suggested that factors contributing to the increased number of injuries among younger workers included differences in the jobs held by younger workers, the increased representation of younger workers in smaller firms, part-time and temporary nature of younger workers' employment, and physical and cognitive developmental factors.

Contrary to the studies that claim older workers do not face an increased risk of injuries in the workplace, another body of literature argues that older workers risk more serious accidents and injuries while at work. The propensity for occupational accidents and injuries among older workers has been explained by the decremental theory of aging (Laflamme & Menckel, 1995). This theory proposed that “as a person ages, some work capacities both physical (e.g., cardiovascular function, muscle strength and endurance) and mental (e.g. sensorimotor performance, decision time, memory), weaken progressively, which in turn lessens a person’s ability to cope with job demands” (p. 145). However, despite these documented normal changes of aging, older adults have been determined to be active, productive, and contributing members of the workforce (Bass & Caro, 2001; Harrison & Maltchev, 2006; Hursh, Liu, & Pransky, 2006). Although some research suggested that occupational injuries may be less common among older workers, when they do occur, they are more likely to result in more severe injuries, permanent disability, or death (Folkard, 2008; Head, Baker, Bagwell, & Moon, 2006; Wegman & McGee, 2004). Additionally, older workers take longer to return to work following an injury or accident, and heal more slowly (Folkard; Laflamme, & Menckel).

After a review of severe occupational injuries in older workers aged 50+, Grandjean et al. (2006) reported a greater risk of fatalities in older workers than in younger workers, mostly as a result of falls. In this study, industrial workers were the largest group who experienced severe occupational injury; construction workers were the second-largest group. Approximately 19% of injuries resulted in the death of the older worker, with crush injuries being the most prevalent cause. This

research supports the systematic analysis conducted by Salminen (2004) indicating that younger workers had a higher incidence of occupational injury but older workers had more serious and sometimes mortal injuries. Folkard (2008) found a clear increase with age in injuries caused by falls, either from an elevation or on the same level, supporting the findings of Grandjean et al. It is noteworthy, however, that this research was carried out among industrial workers whose workplace certainly has a higher risk for falls, like the workplace of home support workers who have similar physical demands (such as climbing stairs, reaching, lifting, and transferring weight) in their jobs that may put them at a higher risk of falls.

Risk, Health, and Safety in the Home Support Sector

A wealth of research investigates the health and safety of aging workers in various sectors such as construction, forestry, industry, and retail sector (Folkard, 2008; Gall & Parkhouse, 2004; Grandjean et al., 2006; Laflamme & Menckel, 1995; Punakillio, 2003; Root, 1981; Schibye, Hansen, Srgaard, & Christensen, 2001); however, less attention has focused on the health and safety of “aging” workers in the home support sector. Research has indicated that home care programs are reportedly underfunded, and workers are undervalued, highly stressed, and often exposed to numerous health and safety risks every day (Aronson, Denton, & Zeytinoglu, 2004; Dellve, Lagerstrom, & Hagberg, 2003; Meyer & Muntaner, 1999; Taylor & Donnelly, 2006). Health and safety are critical issues facing home support workers, in that workers may often work in unsafe, high-risk neighbourhoods, and travel in poor weather conditions. In addition, they are sometimes required to work in

unsanitary work environments and to engage in heavy lifting of clients, often without the necessary safety equipment, such as lifts, adjustable beds, or bathing equipment.

In a most recent study by Sims-Gould, Byrne, Beck, and Martin-Matthews (2013) it had been recognized that there are increasingly unpredictable work situations relating to the nature of the clientele including differing medical and psychological conditions and circumstances. Crisis in the delivery of home care was found to include physical, environmental, relational, and organizational factors. In relating to the focus of my research, these researchers supported that organizational crises were related to home support agencies and their rules, policies, and operations and they maintained that analysis of these crises enhances a greater understanding of how home care policies may be more responsive to the challenges of home care.

The study of occupational health and safety risk is rooted in epidemiological data that included morbidity and mortality rates for disease, injury, accidents, and disasters. Researchers in the social sciences often oppose an objectified understanding of risk and argue that risk is a subjective experience (Krimsky & Golding, 2002; Slovic, 1992; Weber & Milliman, 1997). Humans are responsible for creating risks and it has been suggested that knowledge about one's exposure to risk is mediated through discourse and by social and cultural contexts (Lupton, 2006). This approach contrasts with the scientific approach in that it takes into account the broader social, historical, and cultural contexts that drive what it means to be at risk.

The concept of risk management has penetrated all that we do regarding risk. Risk exists at both the individual level and the organizational or employer level. Organizational culture includes the sets of beliefs and assumptions of employers and has

been defined by Cooper (2000) as a concept used to describe corporate values that influence members' attitudes and behaviours. Organizational culture reflects the values and philosophy of an employer and these values become institutionalized through the implementation of management practices. Sullivan (2000) suggested that many factors make up a workplace organization, including the organizational philosophy on occupational health and safety, labour markets and unions, the internal responsibility system, and the risk and physical conditions of the work. The internal responsibility philosophy posits that both employees and employers are responsible for their own safety and the safety of their co-workers. It also holds employers responsible for ensuring that appropriate precautions are put in place to protect the health and safety of all employees (Lewchuk, Robb, & Walters, 1996). More specifically, safety culture, as a sub-concept of organizational culture, affects members' attitudes and behaviours in relation to health and safety (Antonsen, 2008; Cooper). This concept of safety culture determines the commitment and proficiency of an organization's health and safety management.

The employers' understanding of risk and risk management and the importance placed on the management of risk affect health and safety precautions in the workplace. Management's involvement in occupational health and safety strategies has been reported to influence the incidence of injuries and accidents (Barr, 1998; Vredenburg, 2002). These strategies include the involvement of management in safety; the implementation of safety training, precautions, and incentives; and open communication and information exchange about health and safety. Research indicates that the safety climate of an organization predicts the way employers behave with respect to safety in the workplace (Williamson et al., 1997), and consequently this safety culture shapes employees' safety

behaviour (Berends, 1996). Hale and Hovden (1998) suggested that attention has to be paid to the third age of safety. They referred to the first age as the technical measures to prevent injuries, the second as the move from the focus on the individual to the rise of ergonomics and risk analysis in the 60 s and 70s, and the third age as workplace culture and management systems.

Considering organizational level of risk and organizational culture, the literature also highlights individual levels of risk, risk perception, and management. In a study on health and safety and the perception of risk in home health care, Kendra (2002) concluded that home health aides did not perceive the frequency of encounters with risk as often as their home health care administrators. Kendra (1996) used the Home Health Care Perceptions of Risk Questionnaire (HHCPRQ) which was developed from the results of a pilot study (Kendra et al., 1996), to conduct a survey of home health care administrators and field staff in 25 states in the United States. In this study, she compared the perceptions of risk of home health care administrators to those of field staff. The researched focused on the frequency, level of risk, and availability of support to staff while they provide home care services. The results indicated statistically significant differences between field workers' and administrators' perceptions of risk, with field workers believing they were at risk in more situations; however, there was no difference between administrators' and workers' perceptions regarding the level of risk that field workers face. Statistically significant differences existed between field workers' feelings about how much support was provided to them in the field and administrators' perceptions that they provided more support than was perceived by the staff.

Expanding this research, Kendra (2002) noted that administrators and home health aides agreed on the level of risk but not on how frequently these risks are encountered. Some reasons suggested for this difference were home health aides' level of education and the job experience and skill instruction required for the job. It was also suggested that because home health aides do not perceive themselves to be in situations that pose risk, they may be less likely to associate agency supportive measures with minimizing risk, and they may not be aware of what the administrators do to reduce safety risks.

Lang et al., (2006) as part of a joint initiative with the Canadian Patient Safety Institute (CPSI), Capital Health (Edmonton), and the Victorian Order of Nurses (VON) suggested that there has to be more focus on safety in home care. This collaborative team identified that the shift in thinking towards recognizing the complexity of care in the home support sector is quite different from that in the institutional setting with regards to patient and worker safety and the traditional patient safety perspective does not always fit within that context. These complexities included: the relationship and communication between client and families and caregivers/providers; unregulated work settings; the multidimensionality of safety (physical, emotional, social, functional); a reduction on the focus on prevention and health promotion; the challenges of human resources; and the maintenance of competence.

Further to this Lang, Edwards, and Fleiszer (2008) recognized that research on patient safety has been conducted within the institutional setting which has resulted in a knowledge gap about safety in homecare. These researchers identified that safety becomes a failure of systems rather than that of humans and there are

many change processes that need to be addressed to create safer environments. Lang et al., (2009) in a joint collaborative initiative with the Canadian Patient Safety Institute (CPSI) described the current state of home care through a national environmental scan. This environmental scan included a pilot study with home care recipients and providers, key informant interviews from across Canada, and a thorough literature review. Interviews with key informants highlighted four themes which impact safety in home care. These included fragmentation (e.g. disconnect with approaches to care between acute care and home care, multiple providers); vulnerability (e.g. isolation, exposure to infection, abuse); considering the home as a haven (e.g. the home being used as a hospital room, the medicalization of personal space); and incongruence (e.g. unregulated health care workers' responsibilities versus their skill and training, family expectations). It has been recognized and supported that patient safety is largely affected by worker safety and, therefore, the two must be considered together.

In a recent study, Craven, Byrne, Sims-Gould, and Martin-Matthews (2012) explored the types and patterns of safety concerns encountered in home care settings. These researchers recognized that a safe work environment cannot be standardized or regulated as in other care settings, and, therefore, home support workers are exposed to occupational health and safety hazards. The model demonstrated that safety concerns were not just multidimensional but also intersectional, as it is at the intersection of these concerns that one can better understand the patterns of home support workers' safety. The workers identified four main types of safety concerns: physical (e.g., injuries, trips, falls, communicable diseases), spatial (e.g., physical

characteristics inside and outside the client's home, geographic location), interpersonal (e.g., interactions between workers and clients and their families) and temporal (e.g., workers' schedules, time pressures). Craven et al. indicated that they expanded previous work by Lang et al. (2010) who highlighted that homecare safety has to focus on reducing the risks in diverse environments that are uncontrolled or unregulated. Lang recognized that risk exists in all healthcare settings; however, private homes lack the uniformity that does exist within institutional environments. The spatial dimension of these risks indicates that safety issues are embedded in the workplace, which is an unregulated private residence. This research supports the tailoring of interventions for the protection of health and safety to individual safety concerns that may differ in each home.

The key findings of the literature review that focused on health and safety in home support can be classified into three main themes: constraints of control in the unregulated work environment, physically demanding work, and physical hazards in home care. These three concepts have been identified as leading to increased risk of occupational accidents and injuries within the home support sector.

Constraints of Control in the Unregulated Work Environment

Control over the work environment is an important factor in the protection of health and safety in the home support sector. Home health care workers are thought to have a high incidence and increased severity of injury because of the difficulty in controlling their work environment (Meyer & Mutaner, 1999). Workers in the home support sector are expected to work under conditions beyond their control—without proper equipment, in unsanitary or unsafe homes, or without the support of other

workers—leaving the workers at increased risk of occupational accidents and injuries. One of the first published studies on musculoskeletal injuries among home health care workers examined working conditions and incident reports of lower back injuries among home health aides and hospital nursing aides over a three-year period (Meyers, Jensen, Nestor, & Rattiner, 1993). Their research found a remarkably higher rate of injuries among home health aides- three times that of the hospital nursing aides, and also provided evidence that the unfavourable working conditions common in the home care sector were associated with these increased injury rates. Approximately 88% of these injuries occurred while the worker worked alone and 80% of the workers had used no assistive equipment when the injury occurred.

As in Meyers et al.'s (1993) study, injuries to home health care workers were less frequent than injuries in the nursing home setting but did result in greater loss of time from work and in higher costs, both indicators of more severe injury (Meyer & Muntaner, 1999). The researchers reported that contributing factors may have included adverse working conditions, the intensity of work, and the necessity of using their private vehicles. Most injuries were lower back injuries that occurred in patient-related activities at the bedside, including lifting, pulling, and pushing, and they were most prevalent among home care workers working alone. In addition to lower back injuries, neck and shoulder injuries represented a high proportion of compensated injuries among this working group.

In discussing the lack of control of the work environment, many researchers have identified a lack of appropriate equipment in the home and its relationship to health and safety as complicating their work. Owen and Staehler (2003), in

describing home care workers' or home health aides' perceived stress to their backs, identified environmental contributors to back stress in home support work; these included the client's bed, confined workspaces, low toilet seats, hot environments where clients are bathed, lack of necessary equipment, malfunctioning equipment, and the arrangement of the room where the worker must carry out job responsibilities. These conditions were beyond the control of the workers. Some recommendations suggested by those surveyed for reducing back stress included improving body mechanics, adjusting environmental factors by the use of assistive equipment and hospital beds, and having the client help more when possible. Policy changes were also suggested, for example, allowing more time for each visit and granting permission for more than one worker for heavier clients.

Kim et al. (2010) reported that home care workers are exposed to physically demanding work with few assistive devices such as patient-lifting equipment, ergonomically adapted equipment, or adjustable beds. This study confirmed previous research studies conducted by Hannerz and Tuchsén (2002) and Dellve et al. (2003), who reported that the physical demands of home care are significant risk factors for many musculoskeletal disorders. Kim et al. emphasized the need for organizational and intervention strategies to protect home care workers. Further investigation into organizational policies is needed, as few researchers have addressed the organizational policies and regulations that organize the everyday work of aging home support workers.

Working alone was one of the most prevalent indicators of accidents and injuries for workers in the home support sector. The Newfoundland and Labrador

Association of Public and Private Employees (NAPE) (2008) identified isolated working conditions as a concern for home care workers. Health and safety challenges facing workers in the home differ from those typically experienced by workers in the acute care sector in that, unlike equivalent workers in the acute care setting, home care workers often work without assistance from other staff.

Supporting this, Stevenson, McRae, and Mugal (2008) stated that working alone was a risk factor for the health and safety of home care personnel. In a three-phase participatory action research study using focus groups, interviews with 129 staff members, and chart reviews, the researchers explored staff and client safety risks in home care. A limitation of this study is that it was not conducted exclusively with home support workers. Several risk factors were identified by a risk assessment identification tool that included these indicators of the lack of control of the work environment: poor communication, acute care staff not fully understanding the needs of community staff, working alone, medication concerns, lack of pre-screening of clients' homes, and community health workers accepting a high degree of risk. This research also indicated that patient care information transferred from acute care to community health workers was sometimes insensitive to the health and safety risks for workers in clients' homes. Poor communication between acute and community care is relevant to home support workers' health and safety. The lack of necessary information would leave the support workers providing care in a work situation where they may not be prepared, may not have the necessary equipment and supplies, or may not have the experience or medical training to do their work.

Many home support workers are at an increased risk of violence, abuse, and harassment because they work alone (Barling, Rogers, & Kelloway, 2001; Bussing & Hoge, 2004; Fitzwater & Gates, 2000; Galinsky et al., 2010). Workplace violence and abuse are receiving increased attention because of their effect on workers' health and safety; that effect may ultimately influence recruitment and retention of much-needed workers in this field. The issue of violence and aggression has further implications for home care workers who work alone in often unfamiliar settings and for whom, therefore, the support of another worker is not available in a violent situation.

In an early study, Fitzwater and Gates (2000) investigated the beliefs of home care workers regarding violence in home health care. They wanted to explore attitudes about the meaning of violence, reducing risks, and prevention efforts, and to compare home care workers' beliefs about violence with the number and types of incidents reported in the literature. In their findings, some of the attacks experienced by caregivers included physical attacks (e.g., swinging a fist, bouncing caregiver off the wall, slapping), verbal abuse (e.g., curses, name-calling, observing family fights), sexual abuse (e.g., grabbing or touching in a sexual way, sexual comments), and threats and intimidation (e.g., stalking, complaint calls to employers, threats involving weapons). Similarly, Galinsky et al. (2010) found that reports from 677 home health care aides and nurses confirmed that 4.6% reported one or more acts of violence against them in the preceding year. Factors considered to contribute to these associated risks were working with clients with dementia, routinely handling patients, and perceiving threats of violence by others in the patients' home.

Violence and aggression in the home can have major physical and psychological outcomes (Bussing & Hoge, 2004). Their study of a total of 721 home care workers (all nurses) reported the prevalence of different forms of violence and aggression, as well as emotional reactions and negative psychological outcomes. Their findings suggested that verbal aggression by patients was the most frequent form of aggression experienced by these nurses, and physical violence by patients or relatives played a lesser role. Barling et al. (2001) suggested that home care nurses work alone, and this may enhance the probability of violence and aggression; however, Bussing and Hoge suggested that patients' autonomy and less restrictive structures may reduce aggressiveness in their own home setting and in turn may reduce violence against workers. Although this research was conducted with home health care nurses, the findings can be applied to the work of home support workers.

Physically Demanding Work

Home care work is physically demanding. Workers lift clients and assist them with bathing and transfers; sustain long periods of standing, heavy lifting, and twisting; and frequently have poor posture that results in overexertion. Home support workers help clients in and out of tubs, reposition them in bed without the assistance of other workers, and climb stairs, reach, and bend, in unfamiliar and sometimes cluttered or cramped environments.

Twisting, turning, and lifting, all typical activities performed by home support workers as part of a normal working day, have been identified as risk factors for occupational injuries. In exploring the occupational issues among office and visiting staff of three home support agencies, Denton, Zeytinoglu, Webb, and Lian (1999)

noted high levels of stress, tiredness, and exhaustion. Employees were recorded as suffering pain or discomfort in several body parts, sprains or strains, dislocation and fractures, and bruises. These were attributed to lifting or moving clients, bending and straining, falls, repetitive motion injuries, and motor vehicle accidents.

Brulin et al. (1998) investigated the relationships among the physical and psychosocial aspects of the work environment, socioeconomic data, and lifestyle factors in relation to complaints of shoulder, neck, and lower back injuries among female home care personnel. The research indicated that physical and psychosocial factors are associated with shoulder and neck complaints. The two ergonomic factors most significantly associated with complaints in the lower back were “standing in forward-bent and twisted postures” and “standing in awkward postures.” Considering the intense physical exertion involved in the day-to-day work of home support workers, it was not surprising that many have reported these physical complaints.

This study identified the importance of addressing occupational health and safety concerns and highlighted the role of organizational considerations in preventing long-term sick leave and high turnover rates in home care. Galinsky, Waters, and Malit (2001) conducted a literature review on the topic of overexertion injuries in home health care workers. Their findings supported Brulin et al.’s (1998) conclusion that the main work factors associated with the high rate of back and other musculoskeletal problems in health care workers were forceful exertion and awkward postures during patient care tasks, especially while workers lifted and moved clients.

Home care workers often have injuries that necessitate time lost from work due to the physically demanding nature of their job. The Bureau of Labour and Statistics (2010) claimed that the average time away from work due to an injury or illness is 10 days, with 28% of injured workers requiring 31 or more days away from work. Dellve, Lagerstrom, and Hagberg (2003) studied home care workers in Sweden to explore the factors that contributed to high levels of work absence related to poor health. The retrospective case control study examined the magnitude of exposure to risks 5 and 15 years before disability pension entitlement, as well as the cumulative effect of a number of risk factors for permanent work disability. The results of the study indicated that the most important risk factors were poor ergonomic and lifting conditions, time pressure, and lack of professional caring technique that lead to missed work time. Five years prior to eligibility, the factors considered most relevant included poor organizational support, lack of opportunities for co-working, and a poor working climate. Interestingly, the strongest factor relating to home life was the little opportunity that workers had for rest from the physical demands of the job.

In a recent study, Wipfli et al. (2012) recognized that the majority of previous safety assessment research focused on injury rates and the relationship between job demands and injuries. In their research, Wipfli et al. reviewed focus groups and lost time data sets to learn more about tasks that cause workers pain and concern for injury in Oregon and California. Their results indicated that the top three tasks causing the most pain or cause for concern for injury included unassisted lifting and transferring, moving household items, supporting a client who is walking, and

catching a client who is falling. Lost time injury data suggested that workers are at particular risk for back, knee, and shoulder injuries that occur during these tasks. One of the recommendations from this study included the improvement of caregiver access to mechanical assists and equipment.

Similarly, in a study addressing the risk of musculoskeletal disorders in home care workers, Kim, Geiger-Brown, Trinkoff, and Muntaner (2010) investigated whether physically demanding workloads among home care workers were related to musculoskeletal disorders in the neck, shoulder, and back. Large samples (with a mean age of 52) were recruited (1,643 for Wave 1 and 1,198 for Wave 2), with the waves representing two different stages of the research. The researchers found that the prevalence of physically demanding work was as high as 56% among home care workers, which was significantly associated with the incidence of musculoskeletal disorders, with more than half reporting that their work was always or often physically demanding. The most common tasks reported as physically demanding were lifting and transferring a client without help, pushing a client's wheelchair, supporting a client who is walking and falling, climbing stairs, and standing in one place for a long period. Nearly half of the participants reported lifting or transferring the client without any assistance. Overall, 16.6% of the sample had a musculoskeletal disorder in at least one body part. Disorders of the back (10.2%) and the neck (9.6%) were more prevalent than shoulder problems (7.1%). However, six months later, 12.6 % of respondents had musculoskeletal disorders in one or more other body parts.

Using a participatory action research approach, Zeytinoglu, Denton, Webb, and Lian (2000) examined the associations among age, self-reported musculoskeletal disorders, and work environment of home care workers. They focused on physical work factors, psychosocial work factors, work-related injuries, individual factors (such as number of months in the profession), and mediating factors such as stress. These researchers indicated that poor physical and psychosocial work environments contributed to work-related stress and were related to musculoskeletal disorders. Visiting workers reported risks such as falling on ice, slippery walkways, or floors and such falls were reported to increase self-reported musculoskeletal disorders, which all relate to the physically demanding nature of their everyday work.

Of the 612 female home care workers in that study, 44% reported back pain, 38% reported pain or discomfort in the neck or shoulder, 27% reported pain or discomfort in the arm, elbow, or hand, 22% reported sore or sprained muscles, 20% experienced pain or discomfort in the hips, and 22% had pain or discomfort in the knees. According to Zeytinoglu et al. (2000), it is ironic that home support workers, while caring for others, were risking their own health and damaging their own bodies. Interestingly, in this study the participants' age and number of months in the profession had no effect on their self-reporting of musculoskeletal disorders. The study supported the invisibility of health and safety concerns in women's work that had been discussed by Messing (1998).

Physical Health Hazards in Home Care

In addition to the body of literature on work-related accidents and injuries, other research studies highlight physical hazards in the home and their influence on

the health and safety of home care workers. Home support workers face numerous physical health hazards in the home setting. Some of these hazards include unsanitary conditions (e.g., the presence of harmful bacteria, mold, and mildew), unruly pets or animals, clients or their family members smoking, personal lifestyle habits of the client, abuse, and unsafe neighbourhoods (Canadian Home Care Association, 2003). The management of hazards in the home may be difficult because of the nature of home care and the fact that each home is considered a unique workplace.

The protections that would be available in other sectors may not be available in the home care sector (Craven, Byrne, Sims-Gould, & Martin-Matthews, 2012; Gershon et al., 2008; Mahmood & Martin-Matthews, 2008). A study with a convenience sample of 1,561 home health aides, attendants, and personal care workers who were mainly middle-aged women in one area of New York City found the most commonly reported health hazards in the home were unsanitary conditions (insects, rodents) and air pollutants (animal hair, dust, peeling paint, cigarette smoke, mold) (Gershon et al.). In addition, threats of violence and abuse from both family members and neighbours were frequently reported. Although infection control practices were generally acceptable, they were deemed suboptimal in some areas.

Perceptions of risk among a group of health and social services professionals and managers who were involved in decision making about the long-term care of older adults in Northern Ireland indicated that home support workers are exposed to many risks and hazards (Taylor & Donnelly, 2006). These included the timing of visiting/working hours, access issues, hygiene and infection issues, aggression and

harassment, as well as client transfer and home equipment safety issues. The reality that home care workers provide increasingly complex personal care contrasts with the public perception that home care workers carry out simple tasks such as shopping and light housekeeping. This research highlighted the impact of policy and of bureaucratic and organizational structures that organize the work of these home support workers. Managers and key stakeholders have a responsibility to ensure that care is provided even if it results in less than ideal work situations; at the same time, they have an equally important responsibility to ensure their workers are safe and working in areas that do not jeopardize their health and safety.

To improve safety for workers in community settings and limit physical health hazards in the home, a survey was developed within a regional health authority in Newfoundland and Labrador that would evaluate a safety program referred to as the Western Health Risk Assessment Screening Tool (WHRAST). It found that insufficient information on safety-related issues was recorded on the client intake or referral form (Hutchings, Lundrigan, Mathews, Lynch, & Goosney, 2011). A program of this nature can potentially have great implications for the numerous support workers who provide daily care in home environments that may jeopardize their health and safety.

Summary

The home support sector has changed over the last number of years as a result of evolving demographics and alterations in employment practices. The same social, political, and economic factors that influenced the growth and structure of the labour force over the past 20 years will continue to change the organization of the workforce

in the coming decades. Research on supportive services in the community has identified the issues, challenges, and opportunities for home care and confirmed the demanding responsibilities of home support workers that affect their health and safety. Research in the area of health and safety of aging workers has been conducted, but few studies specifically addressed aging workers within the home support sector. It also remains unclear how workers negotiate the policies and practicalities of their work every day and what impact, if any, these negotiations and decision-making practices have on their health and safety.

Chapter 4

Institutional Ethnography as a Method of Inquiry

In general, Institutional Ethnography works from the local of people's experience to discover how the ruling relations both rely on and determine their everyday activities (Smith, 2005, p. 44)

This study investigated and made visible the everyday experiences, relations, policies, and texts that organized and determined the everyday work of home support workers, the meaning of work, and workers' decisions relating to health and safety. Institutional Ethnography (IE) is a method of inquiry developed by Smith (1987; 1990; 2005) to explicate social relations that are implicit in the organization of people's lives. This chapter provides an overview of IE and specific terms that are unique to this method of inquiry; it also outlines how my study was designed and how I maintained ethical integrity throughout the research process.

Description of Institutional Ethnography

Institutional ethnography is a method of inquiry developed by Canadian feminist sociologist Dorothy Smith. Smith (2005) described IE as an alternate sociology that explores, discovers, and learns from people's everyday knowledge of their lives. IE enables researchers to answer questions about how things work and why things happen the way they do. Researchers from a variety of disciplines have used IE to explore a broad range of institutional processes, practices, and social problems. These include health care (Campbell, 2001; Diamond, 1992; Gustafson, 2007; Rankin & Campbell, 2006), education (Griffith, 1992), and domestic violence (Pence, 2001). In each of these studies, the researcher used the experiences of a particular person or group of people as the entry point to investigate how institutional

processes shape their everyday world. In my study, the entry point is the front line home support workers who were willing to share their experiences with me.

IE investigates “what actually happens in the realm of practices and relations through which people are governed” (Mykhalovskiy & McCoy, 2002, p. 20). Smith defines IE this way:

Institutional ethnography explores the social relations organizing institutions as people participate in them and from their perspectives. People are the expert practitioners of their own lives, and the ethnographer’s work is to learn from them, to assemble what is learned from different perspectives, and to investigate how their activities are coordinated. It aims to go beyond what people know to find out how what they are doing is connected with others’ doings in ways they cannot see. The idea is to map the institutional aspects of the ruling relations so that people can expand their own knowledge of their everyday worlds by being able to see how what they are doing is coordinated with others’ doings elsewhere and elsewhen (Smith, 2005, p. 225).

Smith (2005) proposed that there are two main aims of Institutional Ethnography. The first is to produce a map of ruling relations “and specifically the institutional complexes in which they participate in whatever fashion” (p. 51). The second aim is to “build knowledge and methods of discovering the institutions and, more generally, the ruling relations of contemporary Western society” (p. 510).

Researching Without a Theoretical Framework

In keeping with Smith’s critical social theory, I conducted this research without a beginning theoretical framework while considering the main constructs I was studying. I

entered this research without a pre-determined theory on aging, work, and health and safety. According to Smith (1987), a theoretical framework provides a critical lens within which to conduct an inquiry and provides structure to incorporate the experiences of those studied into predetermined categories to shape the study's findings. Smith argues that a framework takes away from the subjectivity of the participants, displacing the knower's own experience and knowledge. However, despite Smith's claim to research without a theoretical framework, IE is not without its own theoretical foundations. This methodology draws on theoretical underpinnings such as Foucauldian theory, feminism, standpoint, and Marxism, all of which will be described below.

This next section of the chapter will introduce the theoretical underpinnings of IE as described by Smith, while defining key terms and concepts.

Philosophical Underpinnings

This methodology uses common terms in special ways. Although some of these terms may be difficult for the uninitiated reader, I was committed to using IE as the method of inquiry for this research. Having a clear understanding of the central concepts of IE, including terms such as *standpoint*, *problematic*, *disjuncture*, *institution*, *text*, *social and ruling relations*, and *discourse*, is integral to understanding the complexity of IE and the benefits of using this method of inquiry to explore the health and safety of aging workers within the home support sector. I will draw on the philosophical underpinnings of IE throughout this chapter.

Feminism and Standpoint

Smith's research developed through her emerging feminist consciousness and her involvement in the women's movement of the 1970s (Campbell & Gregor, 2004;

Smith, 1987). The conversations that took place in the university setting about how people lived did not coincide with Smith's experience. Early in her life as a single mother and an academic, Smith realized she was living in two different worlds. From this awareness came her notion of *bifurcated consciousness*, which is how she defined moving between the world of mothering and the discursively organized world of the university (Smith, 1987). Campbell and Gregor argued that "women were not adequately represented by the forms of knowledge that claimed to be speaking about them" (p. 14).

Smith discovered that she had been silenced and deprived of the authority to speak; she felt that women's experiences were not visible in the construction of knowledge about the world. She saw the women's movement as an opportunity to bridge the gap between women's actual experiences and the sociological theories that were intended to represent people and experiences. Embedding theory in women's experiences produced an approach that was different from traditional sociology in which she was educated. She clarified:

If it is a sociology that explores the social from women's standpoint and aims to be able to spell out for women just how the everyday world of our experience is put together by relations that extend vastly beyond the everyday, then it has to work for both women and men (Smith, 2005, p. 1).

Over Smith's academic career, she guided the development of IE to extend beyond feminist critique to a means of questioning the hegemonic structures of knowledge (Campbell, 2004).

According to Smith, the aim of inquiry is to produce knowledge for the benefit of those without power (Smith, 1987; 1990; 2005). A *standpoint* “is the result of lived experiences that occur within a web of material arrangements and relations of social power” (Hesse-Biber & Leavy, 2004, p. 10). An awareness of the standpoint from which a researcher approaches research offers a stance from which to conduct research into social organization. Smith (2005) identified the concept of standpoint in people’s everyday lives as integral to IE.

According to Harding (2004), standpoint theory argues that because women’s lives and roles are significantly different from men’s, women hold a different type of knowledge. She claimed that their location as a subordinated group allows women to see and understand the world in ways that are different from men. Standpoint theory supports what Harding calls strong objectivity, or the notion that the perspectives of marginalized individuals can help create more objective accounts of the world.

Smith views standpoint differently from Harding, as Smith has now broadened her notion of standpoint to include any subject who “disappears” in objectified knowledge. For example, Smith refers to her thinking as sociology for people rather than just sociology for women. Women’s standpoint has been criticized because it fails to take into account diversities of class, race, and gender. Smith’s notion reflects a move away from the focus on women’s standpoint epistemology that was central to her earlier work. According to Smith, standpoint can be expressed as a way we view the world based on the knowledge and experiences that influence how we socially construct the world.

It is important that the researcher identify the position taken in the research. Smith (2005) explained that it is possible to have multiple standpoints in a single inquiry and each standpoint will position the researcher differently; however, the researcher must identify a single standpoint prior to beginning the inquiry. Noting the connection with Marxist class relations and the patriarchal society, Hesse-Biber and Leavy (2004) noted that power and knowledge are related: "as knowledge and power are intimately linked, when social life is 'hierarchically structured' different standpoints are produced" (p. 9). Considering my research, exploring the everyday work of aging home support workers can be viewed from the standpoint of front line workers, agency owners, and managers. Each standpoint will offer a unique position for the inquiry and will introduce different processes and discourse(s) that penetrate the actualities of people's daily lives (Mykhalovshiy & McCoy, 2002, p. 19). My research explores the work of aging home support workers and, in particular, health and safety considerations for this group of workers. The standpoint of these front line workers is the point of entry into the discourse and the social relations that organize their everyday work.

Problematic and Disjuncture

Most research begins with a formal list of research questions to be explored. IE begins with a research problematic. A research problematic, as defined by Campbell and Gregor (2004), is not the problem that needs to be researched, nor the formal research question. The research problematic "identifies how the researcher will take up the inquiry from a standpoint in the everyday world" (p. 48). According to Smith (2005), a problematic is a conceptual research tool that contains an

identified “rupture” or “disjuncture.” This disjuncture implies knowing something from a ruling as opposed to an experiential perspective. The problematic has been compared to a puzzle that is yet to be discovered using the standpoint of those on whom the exploration is centred. At that point there is disconnect between what is textually defined (i.e., defined through texts such as policies and documents), and what is happening in everyday experiences.

Social Relations and Power Relations

The main goal of IE is to understand and explicate social relations and how they are taken up or influence the work of others. IE differs from traditional ethnography in that the goal is to create an understanding of power structures within institutions that affect the everyday. The foundation of Smith’s work is the understanding that IE is an ontology that views everyday work as a coordinated and interconnected interdependence of people’s activities. In other words, the activity of one person or group affects the experiences of another and it is these activities and experiences that constitute a social relation. Often, these relations are unknown and, therefore, IE helps to expose the social relations that connect different sites and actions. Smith (1987) points out that the world may be experienced as disorganized, yet when social relations are made visible, we discover that it is organized to happen as it does.

The point of entry for exploring social relations is the local site; it involves exploring what happens from the standpoint of those experiencing a problematic.

The point of entry for exploring social relations is the local site and it involves understanding the experience as people live and understand talk about it

(Smith, 1987; 1999; 2005). Smith further suggested that in order to understand fully how people's lives are organized, research has to look beyond the everyday setting and this involves the second point of investigation, the extra-local. Analysis of the extra-local setting entails exploring the activities and processes that shape local experiences by uncovering social relations that mould activities, ways of thinking, and experiences. For example, the extra-local setting would include the analysis of large organizing bodies such as legislating committees, including Workers Compensation and the Regional Integrated Health Authority, or agency policies, as well as government policies such as the Occupational Health and Safety Act. Considering the context of power relations, a central aim of IE is to explicate how people negotiate social relations and take up, accept, or resist the forces organizing their everyday work. These social relations are connected with the concepts of power relations that are central to the work of Michael Foucault.

IE shares with Foucault the concepts and interest in texts, power, and governance, yet there are some differences between the two. Foucault's work centered on how power relations frame knowledge and discourse, and how knowledge and power are socially, politically, and historically constructed (Foucault, 1972). Smith noted that Foucault defined discourse as large-scale conversation in and through texts (Smith, 2005, p. 44). She extended the concept to mean "a field of relations that includes not only texts and their intertextual conversation, but the activities of people in actual sites who produce and use them and take up the conceptual frames they circulate" (Smith, 2006, p. 44). What Foucault conceptualized as knowledge/power is for Smith a social relation that comes into play as actual people participate in knowing and acting knowledgeably (Campbell &

Gregor, 2004, p. 41). Foucault's conceptualizations of power relations, knowledge, and discourse contribute to the debate on workplace health and safety. Power dynamics in health care, and, in particular, workplace standards and policies inherent in employment in health care, are sometimes conceptualized as being paternalistic, and therefore a deeper exploration of the meaning of these experiences is warranted.

Texts and Ruling Relations

Smith (2005) used the term *text* to refer to any material, object, or document capable of being transferred, stored and widely distributed. These characteristics allow it to be used by different people at different times and in different places, yet it may be used and interpreted differently. Texts can include anything from paper, files, pictures, films, policies, or websites, to books. For Smith, texts are present in the everyday world and "produce the stability and replicability of organization or institution" (p. 228). She insists that ruling relations are mediated largely by texts and it is largely through printed materials that everyday lives are organized.

Examples relating to my research include workers' understanding of agency policies, Provincial Home Support Operational Standards, and training programs that were a large part of their daily work experiences. Although these texts are present in their everyday work, they are often unknown or invisible to the workers.

Texts that are both internal and external to the work setting that organizes working lives are what Smith (2005) referred to as ruling relations. Smith described the organizing and controlling nature of texts and settings across time as *ruling*, and she maintained that ruling constructs knowledge through an account of experiences in people's work. An example of this could include workers' reference to what they

are permitted to do while working in the private clients' homes, as outlined in the agency policies. Smith draws on the work of Marx to conceptualize institutional systems and explain important concepts such as ruling relations. The concept of ruling relations is important in understanding Smith's (1987; 1990) ontology of the social. Smith suggested that ruling relations are largely mediated by texts by directing attention to extra-local activities and social relations such as policies, printed materials, film, and documents that organize and control everyday activities in the local setting.

Often these ruling relations are invisible to the people they affect. IE draws on the Marxist theory that workers (the proletariat) often do not know that the capitalists for whom they work are exploiting them. Another contribution to the development of IE was Marx's emphasis on the importance of understanding the experiences of real people in order to understand what is actually happening. This concept of ruling is important in describing and understanding the everyday work that is coordinated by the institution.

Institution

The concept of *institution* extends beyond any physical structure. Smith (2005) defined institution as "complexes embedded in the ruling relations that are organized around a distinctive function, such as education and health care and so on" (p. 225). An institution is constructed by a pattern of social behaviour and realities. Work could be described as an institution, as could health care, education, or social work. It is noteworthy that these social patterns can exist outside one social setting

and beyond local actualities, in the outside (extra-local), thus influencing a variety of settings.

Work

IE engages in an ethnographic exploration of institutional processes by focusing on the work that people do, which “applies to anything that people do that takes time, depends on definite conditions, is done in particular actual places and is intentional” (Smith, 2005, p. 210). My research explored and explicated the work involved in learning the job, the work of staying safe in the workplace, the work of being able to engage in a job despite an aging body and the normal physiological changes of aging. This definition extends beyond just the work day or happenings in the place of employment but refers to the experiences of home support workers negotiating policies and textual practices on a daily basis. This includes the time during which they get up, go to work and participate in the work day, and return home while continuing with home responsibilities. IE facilitated my understanding of how aging workers’ work experiences are organized by policies, procedures, job descriptions, and other administrative rules.

Epistemological Stance

As a nurse with a background in home care and community health nursing, I recognize the challenges and inefficiencies in the policies and processes supporting home support services, as well as the challenges inherent in the everyday work of home support workers in our province. Efforts to meet the increasing need for supportive community services, coupled with the increasing numbers of older adults choosing to work in this sector in their senior years, sparked my interest in this area

of research. This research made visible the social relations and institutional practices that shaped and organized the routine practices and work experiences of aging home support workers.

When I first began this research and reviewed the various sources of literature and policies related to health and safety, it was evident that the positivist perspective that informed my sources was prominent in the literature. Policies on home support were written, but there was little evidence of critical assessment of the larger organizing policies that influenced the more local, site-specific organizational policies that workers had to follow. The positivist perspective limits the construction of knowledge in that it is based on the understanding that there is one reality that is based on scientific evidence and generalizable to the population.

A positivist paradigm does not consider the other social, cultural, and political forces that challenge the positivist view of traditional policies. Having worked within the positivist paradigm and recognized the disjuncture inherent in the work these people do, I became frustrated with how policies are developed and implemented and whether they are even activated or followed. Different methodologies have the ability to answer different research questions and in assessing different research methodologies, I concluded that IE was the best resource and toolkit for my research to address my problematic. I wanted to explore the everyday work of home support workers from a different point of view, and more specifically to explore the impact of these policies on decisions workers make regarding their health and safety. I decided to use IE as a method of inquiry that

would offer a better understanding of how working lives of home support workers are socially organized.

However, IE is not without its critics. Walby (2007) questions the claim that IE rejects the dominance of theory. As it had been discussed above, IE draws on the theoretical underpinnings of feminism, standpoint theory, phenomenology, and Foucauldian theory. As Smith (1994) argues, however, the purpose of IE is not to produce an account of the participants' perspectives from a theoretical standpoint but rather to explicate how the local settings are socially organized and brought into being (how the local lived experience is shaped by the extralocal ruling relations). The limitation is not in the method of inquiry but in the risk that the researcher, while engaged in data collection, may lose the presence of the subject while trying to explicate the ruling relations that are prominent in their everyday work. I was aware of these limitations prior to engaging in this method of inquiry and paid particular attention to ensuring that these limitations would not affect the credibility of my research.

Study Design

Aims of the Study

This research investigated five broad areas:

1. The everyday experiences of aging workers in the home support sector and more specifically, the work that they did.
2. Factors influencing aging home support workers' decision to remain working and the meaning of work for them.

3. The multiple social relations that generated these experiences and gave meaning to the experience of work.
4. The ways in which their work was constructed and influenced by the work of others and coordinated with outside events, policies, and regulations; and
5. Workers' descriptions of their age as a factor that influenced their ability to do their job, to protect their health and safety in the workplace, and their decision to stay in the workforce.

The establishment of trustworthiness in qualitative research is essential to determine the accuracy of the research and enhance successful uptake of the findings to be sure that I can trust my findings. Trustworthiness can be described as the confidence that the research findings are an indication of the experiences, that the findings can apply to workers in that setting, that the findings would be consistent if replicated, and that the findings are determined by the subjects and not motivated by the biases or interests of the inquirer (Lincoln & Guba, 1985). Guba (1981) suggested constructs for evaluating the trustworthiness of qualitative research: credibility, transferability, dependability, and confirmability.

In my research I addressed each of these constructs to ensure the trustworthiness of my research. Strategies to ensure trustworthiness, including multiple methods of data generation (interviews and textual analysis) and prolonged engagement and member checking, have enhanced the trustworthiness of my research. I ensured a clear audit trail of the research to guarantee dependability and confirmability.

Setting, Recruitment, and Selection of Participants

This research was conducted with older front line home support workers. I was interested in exploring how the roles and responsibilities of men and women as they work to provide care and support in people's homes affected their ability to maintain their health and safety. My data generation began with several meetings with agency owners, policy makers, and key stakeholders with the provincial government, as well as representatives of the Health Authority. To protect the anonymity of participants in a province where those in government positions may be readily identifiable, the titles of these policy representatives or key stakeholders were withheld.

Workers were recruited from three unionized home support agencies in the capital city region. The 12 front line workers (9 females and 3 males) were all white, between the ages of 58-68, and had been working in the home support sector for over one year (varied between 1 and 15 years). None of the participants had any formal training but many of the workers had previous experience as informal caregivers providing care for family members which led them to working in the context as a formal caregiver.

Convenience sampling was used to recruit informants who were able and willing to participate and who could clearly describe the everyday experiences of the home support workers. I met with managers to explain the nature and purpose of my research, and letters of intent were distributed to agency managers to elicit their support (see Appendix A). A research poster was also distributed to management to display in common areas in the workplace or distribute with payroll cheques, to elicit

interest from participants (see Appendix B). Incentives were offered; these included a Tim Horton's gift card or \$20.00 cash, along with reimbursement for travel if the informant had to drive to the place of the interview. Potential participants were approached by agency managers and advised that participation in the study was strictly voluntary and would not affect their employment status or duties at their place of work. Agency owners provided me with a list of names of participants who expressed interest in being contacted to participate in the research

Since I defined older workers as 50 years and older, inclusion criteria comprised that the participants had to be age 50 + and employed with the agency on a part-time, full-time, or casual basis for at least 1 year to be considered for the research study. Literature and government documents define older workers with ranges from 40+ to 65+ years. I decided to focus my research on workers in the 50+ age group for a couple of reasons. First, I was advised by agency owners that there are few home support workers working beyond the age of 65 and, therefore, early in the research process I was aware that the recruitment of workers at this age would be challenging. Second, I was interested in exploring how the normal changes of aging may impact older workers' ability to do their job while staying healthy and safe in the workplace. Most adults by age 50 are experiencing some of the normal physical changes of aging. Other inclusion criteria included being cognitively well, able to speak English, and able to provide informed consent. Cognitive status and ability to provide consent were determined by management of the agency, as they provided me with a list of names of workers who would be eligible to participate in the study. In return for access to employees, I agreed to provide a summary of the research

findings to the agencies so they would be better informed about challenges, opportunities, and health and safety considerations from the standpoint of these aging workers.

According to IE, the researcher does not initially know the exact number of participants in the research, since this is determined as the research progresses. In IE, sample size is not a significant issue because IE addresses the use of language and social relations and not necessarily the number of people involved (Bohls & Bombard, 1998). Therefore, questions about sampling do not involve who and what to include, or for how long. Rather, the focus is on the need for a diverse sample that will include employees as well as their employers and the array of decision makers (such as agency owners, management, and policy personnel at the Health Authority) who participate in the construction of their work. In addition to the front line workers, I also interviewed 3 agency owners/managers, a policy representative from the Regional Integrated Health Authority, and a representative from Eastern College responsible for development and delivery of the Home Support Worker program. These policy representatives and key stakeholders were able to provide me with the texts that I needed to analyze if I could not locate them from other sources. As well in my conversations with these people, they were able to provide clarification of how these policies were developed and how they organized home support workers' everyday work.

Data Generation

From an IE perspective, data are generated, not collected. Smith (2006) wrote about generating data with the ultimate goal of explicating what is happening

in a local setting as people know and live it. The sources and methods of data generation are varied and often depend on availability and accessibility. It is difficult to know the exact sequence of events or sources of data (DeVault & McCoy, 2006). In this study I used a number of strategies in an attempt to make visible the social relations that shaped the lives of aging workers in the home care sector. I collected information from a variety of sources, including interviews, field notes, and institutional texts.

Interviews and Field Notes.

Lincoln and Guba (1985) suggested that “prolonged engagement requires that the investigator be involved with a site sufficiently long to detect and take account of distortions that might otherwise creep into the data” (p. 302). Data collection for my research began in the summer of 2010 and ended in the winter of 2012. Prolonged engagement in the field enabled me to get to know the research participants, broaden my comprehension of the work they do, build trust with agency contacts, and understand more deeply these workers’ experiences. The length of the data generation process contributed to a comprehensive and clear understanding of the everyday experiences of the workers and the social relations that organized those experiences.

The data generated from the interviews described the actualities of people’s lives. In my meetings with the front line workers, I used semi-structured interviews (see Appendix C) to discover the discourses and institutional processes that shaped their experiences. The questions were used as probes to generate discussion and guide the interviews. According to Rapley (2004), interviews help the researcher

understand the biographical, contextual, historical, and institutional elements that are brought to the interview by both parties. Interviews took place at two institutional levels: first with the front line home support workers, and second with policy makers and administrative personnel responsible for the development and implementation of organizational texts and policies.

I began the investigation from the standpoint of the front line support workers by interviewing aging workers who provided direct care to clients in the home setting. Interviews took place at a time and place convenient to the participant. They usually occurred outside the workplace, in a quiet and private area, unless participants preferred to hold the interview at their place of work. All interviews were conducted before or after a shift or on the worker's day off, with the exception of one interview that took place at the participant's place of work at his request and with the approval of the agency. I met each of the front line workers once but, if necessary, contacted them by telephone for follow-up, to confirm that my understanding of their experiences was correct. I met the agency owners and policy personnel on several occasions during the data generation stage.

Each interview focused on the everyday work experiences of home support employees and how their work may be constructed or organized by intra-local and extra-local texts or ruling relations. Smith (2004) suggested that interview questions will vary between participants depending on how the interview progresses and how the experiences that are described by the informants lead to other questions. Semi-structured interviews allowed me as the researcher to determine the topics to be covered, but the interviewee determined the information disclosed and the

importance or meaning of those topics (Green & Thorogood, 2004). The interviews with front line workers were recorded and transcribed for analysis. I did not take notes during my interviews with the front line workers, as I did not want to distract from the conversation and interaction with the interviewee.

Lincoln and Guba (1985) noted that using member checks where “data, analytic categories, interpretations, and conclusions are tested with members of those stakeholding groups from whom the data were originally collected is the most critical technique for establishing credibility” (p. 314). Following the interviews I developed summaries of the interview data and sent these summaries to the respective participants. The purpose of these summaries was to confirm with them that my understanding of their experiences was an accurate description of the experiences they described at the time of the interview. These summaries were mailed out along with a form to be completed by the participant indicating that they had read the summary. The participant had the option of agreeing with the summary or suggesting changes or clarifications to the summary. Seven of the twelve participants returned the forms. One of the seven provided a simple point of clarification. Member checking allowed the informants an opportunity to validate or clarify the findings of my research; thus, it enhanced the trustworthiness of my findings.

As an insider familiar with the settings of home support, I ran the risk of inadvertently making assumptions about the data I was generating and not seeking appropriate clarification of specific practices or activities. To counter these risks, I supplemented my interviews with field notes and personal journaling. Immediately following the interview, I wrote detailed notes about the interview. These data

sources were my reflections on details of my observations, thoughts, reactions to people and events, and explanations of the contexts of my observations. The field notes were included during all stages of the data collection process. The field notes, therefore, were written paying special attention to body language and other non-verbal cues that could not be captured by a recorder. Green and Thorgood (2004) suggested that field notes be used to describe what was happening, who was involved, and how the meaning of the experiences was being produced in the setting and in the given context.

I was sensitive throughout the interview to variations in the informants' narratives. Any inconsistencies were explored through further discussion and clarification, asking the same question in a different way, or seeking examples. For example, in discussing risky behaviours in the workplace, I explained what I meant by risk and asked them to provide an example of a risky work behaviour that they may have encountered, and what they did. During the interviews, I was attentive to alternate discourses or processes that needed to be explored and explicated. The interviews suggested the need for alternate data generation strategies, such as textual analysis and mapping. Throughout the interviews with informants, I continued to ask questions and reflect on my observations and field notes about a particular phrase or activity until I was clear about what meaning they attached to it.

I also interviewed policy makers, managers, supervisors, and government officials who were involved in the development of organizational policies for home support. These people govern routine practices and ways of working but may not be directly involved in the everyday work of these home support workers. I believed

that interviewing administration, policy personnel, and supervisors would help me understand the political, historical, and social context of the work involved in the home support sector. Two agency owners and the policy representative for the Health Authority were not comfortable with having the interview recorded, so I took field notes. These notes detailed the conversations and events that had taken place. Semi-structured interviews were used with questions as probes developed to generate discussion and guide the interview (see Appendix D and E).

Institutional Texts.

The third source of information gathering is the study of written documents or texts. Smith (2006) stressed that the incorporation of texts is essential to conducting an institutional ethnography, since work is coordinated by texts. Textually-based forms of knowledge are central to understanding and describing the institution of home care. I explored how ruling relations and social relations are organized, enforced, and maintained through texts. I reviewed the documents and standard forms and policies that participants referenced when describing their everyday activities. Examples of the local texts I explored in my research were policies on job descriptions, job orientation procedures, and health and safety training programs, as well as larger extra-local programs and policies, including the Provincial Home Support Operational Standards (1995; 1998), the Newfoundland Association of Public Employees (NAPE) (2008; 2010) contracts, and the documents related to the Home Support Worker/Personal Care Attendant Training Program (2010) which is offered through a local training college. The workers made no reference to the WHSCC and therefore this text was not included as part of the analysis.

Smith (2004) stated that the everyday is organized by text-mediated intra- and extra-local relations. Based on the information gathered from the interviews, the participants identified and spoke about many texts that influence the coordinating or organizing of the work of an aging home support worker.

Data Analysis

In analyzing the data and learning about the experiences and the everyday work of aging workers, I attempted to explicate what was happening in the local setting as the people who know and live it can describe it. In other qualitative methods there is a clear process of coding and analysis of data, however, in IE the approach is significantly different. Interview transcriptions, field notes, and texts were analyzed and compared to each other to confirm or describe participants' experiences and their meaning. I sought clarification of the data as they were generated, by asking informants to explain the rationale behind the language they use and the practices that I heard them talk about.

I reviewed texts and constructed a schematic diagram to explicate the network of textually mediated relations that are at play as aging workers prepare for and negotiate the challenges and opportunities of their job. I completed a line-by-line analysis of the relevant sections of these texts to gain a greater understanding of how they influence the work that home care workers do. Data generation continued until I had enough data to map out and understand these social relations. The goal of data analysis is to fill in all pieces of the map by looking for patterns in the data that explicate the experiences of older workers and how these experiences are organized

by outside texts and power relations that are either visible or invisible. The data were compared and analyzed to test the quality of the information obtained.

Data analysis generally occurs in two stages referred to as level one and level two data (Campbell & Gregor, 2004). During the initial stage of analysis, I compared and considered the variability of the data and examined the data as a whole for any contextual features that may produce consistencies or contradictions. The effects of texts were not readily apparent at first and, therefore, I developed a tentative analysis for key texts, phrases, or processes that were evident, and returned to the data to further investigate my analysis. The data provided a detailed account of the social organization of their work in the home care setting.

The second stage of analysis focused on how the experiences of those in the local setting connected to the relations of ruling (Smith, 1987). For example, when the participants made reference to activities that they were permitted to do I went to the Operational Standards to analyze this text to identify how the texts organized the limits of their everyday work. During this stage of analysis, I reviewed institutional texts, spoke with policy makers and key stakeholders, and produced an account of people's talk, experiences, discourses, and practices, and how these shaped workers' experiences in the workplace. I analyzed the data and sought to understand how people's actions and activities were coordinated across participants and time. In this stage of analysis, the focus moved from a specific process or discourse towards a more general analysis that explicated the social relations that organized their everyday lives. These data were included in the map that helped to pictorially explain

their everyday work and how their work was organized by these larger textual practices.

This second stage of analysis required an analysis of texts, discourses, and practices, where they originated, and what they accomplished. From the interview transcriptions, my attention was drawn toward the policies and standards, government legislation, and bureaucracy that explicated the routine practices and experiences the workers described. I explored texts and examined if and how texts that were often invisible to the workers organized the everyday experiences of the aging worker.

The functions of some everyday language, practices, and texts were visible and transparent and therefore the interpretation was automatic, as with the general job descriptions. Others, such as the policies on delegated nursing functions, required more extensive thought, investigation, and analysis. In order to produce an accurate account of the functions of the everyday practices that occur in the local setting, it was necessary to draw on additional sources of data. DeVault and McCoy (2002) compared this process of analysis as unravelling a ball of string, “finding a thread, and then pulling it out” (p. 755). Only step by step as the data collection and analysis proceeded did I know what additional sources were needed to fully understand the social and institutional relations that give rise to everyday experiences in the local setting.

Campbell and Gregor (2004) added that the analysis of data aims at determining how information can be generalizable. With IE, generalizability “relies on discovery and demonstration of how ruling relations exist in and across many

local settings, organizing the experiences informants talked about” (p. 89). From an IE perspective, tracking and mapping of data in various forms can enhance the trustworthiness of my research.

Ethical Considerations

Ethics approval for this research was granted by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) of Memorial University, St. John's, NL, (see Appendix F) and the Research Proposal Approval Committee (RPAC) with the Eastern Regional Integrated Health Authority. The RPAC approves and monitors all research conducted within the Health Authority; because home support agencies are regulated and organized by the Health Authority, this approval was necessary in addition to ICEHR approval. Consideration of the Tri-Council Policy Statement 1 (1998) for research involving humans was incorporated into the planning and implementation of the research. Written informed consent, including consent to tape the interviews, was obtained from the participants (Appendix G). Participants were informed individually and in writing that they could withdraw from the study at any time without any repercussions. A transcriptionist who was not associated with any of the participants was hired from outside the home support sector. Assigning code numbers to interviews and transcriptions, along with the utilization of password protected computer files, further ensured confidentiality and anonymity. There was only one copy of the identification numbers corresponding to tape recordings and consent forms. The consent forms, taped interviews, written transcript coding notes, and researcher's field notes were always locked in a safe

place. Additionally, consent forms were separate from the transcriptions to further ensure confidentiality.

Before the interviews began, I again explained the aims of the study and reassured the participants that they had the right to withdraw from it at any time. Benefits and risks of the research were fully explained to the participants. While there was no direct benefit to the workers from this study, participants were informed that this research has the potential to contribute to a growing body of knowledge. They were also informed that, in the future, the results of this research may have an impact on policy changes and employers' responsibilities in addressing the needs of aging workers. The participants and the agencies who participated in the study were sent a summary of the findings of the study.

There was no direct risk to workers for their participation in the study; there was, however, the inconvenience of committing their time for an interview. The only other risk that was discussed with some participants was their concern that their managers may be aware of that they were speaking out about health and safety issues in the workplace. I again assured participants that I had the support of owners and management in conducting this study, that management was interested in understanding the challenges and needs of the aging workers in their agency, and that no individual workers would be identified. I reiterated that their privacy and confidentiality would be maintained at all times during the data generation and analysis and dissemination process.

Summary

In this chapter I provided an overview of IE as the method of inquiry that guided my investigation of the meaning and organization of work, health, and safety of aging home support workers. This chapter provided an explanation of the philosophical underpinnings of IE and the appropriateness of this methodology for my research problematic.

The focus of this research is on health and safety; in the next three findings chapters, I will describe the courses of action that allowed me to map the ruling relations between front line workers and their experiences in home care, with an emphasis on decisions to protect their health and safety. I will explain the conceptual map of workers' everyday experiences and how these experiences are organized by the textual practices that affect the institutional order. Three main themes form the foundation of my findings to explicate the workers' everyday experiences. These include "Crossing Boundaries: More Than Just a Job," "Making It Work in Unhealthy and Unsafe Work Environments" and "Becoming a Home Support Worker: Experience, Orientation, and Training Needed to do the Work."

Chapter 5

Crossing Boundaries: More than Just a Job

I don't have to work ...It's just that it's giving back, it's helping out, and I look at life: if someone looks after the children and elderly, the rest of the people in between can look after themselves. But we have a responsibility to care for the young and the elderly (Rita, age 64).

In this investigation I set out to explore the everyday work of aging home support workers with a focus on health and safety. The first thread identified in the analysis of the data was that of Crossing Boundaries: More Than Just a Job. Decisions around work were largely shaped by larger agency and organizational policies that infiltrated workers' day to day practices. In this chapter I explicate how close relationships with clients and the meaning of work were often determining factors of whether workers followed or resisted organizational textual policies and practices.

Bureaucratic and organizing policies such as the Newfoundland Association of Public Employees (NAPE) contract were identified by the workers and policy personnel as regulating workers' day-to-day decisions regarding their hours of work and the clients that they worked with. The disconnect between the NAPE contract as well as the OH&S Act stipulating that workers can work a maximum of 40 hours a week and the numbers of hours that workers are actually working is evident. Stories told by the home support workers provided evidence that the boundaries between workers' personal and professional relationship with their clients were often crossed.

Workers talked both about both their reasons for working as well as the reasons for choosing the number of hours that they worked (i.e., full time, part time, and the number of hours that they worked above the specified 40 hours a week). Many factors

were highlighted that led to their choice of hours such as their personal relationships and emotional connectedness with their clients, the physical impact of work on the aging body, as well as the NAPE contract. To illustrate how the everyday experiences of these workers are organized by ruling practices from organizational texts, I provide a map (See Figure 1) illustrating the texts that are activated.

Workers began the discussion talking about the shifts they worked and their work schedules. The number of hours that the home support workers worked was closely linked with the meaning that they attached to their employment. In general, frontline workers talked about two main reasons for working – either for the extrinsic or for the intrinsic benefits of work. Three of the twelve workers reported that they were working for financial reasons, five were working for the non-financial rewards, and four were working for a combination of these two reasons. The three working for extrinsic rewards of work reasons noted that they had to work to make financial ends meet, to subsidize their Canada Pension, and to support their everyday living. Many of these older workers were working in excess of full time hours with two and sometimes three different agencies make enough income to support themselves and their families.

Map of Everyday Work in Home Support for Aging Workers

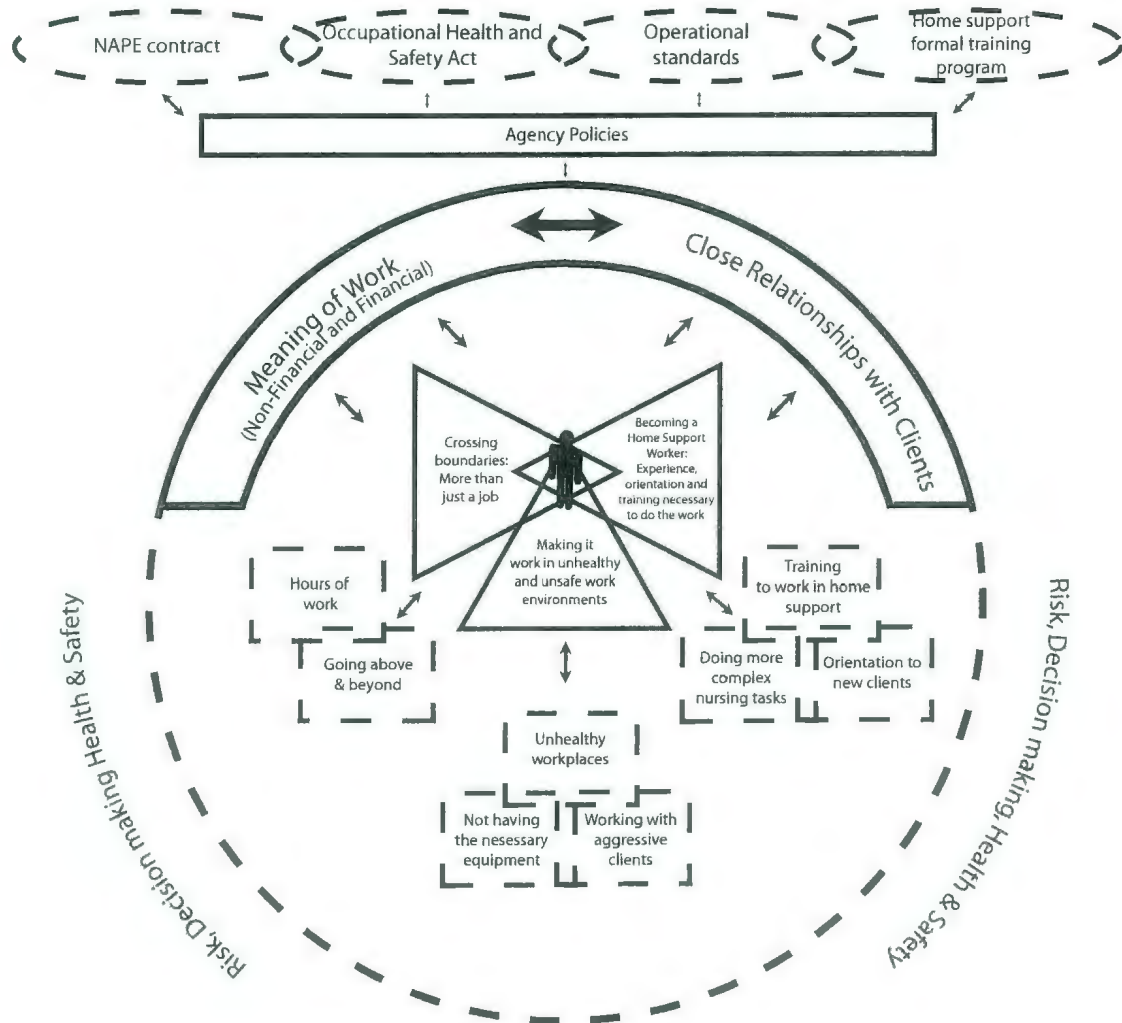


Figure 1: Map of Everyday Work in Home Support

Two workers talked openly about the financial incentives of work; however, they talked around the subject and quickly switched the conversation to the non-financial rewards of their work. Some workers appeared to have a level of discomfort in describing their financial necessity for work but openly discussed the non-financial rewards of their work.

The following section in this chapter highlights, from the stories of the front line workers, the factors that influenced their hours of work and ultimately how these decisions led to a crossing of boundaries between the personal and professional relationships with their clients. Hours of work were determined by the stipulations of the union contract, the close personal relationships with clients, or the limitations of their aging bodies or often a combination of these reasons.

Hours of Work Determined by the Union Contract

Not all agencies are unionized but those workers that I interviewed for my research were all working for a unionized agency. Several workers made reference to the NAPE contract and discussed how this union contract influenced both the hours of pay and the benefits that they receive. It is noteworthy that the same contract does not represent all agencies as they are negotiated separately; however, there are many similarities among the NAPE contracts for each agency relating to hours of work and benefits. The NAPE contracts are public documents that define the conditions of employment and are meant to enhance the working relationship between the employer and employees. I located and analyzed the NAPE contracts from the three agencies that participated in my study.

Hours of work were the predominant issue that workers referred to that structured their employment experiences. For example, the NAPE contract states that “the normal

hours of work for employees scheduled on a weekly basis shall be up to forty (40) hours". However, six of the twelve workers were working in excess of 40 hours a week, most often working with two different agencies. The workers in this study worked anywhere from 20-110 hours a week. The NAPE contract (2008; 2010) states that "all overtime hours worked shall be compensated at the rate of one and one half (1.5) times the employees' regular rate of pay". Although workers voiced that this was reasonable, the problem from the stories of the workers as well as the agency managers, was that agencies are no longer willing to pay overtime. As explained by one agency manager as well as the policy representative from the local health authority, agencies are not receiving funding from the government for overtime hours to subsidize the home support program. Therefore, if an agency has to pay overtime they are not reimbursed from the provincial government to cover the agency costs to pay the employees. Therefore workers reported that they were being scheduled for their regular weekly hours and not called for overtime shifts unless absolutely necessary.

Some workers were finding this to be a problem in that they had become dependent on these additional shifts for extra pay and now that the union is representing them this extra pay is no longer available. For some workers like Patsy, age 67, this has resulted in a dramatic reduction in her monthly salary. She suffers from several chronic illnesses and has been advised by her physician to give up work. However, Patsy is an example of a worker who, due to the financial necessity for work, continues to work despite her doctor's advice. The union, having mandated time and a half, and the resulting agency policy restricting overtime pay, had resulted in Patsy as well as others having a reduction in their pay:

Before the union done that, when I was working long hours, I was used to bringing home \$1400 every two weeks. And then it went down to \$900, and now it's down to less than \$800 ...if we could work extra hours, I wouldn't need to work the hours that I was working, but I would've worked 100 hours, 95-100 because then that would have given me a pretty good cheque.

Another worker described in detail that since becoming unionized by NAPE, the working conditions had improved with regards to hours of work and pay. However, he explained that the clause governing overtime work means that the agency will not schedule him to work overtime hours. Therefore, he has to work for two different agencies to make enough money to make ends meet. Often this means working double the hours to make the same money he had previously made.

And they [union] prevent you from ... you can't do any more than 40 hours a week because they're going to have to pay you overtime ... So it forces you to go outside the current company you're with and seek ... and a lot more [workers] than not are doing 60, 70, 80, 90, 100 hours a week between two or three companies in the city. (Len, age 60)

One worker is the Occupational Health and Safety representative for the agency and an advocate for the rights and privileges for home care workers. She receives many calls from concerned workers. When she was asked about the role of the union in determining hours of work she replied:

But that is a labour standards rule by anybody ... Anything over 40 hours in one week is time and a half. It's overtime pay there. That's not just NAPE. But what was happening out there, those workers and it cannot be done, there's no way in

God's world that they can ... these workers out there can be working 130 and 140 hours every two weeks. They're not going to be able to do justice to their clients ... It's unsafe. I have done that and I have gone about it. I have brought it to the surface and there's a stop put to a lot of it. But there's a lot of the girls are breaking the rule, and doing this because they're saying, 'we need more money.'

(Flora, age 67)

Workers recognize the physical exhaustion that they experience from the lack of sleep having only a little break between shifts when working with more than one agency. The workers' decision to reject the 40 hour a week policies or guidelines indicated by their union contract is placing their health and safety in jeopardy. Workers have found a loop hole that allows them to work extra hours by working with two different agencies to increase their weekly salary despite the well-defined policies as stipulated in the union contract.

Rita discussed that she has to work long hours with uninterrupted shifts because of the fact that she is working with two different agencies. In addition, she works several long shifts sometimes spanning over three days:

I mightn't be at it so much, because I said a couple of weeks ago I got to cut back, I'm doing too much, and I'm not getting my proper rest, and I got no time for me, and then pretty soon it's going to be winter, and it's harder again, trying to get out".....it's nothing for me to go to a place and stay there 72 hours, around the clock before I get home again. (Rita, age 64)

Similarly, Len has been working in home support for little over a year. He works approximately 72 hours a week, working between two different agencies. He talked

about his scheduling of hours and that he has little time between his shifts. In Len's situation he works a 12 hour night shift and continues on to work with another agency:

When I get off at ... if I'm doing one of the night shifts, I get off at 8, so I'm usually home at ten after eight or so, depending on traffic, and I'll go home and, freshen up, get a quick shave... and I'm out the door and down the road for 9:00. Because I work seven days a week with the 80 year old couple, and I do them from 9-1:00. So when I go in the morning, my first responsibility is if there's any shoveling or that to be done ... like last night I did a shift with him, so I did shoveling. (Len, age 60)

The emotional connectedness with their clients as well as the rules stipulated by the NAPE contract are factors that largely determine the hours of work that workers decide to do. The physical effects on the aging body were also described by many as also influencing how many hours they work.

Hours of Work Determined by Personal Relationships with Clients

While some workers reported working strictly for monetary reasons all workers discussed the non-monetary and personally satisfying value of their work. They described that they are working for various reasons such as to be engaged in society or because they have an emotional bond with their client and are not willing to give up working with them. It was evident from conversations with these workers that the hours of work are often determined by the emotional connections and personal relationships that these workers have with their clients. Despite the often uncertain nature of the work as well as the hours of work, workers still chose to remain in this work. One worker in

particular described the work of many home care workers, indicating that there are long hours, days on call, and uncertain split shifts that make the job difficult:

There are a lot of them that take time off. They have to. And this is the way home care is. It's not a job that's a 9-5. When you go into home care, you're there 24/7, on call. Because even though you finish up with one client, you could get a call that such-and-such a person needs some help down the road. So you go. You're on call 24/7. It's a hard job out there. (Flora, age 67)

Workers' descriptions of their employment experiences in home care illustrate how translocal work processes infiltrate routine practices at the local level. The NAPE contract was identified by workers as impacting their schedules, expected hours of work, and the uncertainty of their work schedule. The NAPE contract (2008; 2010) states "..... the parties, therefore, agree that the work schedule for employees may be arranged on a flexible basis in the interest of client care and/or efficiency of the Employer's operation". For the three different NAPE contracts that I analyzed this clause appears in either Article 14 or 15, depending on the agency contract. Despite the uncertainty with the scheduling of their hours, workers described that they continue to work in this field of work because of personal relationships with clients and want to work their schedules around the needs of their clients.

Bill, age 58, has been working in this sector for just over four years. Despite needing the financial compensation for this work, he also talked about the great reward he receives from his work with his two young clients and their families. He talked at great length about the emotional connections that he has with his clients that determines his decision to work many hours, often in excess of 60 hours a week. He described that he is

working in this field despite the long shifts, low pay, and physically demanding nature of the work. His family has been encouraging him to reduce his working hours because of his age but because of the emotional connection that he has with his clients and their families this was not something that he was willing to give up:

You explain to me how I can cut back. I love them both, it's very rewarding to go and look after them, it's very rewarding to know that I'm making [client's name] day easier and his mother and father, because they don't have worries about [client's name] care while I'm there. And I make his day easier. So it's very rewarding to go home like a wet rag at the end of a twelve hour shift, especially when you've done four or five of them in a row.

Similarly Rita, age 64, discussed the close connections that she shares with some of her clients that often makes a difficult day worthwhile and has kept her in this field of work:

Some people will stay, especially if they have a client that they really, really have a good rapport with, you know, and you stay for the sake of them. They don't want the change, so you just stay on for that reason. You know, I've said that about some of my clients, 'Well, I'm going to leave after so-and-so gives up'. But that person gives up and you get another client that is just as nice, and you stay.

Rita described:

I don't have to work ...It's just that it's giving back, it's helping out, and I look at life- if someone looks after the children and elderly, the rest of the people in between can look after themselves. But we have a responsibility to care for the young and the elderly.

One female worker explained that she was feeling tired having worked so many hours. Despite this feeling, she continues to work extra hours for her client. She described that she has difficulty turning down shifts because she doesn't want to let the client down. For her, despite her tiredness, the meaning of work is determined by the satisfaction she acquires from attending to the needs of her clients:

Just burnt out because I can't say 'no'. The office keeps telling me, 'You know if you want, say no', but it's not the office I can't say no to, it's thinking about the client...that, you know, needing help.(Marg, age 60)

In discussing the meaning of work Len, age 60, explained that his desire to work in this field is simply to contribute to the health and well-being of the clients he works with and most importantly to provide the best care to his clients:

I want to leave a legacy. I don't want to go quietly into the night. I want to let people know that I was here; the good, the bad, and the ugly. I think that's the bottom line. If I can leave them in a better condition ... when I can leave in the night, or the day or whenever, and know that they've had the best – at least in my standards – then I know that I've done a very good job for them that day, and I know that they're happy. I think the bottom line is happiness.

In crossing the boundaries between Len's professional and working relationships with his clients, his day to day work goes beyond just providing the basic care in return for his paycheck. He explained that he strives to make his clients' days better and he personally gains great personal rewards for this. His deep commitment to his clients and their families is the great motivator behind his work.

However, despite the number of hours that employees may choose to work, the decision of how many hours to work is often determined and organized by larger organizing policies such as the NAPE union contract. It is in these situations that a disconnect develops between the personal and close relationship with clients and what is actually “allowed” or stipulated in the union contract.

Hours of Work Determined by the Physical Effects on the Aging Body

Some workers were aware of the physical effects of their work on their aging bodies, and therefore, have made decisions regarding the types of clients that they care for as well as the hours of work. These decisions were made in consideration of two main factors: their ability to work with clients requiring a high level of personal care and heavy lifting, as well as their ability to continue to work long shifts and many hours a week despite the normal physiological changes of aging.

As suggested in the Theory of Productive Aging (Butler, 2001), older workers can continue to be productive and contributing members of the workforce, however, there are inevitable physiological changes that occur as one ages (Costa & DiMillia, 2008; Roth, 2005; Touhy, Jett, Boscart, & McCleary, 2012) that may have an impact on both productivity and occupational safety (Crawford, Graveling, Cowie & Dixon, 2010; Silverstein, 2007; Wegman & McGee, 2004).

Physical strength has been found to remain constant throughout young and middle adulthood and then declines as one progress into late adulthood. deZwart, Frings-Dresen, and van Dijk (1996) predicted an average 10-25% decline in muscular capacity by age 65. It has been proven that there is a significant increase in recovery time for those older adults with high physical and psychological demands

(Kiss, Meester & Braeckman, 2008; Roth, 2005), in particular, those with monotonous work and working greater than 42 hours a week (Devereax & Rydstedt, 2009). These normal physiological changes are evident in decreased reflex time, decreased coordination, and reaction speed.

Aerobic capacity is the ability of the body and more specifically the cardiorespiratory system to maintain function during exercise and activity. Normal age related changes in this capacity are evident in reduced ventilation rates, reduced cardiac output, and reduction in peak heart rates (Crawford et al, 2010; Shephard, 1999). Considering this normal reduction in aerobic capacity it would be assumed that this may impact physical work capacity. However, Shepard (1999), reported that fatigue may not be reported by older workers, perhaps due to several factors including their experience relating to age, duration of work life, and seniority which allows for many older workers to request and select lighter tasks.

Recent research by Mohren, Jansen, and Kant (2010) investigated the impact of increasing age on the need for recovery, defined as the short term effects of work immediately following a work day. These short term effects were defined as tiredness, irritability, social withdrawal, and lack of energy. Their research suggested that the need for recovery following work increased with age until age 55, followed by decreased need for recovery in older workers. This was believed to be due to compensation efforts as a result of skill and experience, such as working fewer hours and also working in different work environments. It was suggested that many workers in the 55+ age group had adapted to health problems by leaving jobs or reducing their hours, thus leaving healthy and well workers who remain working.

Some workers in my research had recognized the limitations of their work on their aging body and their ability to do their jobs, especially the care of clients with complex personal care needs. Some suggested that they tire more easily or have chronic conditions such as arthritis that are impeding their ability to work long shifts:

I can't kneel anymore, and if I get down, unless it's something hard to lean on to get up – I can't. I really, really suffer trying to get back up... But the kneeling and the standing, I find that I get aches in my legs and stuff like that, right? I just physically gets tired....So I had to go back to part time.....I'm really tired all the time. (Marg, age 60)

Lifting heavy clients or objects was also an expectation of their job that workers described as difficult. However, despite this, the workers went about this work often for the benefits of the clients:

But I've had clients over the last year, 350lbs, and it took me all it could when they fell down to get them back up... and so I'm not what I used to be, by no stretch of the imagination. But I always try to think that my mind can regulate my body. I just keep telling myself why am I doing this, why am I here, what am I hoping to accomplish, what am I doing for them, am I making a difference for them? And that sort of re-invigorates me, but there are times ... like I said, I always go around with this heaviness. (Len, age 60)

Many workers had suggested that they do not feel that they can work the same long hours as they once could as a younger worker. The long hours and heavy lifting have taken a toll on their bodies and they recognized these limitations:

So domestic care is sometimes a lot where you bend, lift ... you know. So now I want less of that now... and personal care the same too ... Personal care you can be careful not to do lifting, you can say that you don't want that, so in some cases clients have personal care and domestic care together, so if you have both of that you can be totally exhausted. So one or two a day is enough for me now. I'm getting older now, so got to take care of yourself too. That's how I feel. It's a lot more... It consumes a lot of your energy as you grow older. (Mary, age 59)

She continued to say:

I was working maybe 60-80 hours in two weeks. Yes, but now that I'm getting older, I'm just getting 40 hours maybe, every ... maybe two hours with each client, something like that. So, two clients a day is plenty for me...I'd say it's more about doing the hard work of lifting, and longer hours. Working longer hours might be too tiring. I find that now too. That's why I like to just keep to 40 or 45, I don't mind work to 50 or 60, but not 84.

In the above situations, the workers have acknowledged their understanding of the incompatibility between their home care responsibilities and their ability to maintain these hours. Despite the reason for working, or the meaning of work, workers described their decision to cut back on some of their hours as being due to their aging body and because of the physical impact of work on their body and their health and safety.

Workers talked about the physical effects of being an aging worker. One major impact was on their sleep patterns or lack of sleep. Many workers working over-night shifts reported that they may have the opportunity to nap throughout the evening while on their shift, but the sleeping arrangements may be less than optimum to having a good

night rest. Often they will go right to another client first thing in the morning with no break in between shifts. Working two consecutive shifts without a break is contrary to the contract between the employer and the NAPE contract. The contract stipulates that “the Employer shall provide eight (8) consecutive hours off work in each unbroken twenty-four (24) hour period”. However, some workers who are employed by more than one agency may not have the required eight hours off between clients. These contradictory conditions do not reflect the agency’s failure to adhere to the contract but the workers’ decision to work these additional hours and in many cases, consecutive shifts without a break.

But you don’t sleep. You lie down on the chesterfield, which is very, very difficult to sleep on, because it’s a bed that’s got all the springs going up through it. So you doze off, wake up, doze off wake up ... My shoulders sometimes gets... my muscles in my shoulders gets pulled or my back ... But if you go to someone’s home that they haven’t got no family, and they don’t have the means, and they’re on social assistance, there’s no place for you to sleep. You have to sleep in a chair, or sit in a kitchen table chair for 12 hours – that’s very, very hard. Because they don’t even have a proper chair to sit on, they’re lucky that they got what they got, you know. (Rita, age 64)

Similarly, Bill talked about the level of tiredness that he experiences in relation to the shifts and long hours that he works. He described that often in mid-afternoon he feels the need to take a nap but he resists this tiredness:

It’s a challenge at my age, getting through them [the shifts]. You know, I find that somewhere between, say four and five thirty, especially since both of them

[clients] tend to take naps at that hour in the afternoon, and I'm sort of amusing myself and if I happen to be sitting, I'm fighting to stay awake, so I have to get up and do something. (Bill, age 58)

In all of the above situations workers crossed boundaries and made the decision to work extra hours or do extra tasks that were not always in the interest of their own health and safety. These decisions were often made because of the financial need for work, the emotional connections with their clients, and the close personal nature of that relationship which made it difficult to say no to provide this care.

Going Above and Beyond

Many workers described finding home support work very rewarding and often have gone above and beyond for their clients. The sub thread "Going Above and Beyond" captures the altruistic actions that strengthen the relationship between the worker and the client while also adding to the everyday work of home care workers. Many workers described acts of kindness that indicated the workers' intense and deep emotional concern for the happiness and well-being of their clients. Some workers talked about doing extra unpaid work for these clients and their families or doing extra tasks that were above and beyond their job description or expectations. These workers were more likely to cross boundaries and go above and beyond for their clients with regards to working longer shifts, extra hours – beyond the legislated 40 hours a week, and do more tasks outside of those duties defined in the Provincial Operational Standards. For these workers they often cannot afford to give up the pay that they receive for their work that they do. One worker in particular continued to work with violent and aggressive clients

because he could not afford to give up the longer shifts and the steady income that he received for working with these clients.

Workers, whose meaning of work is embedded in the deep, emotional, and personal connection that they receive from the non-financial rewards of their work, spoke about taking what some may consider unnecessary risks in the workplace by doing these extra tasks for their clients. Some of these extra duties include doing additional hours (with or without pay), running errands, and home maintenance tasks that are not part of their job description. Although many of these practices are not organizationally authorized, these workers often rely on these practices to resolve the disjuncture between their commitment to their clients and the needs of the agency to schedule split shifts and complete tasks that jeopardized their health and safety.

Len talked about the extra tasks that he does for his client and his client's family. He mentioned picking up his client's favourite take out and working extra hours for no pay. He described the tiredness he feels at the end of his workday and how his age has impacted his level of energy to do his job. However, when talking about his client's family and the joy and pleasure he gains from helping his client, the tiredness seems to depart, and the enthusiasm in his voice is evident. One family member had asked him to come in to provide respite care for her husband for a few hours. He was quick to agree to this:

I'll come in and I'll do 8-9 hours and you go on. Now, it wound up that she didn't get back for 12-14 but I didn't mind. I spent all the time with him and it was good for her ...my responsibility to her too is ... So Sunday I'm going to go in, for nothing, and do six or seven hours, just to give her a break, so she can go to

church and be with her friends for a quick bite at Swiss Chalet or something. Often you end up doing extra hours unexpectedly. (Len, age 60)

Similarly, Flora who has been working in home support for 11 years noted that many times she does extra shifts for her clients. She expressed her enjoyment in the close and personal relationships with her clients describing that some of her clients are more like friends than clients:

She took sick at one point and time, and she called up and I went in there and I basically done my shifts and then I'd stay sometimes overnight, and that ... That was just helping out, helping the family out and stuff like that. There was no pay there... We're not like client and worker, we're more like buddies. (Flora, age 67)

While some may think that this is too close a relationship to have with your client, these workers find enjoyment and personal satisfaction in their work through these close relationships. Some voiced recognition of the difference in working in homecare with other healthcare sectors such as the hospital setting:

We're not working in a hospital, where you have different clients every single day. If you do have a client for more than that, you're switched around here and there with different clients, so you don't form a bond. So when anyone says to me in home care, don't form a bond, I look at them and say, "Are you crazy?"... That is actual nature, and Newfoundlanders are known to bond with people. That's it. So she's got my cell phone number and everything, and if she needs me in the night, call me, I'm there. And she knows that too. (Patsy, age 67)

One interesting and talented woman described the many additional duties that she does for her client. In this situation, Flora's decision to cross boundaries between what is

described and stipulated in her job description and the other duties that she feels she needs to do for her client places her health and safety in jeopardy:

I walked into a client's house and they had no cupboards ... well there were cupboards there, but gone over the years. So there was nothing there to lay pots and pans on. Everything was slapped on the cupboard – it was a real mess there, and water had come down there and soaked underneath, so I stripped out the cupboard and put new cupboards in there ... I'm after fixing a lot of things like that. Even my own client, she says, 'I'm not only losing a home care worker, I'm losing my carpenter, my plumber, my painter'. (Flora, age 67)

One worker on many occasions described times where he also went above and beyond for his clients. In addition to working extra hours, he described situations where he brought in treats for his client. In recognizing the importance of keeping a positive attitude with his client as he ages, Len was concerned and wanted to do something extra to brighten his day. He described:

There's no rich man, poor man or whatever...Old age really levels the playing field, and for me, just keeping them positive with positive stories and knowing that the mind can perform some very spectacular...I always encourage them to use the mind ... Even the fellow with [disease], as frustrating as that can be. It's a never ending challenge, but I may every once in a while bring him in something special, because he likes A&W papa burgers and...or sometimes I'll bring him some Chinese food or something like that, just something different that he'll remember for a little while. (Len, age 60)

Crossing Boundaries: A Discussion

Deciding between hours of work and doing their day-to-day work became more than just a job. There was an overlap or crossing of boundaries between their professional and personal relationship between the worker and their client and families. This overlap in boundaries influenced their decisions to do extra shifts-sometimes for no extra pay or to perform tasks that were not stipulated in their job description.

These workers were providing care and support to these clients in an atypical work environment. The roles that home support workers play, the increased autonomy with which they work, coupled with clients' increased independence, and the need for maintenance of independence makes for an ambiguous work environment in which decisions are made and care is delivered. In this unique work environment, there are various players who hold power: the client, the agency who employs the workers, as well as the employee or home support worker themselves. All of these players have their own vested interests and concerns. Their deep concern for their client as well as the unstructured nature of this work where there may be no other worker available to do the work, limits these workers' decision making power. Again their decision making is organized by the powerful and ruling limitations of their work environment. Workers' descriptions of their employment experiences illustrate how extralocal work processes infiltrate routine practices at the local level.

These close and emotional connections are what influenced their decisions to continue to work in these work environments with often uncertain work hours and responsibilities. Workers described deep and emotional concerns for their clients' health and wellbeing which made visible the tensions and conflicts that were evident in the day

to day decision making around the protection of health and safety. Previous work by Aronson and Neysmith (1996) suggested that home support workers describe their work as a personalized caring labor that oversteps or seeps out of formal boundaries into informal, unpaid activities that were evident in the stories told by the participants in my study. Their study highlighted that home support workers seek to personalize their activities with their clients and in doing so comes at a cost to workers in that their efforts are unseen and uncompensated by their agency employers.

Home care is a caring and nurturing profession and the very nature of this working relationship and the personal nature of the care that is being provided makes it difficult for workers and clients to stay within the boundaries of a professional relationship. In home support, the delineations of power and rules and regulations are more indistinct than in institutional care. The home becomes not just a home for the client but is in effect, a place of work for the employee. Home care recipients as opposed to those in a long term or acute care setting, are receiving more individualized care, maintaining their own choice, maintaining privacy, and experience normal lifestyles. The negotiation of boundaries within homecare is positive for clients receiving this care in that they can set their own schedules, eat their choice of food, maintain their lifestyles and have the option to reject medical or nursing advice from time to time (Kane, Kane, Illston, & Eustis, 1994).

In conducting research related to boundaries in home support Mahmood and Martin-Matthews (2008) postulated that the boundaries between home and work may become blurred when the home becomes a site of another person's work. They argued that home care agencies often stipulate strong boundaries between work and home life,

yet often boundaries become blurred when support workers do extra work for their clients and develop a personal or affective relationship with their client. This was quite evident in my research as workers described how they went above and beyond for their clients, working extra shifts often for no extra pay, and performed extra duties that were outside of their job expectations. These authors argued that “the manifestation of boundaries between work and home is tied to the social, spatial and temporal context within which homecare work is embedded”(p. 36). Mahmood and Martin-Matthews highlighted that care covered from the public sphere of the hospital setting to the private sphere of the home has further complicated a negotiation of boundary management between home and work. Zerubavel (1991) in an early study indicated that boundaries are fundamental to human culture and are socially constructed in many arbitrary ways depending on how people think and act. These boundaries can be a source of conflict or of order. Workers can move along a continuum of permeable to rigid boundaries in order to find a place where they are most comfortable (Campbell-Clark, 2000). Few workers in my study were able to work within rigid boundaries and they supported the permeability of boundaries within the context of personal and professional relationships in this caring work.

Kane (1995) highlighted the positive effect of the clouding of boundaries in distinction between home and institutional care to improve the lives of elderly disabled people. He proposed that home care has assumed a wider meaning than just care that is provided within the confines of the home. This study focused on the blurring distinctions between home based and institutional based care and the findings of this study can be applied to the crossing of boundaries within the context of home care. Kane’s research

highlighted that there is the clouding of boundaries in another context, that being when home care is moved out of the client's home. Sometimes this care is moved to a place where these clients require assistance as they travel about the community, attend appointments, shopping, and running errands. The incidence of this was quite evident within my research as workers talked about accompanying their clients to appointments and taking them out during the day. Situations where the worker and client stepped outside of the confines of the home enhanced the close, personal, and friendly relationship between the home support worker and the client.

In exploring the nature of the caring relationship within the home setting, McGarry (2008) also supported that the traversing of boundaries between the personal and professional facets of a nurse client relationship was quite common. Through their ethnographic study three themes included the location of care, nature of relationships, and the meaning of the health and illness. This research supported that the role and nature of relationships do not always fit with the traditional notion of the nurse-client relationship.

Other work in the area of boundary management has been conducted in other contexts. Some of these include home based workers striving to manage work and family (Myrie & Daly, 2009) or on job satisfaction in home health care despite risk and exposure to hazards that are often influenced by the fact that the workplace is a home (Sherman, Gershon, Samar, Pearson, Canton & Damsky, 2008). My research adds to a limited body of knowledge by exploring the day to day work of home support workers and their negotiation of policies as well as boundaries that impact decision making practices regarding health and safety for ageing workers. When boundaries between one's professional role as a support worker and the close and personal relationships with clients

are crossed, this often impacts decisions made with regards to protection of health and safety.

Summary

In summary, emotional connections and relationships with clients as well as the meaning of work for older workers were strong factors that influenced the numbers of hours worked, the types of clients they worked with, as well as decisions made in negotiating the various organizing texts in their everyday work. These factors were determined to be influential in the crossing of boundaries between personal and professional lives in the everyday work of home support workers.

Chapter 6

Making it Work in Unhealthy and Unsafe Work Environments

When you got smokers... I can't handle smokers because I got asthma, and a lot of the times the patient insists on smoking, so you have to go over and stick your head out the window or stand in the doorway or something, so you wouldn't inhale the smoke. (Rita, age 67)

The second thread identified in the analysis of the data was the experience of Making it Work in Unhealthy and Unsafe Work Environments. This chapter will highlight, from the standpoint of aging frontline workers, their everyday work in making decisions to protect their health and safety while working in unhealthy and unsafe work environments. These workers discussed three main experiences: working in homes without the necessary equipment required to do their job, working in unhealthy work environments and unhealthy homes, and third, working with aggressive clients.

The Regional Integrated Health Authority (RIHA) write and review the Provincial Operational Standards that organize and regulate the home support sector in our local Health Authority. One policy representative described that the Standards are purposefully vague and non-prescriptive to provide agencies with the autonomy to write, review, and implement their own agency policies. She explained that individual agency policies have to be developed in consideration of the NAPE contract as well as the Operational Standards of the Health Authority. According to the Operational Standards (2005) under Section 8.20 agencies are mandated to have “written, current policies and procedures which reflect the values inherent in the Agency Mission Statement. Policies will be clearly written to give adequate direction to staff, and are available and communicated to staff during orientation and upon revision”. (p. 23) The Operational Standards state that

workers have the Right and Privilege to be free to perform their duties in a safe environment. These Standards are written to consider the health and safety of workers; however, in completing this research it was evident that this does not always happen as workers try to make it work in these often unhealthy and unsafe work environments.

In keeping with Smith's (1990) ideological perspective on work, I consistently tried to make the connection between the experiences of the front line home support workers and their everyday work that is organized by the policies and bureaucratic conditions within the intra and extra local context. In this chapter I draw on Lupton (1993; 1999), Beck (1992) and Slovic (1987) in examining the concept of risk and applied their theories on risk perception to decision making regarding health and safety. My research established the connection between the meaning of work and aging workers' decisions around the protection of health and safety in the home support sector.

Working Without the Proper Equipment

Several workers described working in situations where the equipment needed to do their job was not always readily available and they highlighted the difficulties that they experienced on a daily basis. Some examples where the appropriate equipment was not provided were situations where lifts, transfer belts, or hospital beds were not provided or readily available in order for the worker to safely do their job. One worker described a situation where a lift was available; however, carpeted flooring impeded his ability to use the lift safely:

By the time you get [client], who is probably 180 pounds up, moving that lift around on carpeted floor – like, it hurts sometimes. I have a bad back, I'm very

protective about my bad back... here there's carpet on the floor and it's not conducive. (Bill, age 58)

The same worker voiced concern with his difficulty in providing personal care for this same client due to a commode not fitting properly over the toilet:

The commode was not designed to fit properly over the toilet, so a bowel regime with it doesn't work really well, so we altered it. But, in order to get [client] in there properly, I have a tendency to use my chest, so I stand ... you know, so [client] is going into the chair this way, and as I'm lowering him with my remote in my hand, I have his knees right here, and I'm sort of bending over and pushing him, so that I'm pushing him right back into it. (Bill, age 58)

Another worker who has been working in this field for many years described the difficulty she has in performing a bowel regime in the bathroom of her client's home, a situation quite different from in a hospital setting:

If the counter wasn't in the way.... Trying to reach in and my arms are short. And when you're in a home situation it makes a lot of difference to when you go down to the Miller Center to learn it. To go down there, it's no problem to learn it, because you get at this at the right angle. But when you're into your own home, it's a completely different situation. (Marg, age 60)

Marg has several chronic illnesses and found that the physical requirements of the job are quite challenging because she must provide care without the proper equipment. For instance, her arthritis makes it quite difficult for her to provide care in low beds without the use of an appropriate high hospital bed:

It's really hard because especially when the bed is low. You're bent over, like I said, the lady that I got now, her box spring and mattress is on the floor because she's got the straight leg, and when she kind of falls on the bed... So her bed is only to my knees..... Now it's a high mattress, it's higher than some of the ones I used to do as a young girl. I just wash with one hand, and put the other on the bed, so I'll have a bit of support like that, but some places you can't. And when you're trying, and it's a double bed, and you're in somebody's house and it's a double bed and you got to turn them, you got to shimmy up on the bed. (Marg, age 60)

She discussed her concern that medical professionals send patients home without ensuring that the necessary supports, including equipment, are in place. She expressed frustration that the physicians and nurses didn't always ensure that the patients had the resources or funding for the necessary equipment for those providing care once they returned home:

They sends them home and think "well that's all right"...but they don't have the hospital beds, they don't have ...they haven't got the money to have the stuff, for one thing. (Marg, age 60)

The Operational Standards from the RIHA do not stipulate that agencies must provide the resources and equipment to provide safe and competent care in the home setting. Section 8.20 of the Operational Standards (2005) stipulate "The agency will have policies in place that ensure that clients understand their responsibilities, including...ensuring a safe and healthy environment for care providers" (p. 23). In effect, the responsibility lies with the client/ family to ensure that workers have the necessary

safety equipment to provide the needed care in the home. If the client does not have the financial means to do so the client/family must go through the appropriate channels (i.e. social assistance programs) to have this equipment available. It is expected that upon assessment by the agency, the equipment needs should be evaluated and in consultation with the client or family, ensure that it is available for the worker. However, this is not always happening as workers continue to work in homes without the necessary equipment. The above narratives highlight the disjuncture between what is stipulated in the Operational Standards, what is implemented by the agency, and what is actually happening in the everyday work of these home support workers.

As indicated in the map (see Figure 1) the overarching threads of close and personal relationships with clients and the financial rewards of work were again evident in this second theme of my research in relation to risk taking in unhealthy and unsafe work environments. Those working for the intrinsic rewards such as to keep busy and feel like contributing members of society did not report taking these same risks in the workplace and have many times, in consultation with the agency, chosen the types of clients that they wanted to work with. Some of these workers have refused to provide care in homes where the necessary equipment was not readily available.

One worker explained that she expects that the agency respect her need for a safe workplace and she won't go to work in certain homes. She reported that there were times when she first began her work in home support when she did work strictly for the monetary necessity and worked wherever she had to in order to make a living. She further described that she now sees many workers working in less than ideal situations because they need the work, however, she is no longer in that situation:

Probably not, because I look at it like this – they need me more than I need them. That’s shocking! Because I can say no and not have to worry about it, but a lot of the people ... now there was a time when I needed the money, and I’d take anything that was on the go. I wouldn’t care if I had to get down on the floor... and crawl ... you should have seen some of the situations I’ve gone to, when I’ve had to crawl up a ten foot bank of snow and crawl from here up a 200 ft driveway to get to the patient in the snow.... the workers cry, because they don’t get enough hours, they have to work in these conditions, and it’s bad for their health. They keep getting their back hurt, or whatever. (Rita, age 67)

Mae also reported that she is working in home support for the intrinsic rewards of her work and has refused clients who required heavy personal care:

So I was working one day with a client who requires lifting, with the belt and everything, I said, “Oh my God, he was huge.” No way I could put my hands around him, so I told ... So you just tell them ... Tell them that they need a male nurse for that – somebody big to go [laugh]. So they are very accommodating. You tell them what you cannot do. (Mae, age 59)

Mae attributed her decision to refuse the care of heavy clients to the wisdom and experience that comes with age:

I’m smarter, more experienced. Yes, so more experienced too. Maybe if I’m younger, maybe I would, without thinking, do the way I’ve been doing, but maybe experience and maybe age too, I don’t know... Could be both. (Mae, age 59)

Some workers in this study reported being particularly vulnerable to having an injury and did experience an injury while working without the necessary equipment and

because of limitations posed by their aging body. Rita was one worker who described previous injuries sustained from not having the proper equipment available and also because of her age. She cares for very few clients that require heavy personal care as she finds it difficult as she ages to work without the required equipment:

My shoulders sometimes get... my muscles in my shoulders gets pulled or my back... a lot of them don't have the equipment... because trying to look after somebody in a regular bed, a double bed, when they're sick and they can't get out and they're dying... do you know how hard it is to turn someone and change them and wash them? You're bending over them, and it's killing you. A hospital bed you can put it up to your level... you got a draw sheet and you just turn them and change them and it is easier. (Rita, age 67)

Stella has been working in home support for more than 15 years. She described a previous injury that she had sustained due to heavy lifting over a period of time. She has worked with several clients that have lifts but sometimes one of her clients goes ahead and attempts to move himself without the use of the lift. Therefore she is left to help the client back in position, often without the mechanical lift.

There is an awful lot of lifting... several people I've been with now have had lifts, one that we cranked, others have been the remote... most of my lifting has been with people who've not had any equipment like that... one gentleman... that man would maneuver himself in some way, and get out of that bed with that little board across the bed and get into the chair... I went in several times and found him on the floor and he couldn't straighten his legs out... that was a man that I lifted several times, body and bones. (Stella, age 66)

Stella described another situation when a client's bed fell apart as she was providing care. The client did not have the appropriate hospital bed or even a regular bed that was safe enough for Stella to effectively and safely provide care:

I was doing the transfer from the power chair to the bed, and as I did the swivel to put him on the bed, the bed fell apart...the glue and everything that had been in it was so old...and somebody had changed...day shift or something...or the brother changed the sheets that day and just moved it enough so that when I put the gentleman on the bed, the box spring and mattress went down...I'm caught now because I can't let go of the man afraid of more injuries. (Stella, age 66)

The client's brother who was present at the time could not assist her in transferring the client because of his own medical condition. She slipped a salt beef bucket underneath the bed to keep the box spring and mattress up. When Stella reported the incident to the office she was told that there was nothing that could be done about this. This client continued to receive home care services twice a day with the bed in this condition.

The Provincial Occupational Health and Safety Act (2009) is a provincial legislation that outlines the general rights and responsibilities of the employer, supervisor and the workers. The 10 provinces, 3 territories, and the federal government have their own Occupational Health and Safety Legislation. In our Provincial Occupational Health and Safety Act under Section 5(a) under the title specific duties of employers it states that employers "shall, where it is reasonably practicable, provide and maintain a workplace and the necessary equipment, systems, and tools that are safe and without risk to the health of his or her workers". As well Section 5 (c) states that the employer "shall ensure that his or her workers, and particularly his or her supervisors, are made familiar with

health or safety hazards that may be met by them in the workplace”. However, from the specific story of Stella, there was nothing done by the agency when this situation was reported. The disconnect between the Occupational Health and Safety Act that employers are legally responsible to follow and what was happening in the day-to-day work of these support workers was evident. The ruling relations that organize their everyday work through the development of specific agency policies are often invisible in that they were unknown to the workers and therefore workers continue to take risks to jeopardize their health and safety as they feel they have no other option.

Several workers described previous injuries that they sustained as a result of working in homes which would some call less than ideal for the protection of health and safety. Consistent heavy lifting over a period of time was reported to be the cause of several workers’ injuries. Shirley described that she was getting ready to go to work one day and she felt a gush that she later discovered was a bladder prolapse:

In the meantime I had found that I had a prolapse...so that’s where all the lifting got me...I just felt the gush. I did my shifts Friday and Friday night, Saturday and Sunday. I still went with my shifts and I went to my doctor on Monday and he told me what it was and put me on light duty. (Shirley, age 66)

Despite the Provincial Occupational Health and Safety Act (2009) requiring that employers / agencies provide equipment necessary for workers to safely perform their assigned duties, workers reported having to go without. On closer examination of the Act, the policy states “where it is reasonably practical”. Section 5 of the Act under specific duties of employers it states that an employer “shall, where it is reasonably practicable, provide and maintain a workplace and the necessary equipment, systems and

tools that are safe and without risk to the health of his or her workers”. One has to question what is meant by the term ‘reasonably practicable’ and in which situation would an employer act on these requests to reduce the chance of an injury to a worker.

One worker described a previous injury that she sustained from both doing extra tasks for her client as well as moving clients without the proper equipment such as transfer belts and lifts:

One injury I had while I was only walking. I was going to the store for the lady that I was working with and whatever was I made the step off her step, I busted the muscle in my leg...I was off for 10 or 11 months that time...Another time, well that was more or less a repetitive injury with my shoulder when I done it because I was continuously moving bodies. (Patsy, age 64)

Workers described that they usually work alone and working alone without the necessary equipment is an additional concern for their health and safety. Some workers acknowledged that working alone brings with it some degree of frustration and that adds to the safety concerns in home care. In the home environment working without easy access to other people or support in the case of an emergency, certainly influenced their decisions to complete tasks that otherwise workers may not do alone:

Because you’re there by yourself so you have to do things that you can do with one person, where it always takes two – we work alone. That’s the thing that’s out there; we work alone. We can’t call the office and say, “can you send somebody in? I need to get this person rolled over, they need to be washed and cleaned – they had an accident...” You can’t be doing that. You have to do it on

your own. You're going to have an awful lot of people out there that's going to become sore. So these are part of our problems. (Flora, age 67)

Another worker talked about a situation where she was working alone with a client who had fallen. It was up to Stella to get the client up off the floor while she was working alone and with no equipment:

So yes, we do get into a lot of trouble from time to time...when I went in, this lady again was on the floor... So this was my first obstacle; no assistance anywhere... but between getting the lady from a lying position on the floor to a sitting position, to then we brought over a little stool, and going from one step to the next, to eventually ... I think it was another chair before we got to the wheel chair, so it was just different levels until I finally got her up. (Stella, age 65)

Working alone and without the necessary equipment to move and reposition or transfer clients in the home setting is an issue in workers' attempt to protect their health and safety. Workers talked about why they continued to provide care in these situations. They described taking chances because the client really wanted that task completed or because there was just nobody else to do that work. In all of the situations described above, workers continued to work and provide care to their clients even when they lacked the appropriate medical equipment and when they were alone.

Working in Unhealthy Work Environments

In addition to working in home situations where the appropriate equipment was not readily available, some workers described situations where in their opinion the workplace (client's home) was an unhealthy work environment. From their standpoint, they talked about working in homes that they deemed to be unhealthy and that may

jeopardize their health. Flora talked about working in a home where the client was a smoker:

I went into a client's house and she smoked three packs of cigarettes a day, I came out I couldn't talk. So I stuck it out for a couple of days then I had to go to my boss and I phoned her actually, and she couldn't understand what I was saying to her on the phone...Especially if you go into a house and it's damp and it's wet, and you're looking at water dripping from pipes, and the mold and mildew is around there. (Flora, age 68)

Another worker expressed concern for her own physical health when working with clients who smoke. When asked to talk about the challenges that she encounters in her work that impact her own health she was quick to reply her concern.:

When you got smokers... I can't handle smokers because I got asthma, and a lot of the times the patient insists on smoking, so you have to go over and stick your head out the window or stand in the doorway or something, so you wouldn't inhale the smoke. (Rita, age 67)

One worker explained that the agency should accommodate these differences between worker and client. She described that there has to be an appropriate fit between the client and worker:

It was really hard on us, so that was the thing that needs to be done: try to fit a person in with a person who doesn't smoke, because sometimes you got a client that smokes and the worker don't. Or else you got a worker that smokes and a client that don't, and then you can smell smoke off the worker. (Flora, age 67)

Despite the hazards to their health, these workers continued to work in these homes. Interestingly, the three workers that talked about the discomfort in working in unhealthy work environments were those whose meaning of work was linked to the non-financial rewards for their work so they could have more easily made the decision to remove themselves from that situation:

One time ... my first client, I was saying was a handful, so he smokes, and I don't like smoking environment, so I say that, and they don't give me that client...you just tell them [office] why you think you can't work with them...you can tell the company that you're not going to do that-you can refuse. (Mary, age 59)

This work environment which is largely controlled by the client presents health and safety concerns for the workers in that they have limited control over their work environment. The client that smokes in their own home may continue to do so in the presence of the workers. This is both constructed with and from their clients' understanding of their own rights and privileges in their own home as disconnected from the rights and privileges of the worker. In a workplace outside of a private residence, rules and regulations are instituted that control or moderate the health and well-being of its workers. However, working within the homecare sector, the workers are providing care and performing their job within the individuals' own private residence and, therefore, unhealthy work environments such as smoke, mould, or leaking pipes are possible. Often, the agency will attempt to connect compatible workers with clients to make their working relationship both productive and enjoyable. An agency manager explained that if a client is a heavy smoker, a worker who is a non-smoker may have difficulty adapting to and working in this unhealthy environment. Therefore, the agency will look for a more

compatible worker client connection. Workers confirmed that many times the agency will accommodate a request for a worker to leave working in a client's home if there is not a good compatibility between client and worker.

The NAPE contract states that "in situations where the compatibility between the client and employee is brought into question, the employer and the employee will meet to discuss the cause of incompatibility and to identify, if necessary, the availability of alternative work". Although the contract does not specifically state that this incompatibility can be due to the home environment or health hazards, some workers did state that the agency they worked for were quite accommodating in finding appropriate clients for these workers who feel that they are not able or willing to work in these unhealthy work environments.

Working with Aggressive Clients

A third concern raised by aging home support workers was the violent and aggressive nature of some clients added to their health and safety concerns. Three workers reported working in situations where they had to work with clients who displayed violent or aggressive behaviour. Bill has been working in the home support sector for about four years. He works very closely with two clients who both experience episodes of aggression. Bill described situations where due to the cognitive status of the clients, did not realize that they are hurting their workers. Bill discussed that because of his age and experience, he has been able to protect his own safety using various innovative strategies. In one situation, Bill's client consistently scratches his workers while they are providing his personal care and Bill described a strategy that he developed to protect both himself and his co-workers from this client:

I padded two arms, I took the sleeves out of an old fleece that were lined, I cut the tops, I put foam, about an inch of foam inside because he would – when we were trying to change him, you have no choice when you're trying to change this child, while he's 27 he is child mind you're trying to change somebody, so you have to come up with ways of protecting yourself. (Bill, age 58)

Bill described another incident in which he was not able to make it work in this home situation and, therefore, he removed himself from the home as he was not willing to jeopardize his own health and safety. He works with a client who is aggressive and has hit him:

But if you hit me again, at that point we were nine-something an hour, I said, 'I can't afford for you to beat me up and put me in hospital for this amount of money, you tell me that I'm your friend – friends don't do that to friends.'

Anyway, he did it ten days later, and I left. So I removed myself from the situation. (Bill, age 58)

For Bill, his employment offers both financial and non-financial rewards including the enjoyment of the close and personal relationships that he has built with his clients and their families. However, the hourly wage was not sufficient for him to continue working with a client who had been verbally and physically aggressive toward him on a couple of occasions. Bill made the decision to remove himself from the home in the interest of his own health and safety.

Rita had been working with an aggressive male client who on several occasions has confronted her and other support workers with episodes of violence and aggression. She said that she was working solely for the non-financial rewards of work such as for the

social interaction and the enjoyment of spending time with her clients and not for the financial necessity of employment. Rita laughed as she explained that she was not at all concerned with the safety aspect of her work. She stated that because of her age and experience she will not let anyone intimidate her. She described that on a couple of occasions she was confronted by an aggressive client and she handled it the best way that she could:

I don't concern myself with the safety aspect of it because a couple of times they put their fists up to hit me, I just stand my ground, look at them and say, 'oh no you don't do that!' ... and they'll sort of back off, but if they know that you're afraid of them. Don't show no fear. (Rita, age 64)

It was Rita's choice to continue working with aggressive clients. She openly discussed that if she did not want to work in a particular situation or felt that her health and safety were in jeopardy, she would request to be removed from that work situation.

Another worker described the unsafe working conditions where he felt that his safety was at risk due to the violent nature of their clients. He described a situation where some other workers have been attacked by the client but the workers had no alternative but to go to work because they need to earn a living. Many workers, he described, cannot give up the convenience and stability of 12- hour shifts and therefore continue to work in these unsafe working conditions:

I do four nights a week with a developmentally delayed, violent 65 year old... he doesn't do anything to me because he knows he can't get away with it, but he has attacked his female home care givers – choked them, beat them up ... He's beat his mother also, who's 92....and he's attacked some of the male workers; thrown

teacups at them and that kind of thing, and has beat up the two female home care givers, but when you don't have any alternative for jobs ... but he's subject to bouts of super-human strength... I could see a real reluctance in her even putting her feet across the doorway to come in, and she's been black-and-blued from him. (Len.age 60).

Section 3.20 in the Provincial Home Support Operational Standards under the section of Workers Rights and Privileges states that home support workers should "be free to perform their duties in a safe environment and be free from any actions that would be deemed to be abuse (for example, intimidation, physical, sexual, verbal, mental, emotional, material or financial abuse, etc.)" (p. 9). Despite this policy that was intended to protect the workers, some feel they are still working in unsafe work environments and many have to stay in these work situations. Therefore the disjuncture between the policies that are put in place to protect workers and what home support workers are really doing in their day to day work is evidently jeopardizing their health and safety. Their decision to work in these situations was linked to the meaning of work which was mainly the monetary rewards for work as well as the emotional connectedness that they have with their clients. I again questioned the disconnect between the policies that stipulated that workers should be free to work in a safe work environments, free from abuse and intimidation, yet workers continued to work in these work environments.

Making it Work and Taking Risks in Unsafe Work Environments: A Discussion

In discussing their everyday work, workers made reference to 'what we are allowed to do' and decisions they had to make surrounding the care they provide. Workers struggled almost on a daily basis with trying to make it work in deciding

between taking risks in the workplace to meet their clients' needs and making decisions to protect their own health and safety. Embedded in these experiences were the ruling relations or the texts such as the agency policies, Provincial Operational Standards, and the NAPE contract that organized their day to day work.

While the workers never directly referred to the Operational Standards, they were aware that there were policies that specified what they could do and what their job expectations were. Workers often referred to 'what we can do' and the 'union rules'. Larger extra local ruling relations were often invisible to the workers and in that they were unaware of the specifics within these organizing policies and guidelines surrounding their work. Their daily work often involved negotiating their employer expectations and their decisions of whether to do, and how to do their assigned tasks.

Many workers talked about their job responsibilities revealing how their day to day work was organized by the expectations of the agency, their clients, and their families, as well as the larger governing bodies such as agency policies and union contracts. Through this research I was able to explicate that the decisions that workers made to take up or abide with these policies were constructed through the meaning that was ascribed to their work. In the analysis of the interviews, I found that this is largely due to not just the close and personal connections that these workers have with their clients but also their perception of risk.

As discussed in the literature review chapters, previous research supported that aging workers often work for the financial necessity of paid employment (Shacklock & Brunetto, 2011; Silverstein, 2007; Smyer & Pitt-Catsouphes, 2007), however, limited research was located to support how the meaning of work and decision-making are

influenced by risk perception and health and safety in home support. In my research, those workers whose meaning of work was defined by the financial rewards of work did tend to take more risks in the workplace and did not perceive themselves to be at any great risk with regards to a health and safety. Therefore, the decision to work in unsafe work environments was largely determined by their perception of risk.

I questioned why these workers made decisions to work in these environments and wondered how they were negotiating many external policies to make these decisions. Policies stated that workers were limited in what they were allowed to do, yet these workers made decisions to continue to do other tasks or do their work without proper equipment. The narratives described in this chapter revealed that workers' decisions around health and safety were determined by their subjective perception of risk. The workers in my study did not actually use the word 'risk' but when I asked them to describe situations where they felt their health and safety were in jeopardy they described being actively involved in activities such as lifting clients without the necessary equipment, working with aggressive clients, and working in unhealthy work environments. While they did talk about uncomfortable situations that they found themselves working in, they continued to do this work with a smile. These workers consistently talked about the enjoyment that they have experienced in doing this work and at no time did they talk about leaving this type of work or not enjoying their work.

Wilde's (1982) Theory of Risk Homeostasis suggested that everyone can identify their own level of risk and level of comfort with risk. According to this theory, people have a subjective level of estimated risk that they exchange for the benefits that they hope to receive from that activity. Wilde supported that people continuously evaluate the

amount of risk that they are exposed to and try to reduce their risk taking behavior to a level that they are willing to accept. The degree of risk that people are willing to accept is influenced by their evaluation of the advantages and disadvantages of the risky behaviour and any alternatives available to them. If a person increases safety measures they may, in effect, engage in riskier behaviour simply because they feel that their health and safety is protected. Some workers in my research evaluated that their need for financial compensation far outweighed their decision to protect their health and safety and remove themselves as the caregiver for a particular client. These workers were different than others who were not working for the monetary incentives and, therefore, could make the decision to refuse working with that client for the protection of their own health and safety. They felt that their own health and safety was important and their perception of risk was centered on the fact that the costs to their own health far outweighed the benefits of doing this work for their client.

Risk perception was defined by Kendra (1996) as “a personal determination of the extent of risk and, as such, is multifaceted. One’s culture, previous experience, values, and attitudes are influencing factors in the perception of risk”(p. 387). The perception of risk has changed from its historical roots based on statistical evidence to a current perception of risk that is rooted in people’s lived experiences and social relations and has influences from outside sources such as media, political, economic, and social influences. The concept of risk and risk taking in the workplace is what constructed their decisions around the hours worked, their decision to work in unsafe work environments, and what training they needed to do their job safely.

Risk assessment as well as the minimization of the impact of risk has become a focus of today's society with reference being made to the society at risk (Beck, 1992). This has been evident so much so that our personal and professional lives are becoming proliferated with discussions about risk, and risk in the workplace is no exception. The social constructivist perspective that I support defines risk as being socially constructed and as the result of the social, historical, and cultural contexts in which individuals work and live. This perspective recognizes the social and cultural meanings that impact workers' perception of being at risk. Beck supported that risk exists in terms of the individuals' knowledge about risk and identified that power as well as access to knowledge are vital in a risk society. He maintained a position that lies between realism and social constructionism supporting that real risk exists and can be objectively measured though science. He also supported that risk may be conceptualized differently in different historical and cultural contexts. Beck referred to the "risk society" and supported that it is the context in which risk is embedded that creates the perception of risk. I question whether some workers had the knowledge of risks they were taking when working in a job where their health and safety was jeopardized. The majority of the workers in my study continued to do this work without questioning the agency or the policies that were organizing their day-to-day work.

Slovic (1999) argued that risk is socially constructed and he suggested that the assessment of risk is subjective by representing thoughts and interpretations that involve psychological, social, cultural, and political factors. He postulated that risk is not independent of our minds and cultures and isn't something that can be measured, but instead a concept that individuals use to help them understand and cope with the dangers

and uncertainties of their life. The workers in my study clearly defined their reasons for working in often high risk workplaces. These workers were working in homes where their health and safety were at risk yet they continued to make the choice to remain in these work environments.

Similar to employers' knowledge of risk, employees' knowledge and understanding of the organizations' commitment to safety are believed to be influential in shaping a positive safety climate (Dedobbeleer & Beland, 1998; Flin, Mearns, O'Connor & Bryden, 2000). In interviews with agency owners and managers, some stated that they had well-defined policies around health and safety training, orientation, and hiring practices. This was, however, not confirmed by the front line workers. It was quite evident that from the standpoint of the frontline workers, there was diversity among agencies with regards to hiring practices, the orientation and training provided, as well as work expectations. It was evident that the work of home support workers is somewhat regulated, however, these regulations are not always played out in the same way with agencies. There are regulations in place such as the Operational Standards but how these texts are activated and evaluated varies among employers. Again this may be due to the fact that the Operational Standards are vague and non-prescriptive with regards to requirements for orientation and training.

Summary

In building on the previous chapter that focused on the meaning of work and workers going above and beyond for their clients, this chapter described overarching concepts that further explicated workers' everyday experiences and decision making practices to protect their health and safety. While the purpose of this study was not to

establish causal relationships between risks and decisions made with respect to the protection of health and safety, it appeared that workers whose meaning of work was constructed from economic necessity were more likely to make decisions that had the potential to put their health and safety at risk.

This chapter focused on risk both on the individual and organizational level and how experiences were shaped by workers' perception of risk and the powerful contradictory practices of the organization. From this research I identified that despite many textual practices in place to protect the workers' health and safety (i.e. NAPE contract, the OH&S Act and agency policies) there was a disconnect between these textual ruling relations and what was happening in their everyday work.

Chapter 7

Becoming a Home Support Worker: Experience, Orientation and Training

Needed to do the Work

I always assess the situation before I go in. You assess the situation, don't get yourself caught into something you don't expect or cannot do. Because I am smarter, more experienced. Yes, more experience too. Maybe if I'm younger, maybe I would, without thinking, do the way I've been doing, but maybe experience and maybe age too. I don't know, could be both (Mary, age 59)

All workers talked about the satisfaction and enjoyment that they garner from their work in home support, however, many workers talked about the stress associated with carrying out their day-to-day responsibilities. Incorporated in the discussion of experience, orientation, and training there were three threads that explicated workers' everyday experiences including: training to work in home support; workers' orientation to new clients; and doing more complex nursing tasks, referred to as delegation of nursing function.

In this chapter I explicate how the textually mediating nature of work with regards to health and safety both organized and shaped the everyday experiences of these aging workers. Workers described situations where they felt compelled and obligated to perform tasks and work in situations that jeopardized their health and safety. The decisions to perform these tasks were influenced by the meaning of work, perception of risk, and personal relationships that these workers had with their clients.

Texts often have the power to position organizational interests above the knowledge and experiences of front line workers by drawing workers into organizational ways of knowledge that influence their judgements and decisions as discussed in the previous chapters. However, what is explained or stipulated in these texts is not always

what is happening in the day to day work of these front line support workers. These contradictory conditions create tensions for the front line home support workers and raise questions about the legitimacy of these documentary practices. Workers did not have a full understanding or recognition of the powerful influence of these ruling relations and the role of these texts in positioning organizational needs and priorities ahead of their own knowledge and decisions.

This chapter will focus on the concept of power and ruling relations with respect to the activation of texts. The uptake of these texts was evidently influenced and organized by the workers' understanding of the power relations that influenced decision making to protect their health and safety.

Training to Work in Home Support

The first thread identified in the experiences discussed by the front line workers was the training required to work in home support. Agencies decide upon, offer, and organize orientation and training for new employees as well as experienced employees needing upgrading and training. Agencies develop policies and procedures to organize specific activities and worker functions. These local texts are also organized by other local and extra local texts. For instance, agency specific local texts abide by the requirements as set in the Occupational Health and Safety Act, the Provincial Home Support Operational Standards as well as the NAPE contract. Thus front line training is governed or organized by agency-specific texts that are in turn organized by extralocal texts.

Some workers described their discontent with the training received by the younger, or more specifically described inexperienced workers who were coming to work

with the agency. According to the older workers, the younger and inexperienced workers often do not receive adequate training before working in home support. A local college provides a comprehensive training program (Home Support Worker/Personal Care Attendant program) that includes a theory and practicum component that qualifies graduates to work as a Home Support Worker or as a Personal Care Attendant. This program costs approximately \$5000. The workers that I interviewed as well as agency management indicated that many graduates of this program often choose to work as a personal care attendant in acute or long term care rather than home support as the pay is much higher in these other workplaces. As of October 2012, the rate of pay for unionized home support workers was \$12.75/hr, and workers doing the same work in the acute care or long-term care setting receive on average \$19.00/hr.

Despite the pay differential for those completing the course, the college representative explained that many home support workers, and in particular, the older home support workers, do not complete this course for one of two reasons. First, some do not complete the course because of the cost of the course and identified this financial commitment that they cannot take on at this point in their lives. Secondly, others decide not to do the course as they have been away from school for many years and do not feel a level of comfort in returning to school. This leaves many older home support workers with little formal training and consequently dependent on the agency training programs. Therefore, because of the increasing need for support workers, along with the lack of availability of trained and experienced workers to work in this sector, home support agencies are often left having to hire untrained workers to provide the required care.

Older workers explained that the inexperienced newer workers add to their daily responsibilities in that they need to dedicate extra time to orientate new workers. Some of this extra work involves teaching new skills as well as providing step by step guidance in carrying out specific tasks and this has become part of their everyday work and an expectation of their jobs. The Operational Standards do not state that extra training and supervision of staff may be part of their job description; however, this has become part of their everyday work for which they receive no extra pay. Many did talk about the fact that they didn't mind doing these extra tasks as it was for both the benefit of the worker as well as the client. Many workers reported that because of their age and experience they were well prepared to deal with these situations and managed well despite doing these extra responsibilities.

Nina described taking on a supervisory role and doing extra training and education with these new workers. This extra supervision has become part of her everyday work:

There have been a few little things I've been able to teach the younger workers or the inexperienced workers that we've had that will help them too- safety wise. If you're trying to shift someone up in the bed, you raise the foot of the bed- and it makes it easier...when it comes to doing the personal care and incontinent people, it's just like they don't know what they're doing...so I find that the other girls look to me for direction and I have to direct them all the time...it adds extra to my day I find that when I'm working with some of them it's more like I'm their supervisor. (Nina, age 67)

Patsy described a situation where she had to provide training for a worker who needed extra guidance with providing personal care due the inexperience and lack of training that she had received prior to working for the agency:

No training. They're coming in off the street for a job, no training... When I first went into home care, I had to go to school, we had to do a home care course... but when they're coming on now, there's no such thing... one of the issues is the training... and I've gone in places where they're only tiny, but they're older people... and the girls have actually lifted their client's legs and hauled them up this way with their arms and tried to get the diaper on them, and they're hurting their back and straining the patient. I've gone in places and [the manager] sent me there, to show them how to roll a patient. (Patsy, age 64)

Flora suggested that her everyday work became more complicated with the provision of training to inexperienced workers who are more frequently injuring themselves on the job:

One of our girls had happened to have hurt herself, and I realized what was going on so I showed them how to take a blanket behind them- always have a sheet under them [client] that you can ...draw sheet, and you haul that forward towards you, and then get a pillow, put behind their back to keep her on her side, because you have to wash her... I've probably come up with some skill that's easier to do than what they were doing... So it's a little bit of training in there... you're going to have an awful lot of people out there that's going to become sore. So these are part of our problems. (Flora, age 68)

One agency manager reported that they have strict policies in place regarding the orientation and training of new staff both before and after they are hired by the agency. Agency managers were not open to sharing agency policies mainly due to the competitive and business nature of home support and the fact that managers were aware that I was interviewing managers and workers from several different agencies. However, one manager did share that they have orientation modules that are completed when an employee is newly hired. Topics include communication, personal care, infection control, and working with clients with dementia. However, workers with these three agencies reported that there was variation in the amount of training that they received. This agency-based training varied anywhere from no training at all to 4-6 self-paced learning modules. The workers identified that these modules are not always completed prior to a worker beginning to work with the clients and the ability to begin or continue work is not dependent on successful completion of these modules. There appeared to be no consistency with orientation and training programs received within and among agencies.

The Provincial Occupational Health and Safety Act (2009) under Section 5 (b) states that an employer “shall, where it is reasonable practicable, provide the information, instruction, training and supervision and facilities that are necessary to ensure health, safety and welfare of his or her workers”. This would include new employees as well as employees who have been employed by the employer for a period of time. Despite this legislation, it was apparent that instruction, orientation, and training were not always completed. Many workers reported that they themselves received minimal orientation upon hire with their particular agency. However, these workers all felt adequately

prepared to do their work despite their lack of training attributing their age and experience as sufficient to safely and competently do their jobs.

The RIHA requires that each agency develop and implement orientation programs for their employees. Workers talked about the orientation that they received when they went to work with an agency. In the Provincial Operational Standards, under Section 6.10, does not indicate specific guidelines as to the numbers of hours of training that the agency is required to provide or the educational or practice requirements necessary to be hired by an agency. The Operational Standards, Section 6.10, stipulates that the Home Support Worker Training requirements should minimally include a predetermined list of criteria such as an orientation to the philosophy of community based and supportive services; communication and interpersonal skills; orientation to relevant programs; home management skills; First Aid and Infection Control procedures; orientation to rights and privileges of the individual, the home support worker, and professional staff; and finally an orientation to personal care and activities of daily living as influenced age and ability. One line under the criteria of home management skills indicated safety in the home. In this same section, under training requirements, it states as follows: "Home management skills (nutrition, meal preparation, budgeting, housekeeping and safety in the home)". There was no section on occupational health and safety considerations or training that is mandated by the health authority for the agencies. The importance of safety is lost among other requirements of the job and, therefore, as workers have indicated, this gets missed in their orientation.

Stella described the differences in the orientation that new workers are given now compared to when she began to work in home support. She explained that she was given an extensive orientation program that prepared her for work in the home support sector:

I started with [agency], and the rules and regulation – it was a privately owned company and what they did compared to the companies today...chalk and cheese. We did a three-week training, within the building – well two weeks in the building and one in their field with a senior worker... We weren't paid for it, but we had to put in between 35-40 hours to be qualified to go out and do somebody on our own...like I say it was much more professional that what's being done today.

(Stella, age 65)

A policy representative employed by the Health Authority advised that the previous Operational Standards (1995) provided more rigorous guidelines regarding the training of home support workers. Under the section 4.34 (Agency Responsibility) in the 1995 Standards, with regards to training, it stated that “it is strongly recommended that the worker complete an approved Home Support Worker course prior to beginning work”. It also stated that “a worker hired prior to having a course is required to complete an orientation program of at least four days before being independently assigned to clients. An approved home support worker course must be completed within six (6) months of employment”. At that time, this course was formally offered by a local college. There were strict policies with regards to workers who have no previous home support training. This section of the Operational Standards stipulated a minimum orientation which included an eight-hour First Aid course, two days of introductory content regarding home health care, ethics, privacy, and confidentiality as well as one day

in the practice setting with an experienced worker. However, the RIHA representative explained that strict and prescriptive standards did not leave agencies with the autonomy and discretion in structuring orientation and training. Two agency owners agreed that they like these new Standards as they are less restrictive and gives them the independence to structure their own orientation and training programs.

Orientation to New Clients

The second experience of the workers within this thread was that of orientation to new clients. This included orientation to a new client admission to the agency such as when a patient is discharged from hospital, as well as the orientation that workers receive before they provide care with a client when the client has already had previous workers from the agency.

There are two distinct processes for an agency to receive a referral to provide care for a new client. The first process is when a client or family member contacts the agency independently to request that service be provided in the home setting. The second process which was a concern for the workers is when a patient is discharged from hospital. When a patient is discharged from hospital and they require follow up at home for nursing or home care, a referral is sent from the hospital to the community health office with the RIHA. An agency is contacted to provide that care for the client. Many workers described that they sometimes receive little information from the agency about the medical condition of the client, what care, or what skills are required. The workers were sometimes given minimal information to make an informed decision as to whether they feel comfortable in working with that client and secondly, if they feel competent to provide the required care.

Flora explained the experiences that she has encountered on many occasions when adequate information has not been provided. She described that often workers are just given a simple diagnosis such as 'operation':

Now what do I do? You had an operation. Am I supposed to do dressings there? Am I supposed to get you up out of bed to walk you a little bit because of that? What kind of stuff is there? Is there an exercise? What is this girl allowed to eat? We're never sure ... there's a lot of times we're never told that the person is a diabetic, and you're going in and doing up stuff for a diabetic. You could be making a cake ... they don't really know now what's wrong with this person. All they know is she was in the hospital and she did have an operation. Oh, maybe she had gallstones or something.....That's all we know, and that's all they get. Now, in the meantime, along with those gallstones, maybe she has high blood pressure, she may have diabetes, she may be a little bit ... having dementia. We don't know that. It's so hard. And maybe she don't communicate. So now, trying to get her a cup of tea – do you put milk and sugar in it? (Flora, age 68)

Many of the workers explained that they ask many questions to try to get as much information as possible to make the decision whether to provide this care. Some workers want and need to have all of the information up front before agreeing to provide care for these clients. In many instances it has become a situation where it is the responsibility of the workers to take it upon themselves to ask many questions to get the necessary information prior to doing the visit:

But if you don't push them [agency], you don't ask a hundred questions ... Cause they're on the phone saying, 'Can you do so-and-so tonight? We got a new client,

can you do them tonight?' 'Well, I'll get back to you. Can you do them?'(Rita, age 64)

Two workers in particular discussed their frustration with the lack of information provided by the agency pertaining to the needs of the clients. They felt that the agency was responsible for not providing the appropriate information and two workers described that this may be intentional. Few workers felt that if the agency provided the full picture of the clients' needs then many workers may not agree to work that shift. Many times workers reported that they do not know the care needs with this new client until they actually arrive at the home:

Even though it's not nice to say, and before I take the clients, I ask all these questions, and the reason why is because I work elsewhere, I got other people - I can't have a client that's up all night long ... So before I say yes, I'll take a client, I need to know all that. Sometimes they lie to you, 'oh no, my dear, he's as good as gold, you don't have to do a thing, my dear!' And when you go in there. (Rita, age 64)

Some workers described that their age and experience have helped them be ready to work in this area and made them better prepared for asking questions and knowing what to do in often unpredictable circumstances. Mary suggested that she always asks the necessary questions before she agrees to look after a new client to help her prepare for care of this new client. She also expressed frustration with one situation in particular where she was asked to care for a client and then when she arrived at a home, she found out that there were actually two clients that she needed to care for:

I always ask for age or condition first, and then ... and age ... and they will tell me whether they are diabetic or Alzheimer's or Parkinson's, so I like to know all this. To help me prepare. So, if I'm not sure if the way they tell me that, 'oh, just cleaning,' but sometimes when you get there, it's more than that... Different from what they describe... they don't get enough information from the health care or the hospital.....So when I went there, the husband and wife were in the bed, not just her! It's him, he just fell and he needs help. So I had to go there to do two ... Yeah, so I thought, 'two of you, I thought only her.' Because he just fell, so he needs help with the bathroom things. And I said, 'okay.' So I went back and told them about that, what I found out when I went there ... They were surprised too.

(Mary, age 59)

Disconnect between the workers' expectation of who they are expected to provide care for and who is actually awaiting care has been addressed with the RIHA. While I was collecting information for this research a new form (Home Support Services Referral CH0921) was developed. This new form includes a space to fill out information for two clients instead of one which addressed the situation with one worker having to provide care for two clients and not having the appropriate information before visiting the home.

Nina explained that her age and experience has prepared her to work in situations where she may not have the information prior to working with a new clients. She described that due to her age and experience she can relate to her clients and this has helped her recognize what needs to be done and how to respond to her client:

Because of my experience...and it bothers me when I see things aren't done. I think it is because I am older, I can relate to them, I have more life experiences,

you know, I remember what it is like to have a grandmother with Alzheimer's.

(Nina, age 67)

Agency staff reported that they can only provide information to the home support worker that they receive from the hospital. In tracking the series of events that occur with the transfer of information from the hospital to the agency and how this is filtered down to the worker, it was evident that there is disconnect in this process. In speaking with one agency owner she described that she receives the discharge planning form, the Home Support Services Referral (CH0921), from the hospital. The agency passes on the information that is indicated on this form to the worker who is assigned to this client. One agency owner explained that often they receive a phone call from the hospital or community health nursing staff late in the day or asked to take on this new client and given a verbal summary over the phone prior to receiving the referral form. I was informed that sometimes they are given minimal information from the hospital prior to the client being discharged and often left with very short notice to fill these shifts.

Marg suggested that often the agency does not receive the appropriate or adequate information from the hospital and they can provide only the information that they were given:

If somebody's already been in there and they know something about it, I get a lot of information. Other times, I go in and all I know is the name and address. And what's written on the paper is not the same.... When I go in and then come back, they say, 'we didn't know that. That wasn't on the referral from the hospital.'

And that happens a lot... the referral from the hospital does not give enough information (Marg, age 60)

Contrary to these experiences, other workers expressed that they do get an appropriate orientation to new clients. These workers were confident that they had an adequate amount of information to provide care to the client. This difference in workers' experiences appeared to be agency specific with some agencies demonstrating more vigilance in finding out and passing on all of the necessary information to front-line workers. Some workers reported that on some occasions the agency staff assessed the client prior to the home support worker entering the home. Elizabeth explained that the agency she works for always passes on all of the necessary information that the workers need prior to accepting a new client and sending in a worker:

Our supervisor will go and have a meeting with the family. And then, if it's a client, as you say, verbally cannot ... doesn't ... you know, can't tell you what they need, usually there is a family member that will be there, that will say, 'well, I've done it this particular way,' well, you try that and see if it works for you, and this is what we need done..... Sometimes families do request that you go there before you start, and over the years that has happened, and other times you just start, and the family member would be there and tell you. (Elizabeth, age 66)

Similarly, Len explained that he usually receives an adequate orientation from the agency before going in to work with a new client:

If it's a new client that the company has taken on ... now I don't know if every company does it or not, but one company that I was with, once you've been assigned that client, you can go and ask them for an information sheet...If you've got time prior to going to the client, but you're given a verbal over the phone

anyway, if not in person, and if it's a complicated case, it could be that the nurse will be there and show you what to do, just explain. (Len, age 66)

The Operational Standards does not stipulate what information the hospital discharge nurse is required to provide or what information the agency is required to provide to the workers. Workers and key stakeholders in the home support sector indicated that the amount of information provided to the front line workers is both agency specific and dependant on the information provided from the hospital. The discharge nurse completes the information on this form according to what he/she feels is necessary to pass onto the agency. This form contains information relating to the client's demographics, diagnosis, care needs and hours of care required. There is variation in the information provided by the nurses depending upon who is doing the discharge planning, who is filling out the form, and/or how much information the nurse feels that the agency needs in order to provide the necessary care.

A discharge nurse explained that minimal information is provided to the home support worker in order to protect the privacy of the client. The information that is provided has an emphasis on the care required (i.e. personal care, meal preparation or home management) with little attention given to their medical conditions, family circumstances, or additional medical information. This disconnect between the discharge nurses striving to protect the client's privacy and the need for workers to have the necessary information to provide their care while protecting their own health and safety is problematic for the workers. I questioned why this information is not provided and why these discharge planners do not consider the agencies as well as the home support workers to be within the circle of care. In a brief informal conversation around the office

among a group of discharge nurses and myself, there were differing opinions about the amount of information that these nurses provided on the discharge planning summary. These contradictory practices of discharge planning and preparation for the care provided affect the health and safety of those workers providing the care. Many workers are going into the home without any previous assessment and often without the appropriate training. Workers are left to make a short notice decision that often results in workers are taking on skills that they may be inadequately prepared to perform.

In an interview with the policy representative of the Home Support Program, it was explained that it is expected that the agency do a preliminary nursing assessment to determine both the care needs for the client as well as assess the home environment to ensure the health and safety of the workers. However, there is an obvious disconnect between what is written in this extralocal text and what frontline workers report happens in the community setting.

Doing More Complex Nursing Tasks

In each interview, workers talked about the list of job responsibilities which included tasks such as personal care, housekeeping, meal preparation, medication administration, lifting and transfers, and glucometer readings. The third thread in my research that focused on orientation and training and included workers discussing more complex tasks that have become part of their everyday work. The Provincial Operational Standards (2005) outlines the guidelines, regulations, and responsibilities governing home support workers and indicates what skills workers are expected to perform. According to Section 6.5, it is stipulated that these services may include but are not limited to: personal care (personal hygiene, bathing, dressing, dressing and/or toileting); transferring in and

out of bed/chair; assistance with ambulation; assistance with feeding; household management (light housekeeping, laundry, meal planning and preparation, shopping and assistance with banking), and respite (caregiver respite, accompaniment to/during recreational activities, appointments etc.), and behavioural support.

However, some workers described doing more complex tasks that are typically performed by nurses in an acute care setting. Delegated nursing functions are those skills normally performed by nurses that may be delegated to others in the absence of a skilled nurse. This is where the terms 'not limited to' in the Operational Standards section on job descriptions became visible as further organizing workers' everyday work. Many workers described performing skills such as dressing changes, narcotic and insulin administration, tracheotomy care, colostomy care, nasogastric feeds, catheterizations, packing dressings, as well as palliative care and support. Many workers reported that performing these tasks negatively impacted their emotional and psychological health more so than their physical health. Workers talked about the stress and frustration that they experienced in making decisions to do these tasks for many reasons including fear of harming their client or a fear of a loss of pay if they didn't perform these skills.

These extra nursing skills necessitate education and training beyond that for a home support worker. It is an expectation that certain nursing skills can be delegated to home support workers. Section 6.5 of the Operational Standards states "at times it may also be necessary for home support workers to perform selected nursing tasks for individuals who require regular assistance related to their activities of daily living. Authorization to perform these tasks is given by the visiting community health nurse after ensuring that the home support worker is adequately trained". Workers have articulated

that they had been trained but sometimes still feel insecure in doing these tasks, however, they still feel obligated and required to do this work. They described that they feel trapped in having to do these tasks because if they don't they may lose the opportunity to work with that client. Therefore, support workers are taking risks in the workplace that is jeopardizing their emotional health due to the psychological conflict that some workers have described. There is an apparent disconnect between what is stipulated in the job description in the Operational Standards and what workers are actually doing in the home setting. The workers did not actually refer to this work as delegation but they described the "nursing skills" that they were often expected to perform. The workers described situations where they are taking on an increased workload and responsibilities that they are often not comfortable with doing. These workers felt the need to do these tasks for the client's well-being.

One worker who is the health and safety representative with one agency explained that many workers have come to her and have reported that they are not comfortable in doing many of these delegated tasks. Some have even stated that they have to do these tasks because often there is nobody else to do it and they do not want to leave their client in this vulnerable situation:

Some feel that they're not adequate to do it, but they have to do it because that is their client. And it might be a full time client that they have, so they stay there because of that client and they're terrified every injection that they give, some of them are terrified. Some of them – I've had calls from some people, and they're asking me, "do I have to do it?" I said, "That's the thing. You'd have to give up your client because your client needs somebody. They can't give themselves the

injection. You have to do it. So if you don't want to do it, it's one or the other'....They need their client and they're doing things that they possibly shouldn't be doing, just because they need the work and that. (Flora, age 66)

Similarly, Len described that he had to perform these skills because if he didn't there was nobody else there to do this for his client:

You go into people and you know that they can't do for themselves, and if there aren't any family members, who's going to do it? I checked for blood sugar levels, I've done trachs...well if I don't who will? People are miserable, how can you leave them like that? They're human beings. (Len, age 60)

Rita described the conflict that she experiences when working with palliative clients who required the administration of narcotics. She enjoys working with palliative clients and their families, however, she described that she is not comfortable in administering narcotics, which is part of the role of the home support worker in this home which has been delegated to her by the agency Registered Nurse. She feels as though she does not have much choice. If she doesn't do this skill, then who is going to do it? However, based on her age and experience she felt that she would do it and be able to get through it:

Sometimes when you have to give them the morphine that can be stressful. If you got to give it by drop.... That's very stressful, because you know how those little stoppers are? You could give two drops, they could drop five ... fall down, you know..... You give eye drops, you're only supposed to give one eye drop – lots of times two drops will fall down. Well that's alright, because it's an eye drop. But the morphine ...that can be stressful...You just follow directions, and you ... But

if the gentleman is there and he's dying, and he's got to have his painkiller every four hours, there's no nurse going to come in every four hours and do that.

Someone's got to do it, and there's nobody there...."But you got to give them their needle, when the pain kicks in, you got to give them their needle. And the insulin, they got to have their insulin, and they got to have all their medications.

So when the time's morning, noon, afternoon or night, every four hours you got to wake them up and give it to them, or whatever. It's got to be done, it's got to be done. (Rita, age 64)

These above descriptions explicate the uncertainty and the frustration that the workers experienced often on a day to day or shift to shift basis. The decisions to perform these tasks were related to the workers' personal and emotional connections with their clients and their desire to do what they could to meet the needs of the clients and their families. Common in these workers' stories was their ability to know their own limitations in what they are allowed to do and making the decision to perform skills based on what they are comfortable in doing. Some workers described that because of their age and experience they felt well able to deal with these situations but others voiced a level of discomfort with these responsibilities. In each of these situations, most workers talked about their age and their experience as being important factors in their ability to do their work and perform these skills that are typically outside of the role of a home support worker. This related back to the meaning of work for these workers and the decisions that they have to make through the negotiation their expected duties to protect their own health and safety.

Age, Experience and Power Relations Organizing Everyday Work: A Discussion

In my discussions with these workers, many times I reflected on their vast life experiences and their inspiring work ethic that I believe influenced decision making practices as they cared for their clients. Research conducted in the area of the changing workforce that considers the intergenerational composition and its implications is widespread (Dols, Landrum & Wieck, 2010; Lancaster & Stillman, 2002; Wieck, 2007; Zemke, Raines & Filipczak, 2000). Older workers are referred to in various terms including the terms Traditionalists or Baby Boomers. Other investigators refer to these workers in other terms such as the Veterans (Zemke et al.). Lancaster and Stillman referred to older workers as the Traditionalists (those born between 1900 and 1945) and the Baby Boomers between (those born between 1946 and 1964). Lancaster and Stillman described that these groups had work practices and routines that distinguished them from the younger generations. Zemke et al. (2006) described these older workers as being hard workers, dedicated, having respect for authority, and the mind set of duty before pleasure.

Some of workers in my study were part of the Traditionalist generation where loyalty and a work ethic produced during the Great Depression define their work. These workers have been identified as having a unique work ethic and this was evident in their decisions regarding health and safety in the workplace. According to Lancaster and Stillman (2002) “this generation learned at an early age that by putting aside the needs and wants of the individual and working together toward common goals, they could accomplish amazing things” (p. 19). Other studies found that Traditionalists have a hard work ethic and are known to be loyal to their employers, having rigid respect for authority and rules and tend to not rock the boat in the workplace (Kramer, 2010; McDonald, 2008;

Wieck, 2007). Most of these workers demonstrated loyalty to their clients and employer, and, therefore, were willing to do those extra tasks and often take risks in the workplace in order to meet their clients' needs. Distinctive to the traditionalist generation is the notion of the top down approach to work that Traditionalists value based on the military chain of command.

The powerful and ruling practices that organized their work such as the Operational Standards, the NAPE contract, and agency policies, made it visible why many workers continued to do their day-to-day work without questioning the textual practices that organized their day. Therefore, the decision making practice of whether to do their work in often unsafe situations is often a decision that was quite easy for these workers. Lancaster and Stillman (2002) suggested that the Traditionalists work with a heads down, onward and upward approach. In relation to my research, these older workers talked about their workplace duties that they felt may be unsafe, yet they smiled and said that they have to do this work as there is nobody else to do it. Workers reported that they felt that their age and experience prepared them for dealing with often difficult situations and they extended their roles beyond the textually sanctioned practices such as their job descriptions and responsibilities.

Can these workers be viewed as having free will to make the best decisions to protect their health and safety when they are limited in their decisions by finances or their close emotional connections with their clients? The early work of Michael Foucault is helpful in considering this question. Foucault's concepts of governmentality, knowledge, and power offer one approach to thinking about politics, social structuring, and power. Using Foucault's perspective of risk we can explore how government bodies work to

govern, manage, and regulate risk in populations and institutions. Power is not something that is necessarily owned or possessed like a commodity, but rather is all around us and needs to be “analyzed as something which circulates, or rather as something which only functions in the form of a chain...through a net like, organization...not only do individuals circulate between its threads; they are always undergoing and exercising this power” (Foucault, 1980, p. 98). Foucault did recognize, however, that power is not always well circulated.

Foucault argued that we have free decision making power and sense of agency but I question whether these workers really have free will when the financial and emotional meanings of work define or construct their everyday work. Knowledge does not necessarily mean power in that people may not have the power and free will to make educated decisions about their health and safety because of the many organizing external factors influencing their ability to make decisions. Workers’ perception of their lack of power and control over their work shape what they know about their work, decisions they make, and what they do. Workers frequently indicated that they were powerless through comments such a “there’s nobody else to do it” or “it’s got to be done” when referring to reasons for doing the extra skills that they often described that they were uncomfortable providing care to a new client with limited information. As previously discussed, those working for the financial rewards of work took more risks in providing care for their clients and those working mainly for the non-financial rewards were not as willing to take these risks. However, whether working for the financial or nonfinancial rewards of work, all of the workers talked about the fact that there was nobody else there available to do the work and they felt compelled to do this work despite the limited training they had.

Summary

In this chapter I reported on the findings of my study that focused on age, orientation, and training necessary to do the job. Workers described situations where they felt compelled and obligated to perform tasks and work in situations that jeopardized their health and safety. The activation and uptake of texts was evidently organized by workers' perception of risk and their understanding of power relations that impacted decision making regarding protection of their health and safety. My research adds to a narrow body of literature that considers age and risk taking behaviour in the home support sector with a specific focus on aging workers. The findings of my research highlights the decision making and risk taking practices of older home support workers have been closely linked with the meaning of employment.

Chapter 8

Conclusions and Recommendations: Changing the Status Quo

“Institutional ethnography’s focus on explicating ruling relations gives this scholarly research its potential for being a resource for activism and for transformation of the conditions of people’s lives.” (Campbell & Gregor, 2004, p. 61)

The purpose of this inquiry was to explicate the everyday work experiences of aging home support workers, with a specific focus on health and safety. I was interested in making visible the social relations that organized these workers’ experiences. I sought to understand how the relations of ruling were hidden in the routine activities of home support workers and how these relations contravene and contribute to system efficiencies and outcomes.

The Provincial Home Support Operational Standards document outlines the policies governing the Home Support Program in Newfoundland. These provincial standards organize the activities of all health authorities in Newfoundland Labrador. Specific agency policies are developed and structured based on the policies and regulations outlined in this document. It is evident that caregiving work in home support is driven from a top-down rather than a bottom-up approach and there is no direct line from the standpoint of the actual practice in the home support setting to the guidelines and policies that organize the everyday work. This indicates the unidirectional nature of texts. The influence or organizing nature of texts on the everyday work of the home support workers is often not visible to the workers in that they may be unaware that these texts exist.

In the previous three chapters, I described disconnect between workers’ everyday experiences and the series of powerful and contradictory ruling relations that organized

the routine activities of aging home support workers. The findings of this study have indicated that the ruling relations and textual practices that structured work in home care have normalized the everyday work practices of front line home support workers. The problematic uncovered in this research is that while the organizational policies did consider the health and safety of home support workers, these policies were often not known to the workers and, if known, they were often not followed. Workers' understanding of policies was often masked by their perception of their risk and by the close emotional connection between workers and clients. This problematic arose not because people were doing their jobs incorrectly, but because standardized texts that were activated on a daily basis reflected institutional courses of action and not necessarily what was happening in their everyday work. There was a disconnect between the expectations placed on home support workers to provide efficient and competent care to their clients and the policies and organizational processes related to health and safety considerations for workers providing that care.

It is important to recognize and understand institutional sites of regulation and control and how they shape or do not shape workers' everyday experiences. Policies do not always take into account the workers' level of training or how training impacted their perception of risk and their decisions in their everyday work. I was able to make visible the ruling relations that shaped the routine activities of the home support workers. Institutions and, more specifically, policy makers need to recognize how the socio-political reality shapes everyday practices.

The Canadian Association for Retired Pensioners (CARP) has recognized the work of both federal and provincial Governments in formally recognizing the value of

older workers. CARP has recommended removing barriers to encourage continued employment for older workers, helping unemployed older Canadians to transition to new opportunities (CARP, 2012). Researchers, educators, and health professionals are well positioned to implement change in the home support sector. Specifically, leaders, researchers, and policy makers have to be cognizant of challenges facing front line staff in the delivery of home care services and to ensure that processes exist to reduce risk to these health care providers. This recognition of challenges will require practitioners and policy makers to review and evaluate the recommendations from my study, have a willingness to change, and be open-minded to help facilitate these recommended changes. Through exploring alternative approaches and changes in the present work environment, we can change the way work is currently being conducted in the home care setting.

Freire (1993) argued that providing knowledge empowers people to advocate for change through a process called conscientization. Conscientization has been described as the movement from passive acceptance of circumstances that are seen to be beyond one's control to active participation in advocating for social change. He maintained that in order for transformation to occur, people have to engage in this process. However, this is only possible if decision makers are given the opportunity to reflect critically on the practical realities of workers' experiences. The recommendations I have developed from this research require dedicated professionals to openly accept and understand the problems identified in this study and commit to strategies to address these problems. In my discussions with front line workers as well as decision makers and policy representatives who regulate home support, the process of conscientization has begun.

In this next section, I will offer recommendations at the level of policy, practice, and research. These recommendations involve practical strategies for decision makers, managers, key policy stakeholders, and workers to engage in a critical review of current practices, with the goal of improving the health and safety of older health care workers.

Implications for Policy and Practice

The practice of caregiving for clients in the home setting is complex and has become more complex in recent years. Recipients of home care services have multiple and specific care needs. Earlier discharge of clients from acute care settings has resulted in an increased complexity and scope of responsibilities for those providing care in the home. Home support workers must continuously assess conditions and make changes in their care delivery depending on the client's status. My research has indicated that various situational forces organize the work of front line home support workers and shape their everyday experiences. I anticipate that several of my recommendations at the policy and practice level will stimulate critical consciousness for practitioners and policy makers. I have decided to integrate these recommendations into one section, as they are closely linked and, as indicated in IE, many practice issues are influenced or organized by policy. These recommendations include:

- A safety risk assessment tool for home support workers
- Clear and rigorous guidelines focused on education, orientation, and training
- Wage parity with the acute / long term care sector
- Enhanced clarity of roles and responsibilities

Development of a safety risk assessment tool for home support workers

I advocate the development and implementation of a safety risk assessment tool for home support workers as a way to create safer and healthier workplaces. I recommend that this form be completed either by the agency nurse or community health nurse and shared with the home support worker prior to the first visit in the home. Sharing of this vital information to the front line home support workers is the second step in the process providing the information is accurately recorded by the nurse completing the assessment. The development of this tool will aid in an awareness and recognition of unsafe and unhealthy workplaces for aging workers who provide care. This tool will also provide feedback to employers about health and safety risks that workers may be encountering in the homes.

Many aging workers closely connected their decision to complete their everyday tasks to the meaning of work, whether the meaning was primarily financial or non-financial. Workers' perceptions of risk were often clouded by their close and emotional connections with clients. However, a safety risk assessment tool that is reviewed with workers prior to the start of care and on an ongoing basis would provide workers with the necessary information to make an informed decision regarding the provision of care. The completion of this form will also make the agency responsible for notifying the worker of risks to health and safety in the home.

Currently, a safety risk assessment tool does not exist as an agency requirement of in the Provincial Home Support Operational Standards. In an interview with a representative from the RIHA, it was noted that it is the responsibility of the agency to do a risk assessment of the home to ensure that their workers are safe. Disconnect between

the expectation from the agency and what is really happening in the everyday is problematic. There is currently a safety risk assessment tool in place for Registered Nurses entering the home, but not for home support workers. A Community Health Nurse advised that discharge planners at the hospital fill out a Client/Site Risk Assessment Tool for the visiting nurse prior to the first visit. The nurse then would include the information that he/she deems necessary on the Home Support Services Referral or verbally report it to the agency. One agency owner did share a copy of a safety tool their agency developed and uses for conducting a home assessment with her clients that she shares with her workers. However, none of the workers interviewed for my research were aware that any such tool exists, and certainly had not seen a safety risk assessment tool prior to entering a home. Workers indicated that such a tool would be both helpful and necessary. If a safety risk assessment tool were mandated in the Operational Standards, then agencies would have to ensure that this documentation was completed before workers began to provide care in the home setting. Workers then should have access to this information and have a true picture of the home situation before agreeing to provide care in this home. This would also make the agency responsible for ensuring that workplaces are safe.

Clear and rigorous guidelines on education, orientation, and training

Recommendations for clear guidelines for education, orientation, and training are essential to prepare workers for work in the home support sector. As previously suggested the increasing demand for home support services, labour shortages, and an aging workforce are presenting an increasing human resource problem for home support. Increased training and educational opportunities are necessary to prepare seasoned

workers and recruit new workers for employment in this field. I recommend that orientation and training be conducted several times; when a worker is hired by an agency, before a worker begins care for a new client, and as necessary for delegated nursing functions. There is currently a lack of consistency among agencies regarding orientation and training. A reason for this inconsistency is that the Provincial Home Support Operational Standards do not clearly stipulate what orientation and training are required to be conducted by the agency. Standardized training and education programs will improve work environments by making workers better prepared for meeting clients' needs in light of the increased complexity of care needed in the home setting.

The Provincial Home Support Operational Standards state that agencies are required to provide training and ongoing education to workers. I recommend that these standards be revisited to include the older (1995) standards that clearly stipulated the hours and content of training and education provided by agencies. In an interview, a policy representative from the RIHA advised that the previous standards had clear guidelines regarding orientation, training, and job descriptions. However, these were later made more general, so that the RIHA would not be viewed as being the employer by creating specific guidelines for orientation and training. The Operational Standards should require improved training programs to address the increasingly complex needs of clients, and to make the agencies responsible for providing this orientation.

The Provincial Home Support Operational Standards state that workers must be trained, yet none of the workers I interviewed had any formal training. The Home Support Worker / Personal Care Worker (PCW) Program allows graduates to work in various fields, such as with home support agencies or as personal care attendants in acute

or long-term care. Many of the younger workers with the formal training program are working in acute and long-term care; this leaves many of the older, non-trained workers providing this complex care in the community setting.

Workers often depend on the agency to provide training, and it may be the only training they receive while working in home support. Therefore, these workers may need more structured orientation and training programs to provide them with complex skills. Helping older adults adjust to the new realities of the home care workplace through in-house agency training programs will reduce psychological discomfort in their work, which would improve retention of older and experienced workers in this field.

Based on province-wide consultations with individuals and groups about necessary improvements in the health system, the Government of Newfoundland and Labrador (2012) Provincial Strategy for Long term Care and Community Supportive Services addressed many issues relating to home support resource issues and training in our province. This report highlighted several priority directions, including improved education and training for all service providers. This recommendation indicated that recruitment and retention initiatives are needed to ensure sufficient trained workers for the growing numbers of people requiring care in the future. The suggested action was to review the establishment of educational standards in community support services and personal care homes. It was emphasized that many people in the consultations expressed concern with the availability and training of home support workers. However, this report did not discuss the aging workforce in relation to the widening gap between supply and demand for home support workers.

Wage parity with the acute and long term care sector

Workers in the home support sector are providing more complex care and skills than their counterparts working in the government-funded care settings. Additionally, in the acute and long term care sector, other staff, such as Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) are available to help provide this care. However, those working in the home support sector are receiving less pay and working alone, with no support or guidance from other staff. As previously indicated, the pay is markedly higher in government-funded regional health authorities than in the private home care sector. I propose that equally qualified personal care or home support workers receive wage parity with workers in other areas of the health system who are doing similar work. This would reduce the number of older workers working with two or three different agencies in order to make a reasonable income. These workers should be compensated equally, because of the higher risk and independent nature of this work. This recommendation will need to be both advocated and implemented in the very near future to meet imminent demands for services.

Another issue in relation to wages includes the fact that home support workers receive the same rate of pay whether or not they have completed the home support worker program. Therefore, workers who have completed a formal training program receive the same pay as those without any formal training even though they provide the same care. I recommend that there be recognition of credentials and training and therefore, a higher rate of pay which may encourage more workers to complete the formal training program.

Clarify titles, roles, and responsibilities of home support workers

Currently, many designations for home support services exist, including home care services, home support services, and community care services. Titles for those providing this service include “home care worker,” “home support worker,” “home health aide,” and “community support worker.” The variation in titles can lead to confusion and frustration across the country when it comes to discussing programs and services available in the home care sector and what workers are permitted to do. Clearly defined roles and responsibilities for home support workers, with clearly defined limits to what they are permitted to do within their scope of practice, are essential to maintaining health and safety in the workplace. The current system allows for variation and inconsistency in services and programs across the provinces, and the roles and responsibilities of home support workers vary from one client to another.

Defining core competencies is necessary in this sector because the roles of home support workers in many settings are unclear and inconsistent. With respect to competencies, I recommend the development of a provincial list of competencies by each of the health authorities to regulate the skills that can be provided by home support workers within their scope of practice and training. If the worker has not completed a formal training program that has taught a required skill, then the agency should be required to provide in-house training. Workers in my study reported doing tasks such as medication, insulin, and narcotic administration; tracheotomy care; dressing changes; catheter care; and nasogastric feeds. Within this list of core competencies, I recommend that there should be definite standards for delegation and supervision as well as accountability. Delegation has become an important requirement for work in the home

support sector, yet many workers reported completing tasks that they are not comfortable with or competent to provide. Some aging workers, despite this level of discomfort, are still offering these skills to their clients because of their close connection with their clients and their obligation to meet the client's needs.

Implications for Research

Health research and practice are interconnected; health researchers conduct research and use the findings to improve and sustain current practice. As health professionals, we draw on evidence-based research to inform policy, practice, and education. Research enables us to draw conclusions and make recommendations to improve current practices and policies. As health professionals, researchers, and practitioners we must examine the literature more critically, recommend the exploration of new ways of practice, and change current practices, based on what is discovered.

There are three main directions for research:

- development of a well-established research agenda with priorities for provincial and federal home support programs
- further research into the generational difference between younger and older workers with regards to perception of risk
- research investigating the health and safety of non-unionized workers as well as those working under a self-managed model of care
- the exploration of models of home care delivery in other countries

Development of a well-established research agenda

I recommend the development of a well-established research agenda with priorities for home support at both the federal and provincial level. This research agenda should be developed to improve evidenced-based knowledge that will contribute to improved provincial policy-making and effect the provision of services. Most of the research on health and safety in home support dates back to the 1990s, with few recent studies researching home support safety within the current context of increased complexity of clients' needs especially within our local context. More evidence is needed that considers how aging home support workers can offer their experience and support to home care clients. The need for supportive service in the community will increase, yet there are fewer younger workers entering this field of work. Therefore, further research to reflect the increased complexity of care and strategies to recruit and retain aging workers is vital to maintain the level of expertise and work ethic needed in this setting.

Generational differences between older and younger workers

Further research is needed into the generational differences between younger and older home care workers with regards to perception of risk and decision-making practices regarding health and safety. Older workers' decision-making practices were largely constructed through the meaning of work. Younger workers employed in home support may largely be working from financial necessity, although they may enjoy their work and derive meaning from the work they do. Emotional connections with clients may create different perceptions of risk in older and younger workers. A greater understanding of these experiences may positively influence strategies to recruit younger workers.

Research with non-unionized and self-managed models of care

All participants for my study were working for unionized agencies. Many protections afforded workers in a unionized environment may not be available to those working in non-unionized environments or to those employed privately or under a self-managed care model. Further research is warranted to investigate the health and safety of these non-unionized workers, who may have even less training than the unionized workers. Additionally, many workers providing care are not employed by an agency as they are hired privately by clients or families. This happens in both urban and rural areas. In these situations, there are no guidelines pertaining to orientation and training or the delegation of nursing tasks. In this self-managed model of care, the workers have little if any training, no access to accident and injury compensation, and no regulation of hours of work. This poses serious health and safety risks for such workers which necessitates the need for further research.

The exploration of models of home care delivery in other countries

Future research initiatives exploring various models of home care in other countries such as Western Europe or Scandinavian countries is suggested as an area of future research. Considering the evident disjuncture and inefficiencies in our current system, perhaps we could learn from other models of home support that have comparable health care systems in order to revise and develop our current system to more closely mirror other more successful systems of home support delivery.

The Future of Home Care

Considering the aging population and the fact that more seniors are expected to prefer to age in their own homes, it is essential that seniors have access to community-based supportive services. The demand for home care services has been increasing in recent years and the increase is expected to continue. The Canadian Home Care Association (2009) reported that at the same time there is an increasing shortage of home support workers, with fewer younger workers entering this field of work.

The Canadian Home Care Association has identified factors affecting the need for community-based care. These include an aging population with increasing chronic illness, challenges with recruitment and retention in the home support sector, a reduction in numbers of informal family caregivers, and a decrease in community support and volunteerism. Medical advances have resulted in shorter hospital stays and earlier discharges from hospital, which is necessitating increasing numbers of experienced and well trained workers to meet these health care needs. Provinces have addressed the coordination of home support services; however, the problem is that home care falls outside the Canada Health Act. There is, therefore, no comprehensive policy for aligning services, and, consequently, there is variation among the provinces as to what services are offered and how they are financially supported.

Special consideration to positively influence recruitment and retention of experienced and qualified workers in the home care sector is essential. While workers have acknowledged the need to re-evaluate many of the current policies and practices, there is an absence of efforts to initiate these changes. The Public Policy Forum (2007) was an independent organization that gathered 150 leaders across Canada for a round

table discussion of the future of home care in Canada. These experts discussed the role of home and community care in enhancing patient care and stated their vision as follows:

In future, home and community care will constitute a valued and essential element in the continuum of health and social services provided to Canadians. Home and community care will provide patient centered services to assist citizens in remaining independent and functional in their home and community. More than simply a cost-effective alternative to hospital based care; home and community care will provide personalized services to patients and supports for caregivers that are evidence-informed and community-based, and seamlessly integrated into the broader array of health and social services. (Public Policy Forum, 2007)

Interestingly, five years later, many inconsistencies are still negatively affecting the health and safety of the workers providing this care. A disjuncture remains between the expectations of the health care system and agencies regarding the care provided, and what is actually happening in the everyday work of these aging support workers.

It is essential that the health care system consider the future of home care provincially and federally. The continued availability of skilled workers and the appropriate utilization of home care services are paramount. The changing need of clients in the community requires the recruitment and retention of skilled and trained home support workers. The continued need for skilled workers, coupled with shortages of these workers, will be more pronounced as we see a further shift in care from the hospital to the community. With changing demographics come increased numbers of older workers both seeking and maintaining work in the home support sector. Therefore, human resource strategies need to be implemented to keep experienced aging workers in this sector.

Contributions of this Research

The primary conclusion I was able to draw from my investigation is that the current work environment for older home support workers needs to be re-evaluated. My research contributes to two main bodies of literature. These areas include health and safety in the home support sector for aging workers and the meaning of work for older workers, with particular consideration of decisions about health and safety. Research on supportive services in the community has identified issues, challenges, and opportunities for homecare, but has largely failed to address the complex interplay of economic, historical, political, and social factors that have resulted in the challenges for home support workers. Research is needed to focus on these factors and how they organize the everyday work and decision-making processes about the protection of health and safety of aging home support workers.

Although some research does address health and safety considerations for home support workers, it is important to focus on older workers. Research on the meaning of work, employment practices, and health needs of aging home support workers is valuable. Research has confirmed the demanding responsibilities of home support workers, yet little is known about how workers negotiate the policies and practicalities of their work on a daily basis to protect their own health and safety.

I contribute to this body of literature by exploring how workers' everyday work was organized by what were sometimes unknown or invisible policies and operating procedures. I argue that with an aging population and increasing numbers of aging workers choosing to remain engaged in employment, agencies and organizations need to focus attention on recruitment and retention of these skilled

and experienced workers. I argue that consideration needs to be given to the protection of their health and safety, and to decisions made about the protection of their health and safety.

Limitations

Conducting this research was complex and challenging. I was faced with situations that I have identified as limitations in the study. The three main limitations included 1) my inability to utilize participant observation in my data collection, 2) the selection of participants by the managers, and 3) limited access to institutional texts.

Participant observation is one research method that can be used, and it is quite effective in institutional ethnography to help explicate how everyday work is organized. Unfortunately, I was unable to use participant observations for my research. I received approval from the Interdisciplinary Committee on Ethics in Human Research (ICEHR) to do this, but I was unable to gain permission from the agency owners to conduct observations in the home. The agencies expressed concern about protecting the clients' privacy and did not feel able to provide me with names and addresses of clients. I did not have the opportunity to speak with the clients to seek permission to conduct observations. I felt obliged to respect the wishes of the agencies who were allowing me access to their workers. Participant observation would have allowed me to observe first-hand the actions, interactions, and consequences of the multiple activities that shape, limit, and coordinate workers' experiences. Since I did not have the opportunity to do observations, I had to seek more detailed and rich explanations from the workers of their everyday experiences.

A second limitation concerns the recruitment of participants. Agency managers provided me with the names of potential participants who the managers felt would be open and willing to talk with me about their everyday experiences working in home support. There is the potential that these participants were hand-picked based on their work ethic or their experiences with their past or current clients. These participants may be providing me with a description of their work that reflects the best-case scenario of workers' day-to-day experiences. I anticipate that other workers could provide descriptions of their work that may reflect more accurately what is happening in other situations in the home support sector.

A third limitation was related to access to institutional texts. This study, as an institutional ethnography, relied heavily on institutional texts. It was limited by the texts that were available to me at the time of data collection. I had permission to access the larger organizing texts of the RIHA that regulates the home support sector in our province, but I was unable to access agency-specific policies regarding in-house training and orientation programs. Access to these policies and training protocols would have provided me with a better understanding of the exact policies that agencies have in place to protect workers' health and safety. This would have allowed me to describe in more detail the requirements or lack of requirements for orientation and training that is not part of formal training. I was able, however, to analyze larger extralocal texts, such as the Occupational Health and Safety Act and the Provincial Home Support Operational Standards. These texts were identified by administrative and policy personnel as a guide for the development of specific

agency policies, so I could have some understanding of what may be included in agency policies.

Final Comments

The purpose of this study was to explore, with a focus on health and safety, the working lives of workers aged 50+ who provide home support services. Using institutional ethnography, this study made visible the larger organizing policies and ruling relations that shaped older workers' experiences. I have shown how the meaning of work and the perception of risk influenced decisions to engage in risky behaviour in the home support setting. Home support workers are providing increasingly complex care but the perception in the general public is that home support workers provide help with simple tasks such as housekeeping and shopping/respite services.

I have demonstrated several points of disjuncture between organizing policies and the everyday work of aging home support workers. How these workers performed their roles and complied with organizational demands often increased their risk of occupational injuries. The workers were quite concerned about the work that they performed and the health and well-being of their clients. However, they accepted these risks and the constraints imposed upon them, and some did recognize the impact that this could have on their health and safety.

The recommendations I draw from the results of this study are intended to engage practitioners and policy makers in a critical reflection that will lead to action to revise policies. This will require policy makers, agency owners, and managers to appraise the current work environment and the role they play in shaping the everyday work experiences of aging support workers. This study highlights the decisions and

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Appendix A

February 15, 2010

My name is Sue Ann Mandville-Anstey and I am a nurse and a graduate student in a PhD Program (Community Health and Humanities) at Memorial University of Newfoundland.

I am currently conducting a study and I am asking for your support and assistance. The purpose of the research is to explore the working lives of aging workers employed in the home support sector. I believe that by understanding the work, effort and intent that is involved in being an aging worker that I will better understand issues that impact the recruitment and retention of home support workers.

Through interviews and/or focus groups, I would like to explore the working lives of aging workers including topics such as the meaning of work, health and safety, and employment policies and practices that organize how aging workers do their jobs. Interviews and focus groups will take place outside of the participants' work hours. Additionally, I propose to review the policies and documents that govern the work of home support workers as well as contribute to the health and safety of aging workers in this field.

I am asking your assistance in recruiting potential employees who may be interested in participating in my research. The Interdisciplinary Committee on Ethics in Human Research (ICEHR) has approved the proposal for this research. Individuals who are interested in participating in this study will be required to sign consent as per the standard ethical process.

I am interested in meeting with you to discuss the nature of this study and more details.

Sincerely,

Sue Ann Mandville-Anstey BN., MN., PhD (c)

Appendix B

Exploration of the Meaning of Work, Health and Safety of Aging Workers in the Home Support Sector

I am doctoral student at Memorial University and I am conducting a research study on aging workers employed in the Home Support sector. I would like to speak with aging workers, males and females, (50+) to discuss topics such as the meaning of work, health and safety, employment practices and how you go about doing your daily work.



I would really like your input as I anticipate that the results of this research may have an impact on employer and government policies to address the needs of workers to positively impact recruitment and retention of employees in the Home Support sector.

If you are interested in participating or have any questions please call

Sue Ann Mandville-Anstey at 777-8170 or sanstey@cns.nf.ca

Appendix C

Interview Guide for Interviews with Employees

Introductory Statement

I want to talk to you today about how you do your work....not particularly just the skills or procedures, but how you go about your work. By work, I mean anything that takes thought, time, and effort. I am interested in understanding what it means to you to be an worker in the home support sector, - right from getting up and ready for work, how you get to work, job responsibilities, policies and employer expectations through until you complete your shift and travel home. I'm also interested in knowing how being an older worker affects how you do your work, how you maintain your health and safety while working and any health and safety concerns that you as an aging worker may have while working in this field.

1. How long have you been working in this field? Why have you chosen to work?
What factors influenced your decision to work?
2. Current employment status (full-time/part time). How did you make this decision?
(are there challenges / benefits for you with regards to your hours of work?)
3. What types of shifts do you normally work? (nights, weekends, shift work)
4. Tell me about your last shift worked (which day, the number of hours?) Describe your day right from the time you get up, get ready and leave your house, the type of transportation you use, traffic going to work etc. Carry me right through until the time you return home at the end of your shift.
5. Tell me about your typical daily schedule, your routines and responsibilities.
(i.e., working days, nights, shift work, work responsibilities such as lifting, standing for long periods)
6. When you went to work for your last shift...what is the first thing you did?...what do you do when you arrive?

7. How do you find out your clients for the day? Is it done according to client complexity? How do you find out about their care needs? Is it a manageable number?
8. Tell me about the types of clients you care for, more specifically, how do you manage to do all of the work? How do you organize your day?
9. Often in your job I know that there is a lot of work to do and maybe you have discovered many shortcuts. Talk to me about some of these shortcuts that you implement in your daily work. Often shortcuts lead to workplace injuries....How do you feel that shortcuts at your place of work lead to an increased risk for a workplace injury?
10. Tell me about a time when you were working in an unsafe or "risky" work situation (i.e., a time when you felt that your health or safety may be at risk) What did you do? Who did you call? What about a situation that you couldn't get help when you needed it (for example with patient care). How did you handle it? What did you do?
11. I assume that sometimes work goes well and other times, not so well...it is the nature of any job. Can you think about the last shift that you worked where things did not work out as well as your thought they should? What happened? What did you do?
12. Talk to me about the people you work with (co-workers) and the types of relationship you have with them. Do you work together and help each other out? Tell me about your age with regards to the relationships you have at work. Is age a factor in the relationships you have at work? Is this a challenge or support to you?

13. Tell me about your job responsibilities. What is the thing you like most about your job? The least?
14. What kinds of strategies do you use to deal with the ebbs and flow of your work? (i.e., ways of organizing within your family? At work?).
15. Describe some of the challenges that you encounter at your workplace
16. Let's talk about age and age being a factor in how you do your work. Do you feel your age has impacted your ability to do your job? Considering the normal physiological changes of aging (for example, loss of strength, decreased joint mobility, reduced physical functional capability) do you feel that your age has impacted your ability to effectively do your job? How do you feel your body handles the shifts that you do?
17. What do you do at your house before getting ready to go to work? Other chores/responsibilities that you have to do prior to going to work. (caregiving for a family member, child raising)
18. What about home/family responsibilities. Are there times at work that you are concerned about/or preoccupied about your home life (spouse-caregiving responsibilities, household responsibilities)

Appendix D

Interview Guide for Managers

1. Can you describe the policies regarding the hiring of new staff within the agency? Tell me about the review of their application, assessment of work experience and qualifications for the job. What agency needs govern who is competent and suitable for the work?
2. Can you talk to me about how your daily work activities connect with the work of the home support workers in your agency? By this I am referring to your role in the day to day management of the facility...how do you evaluate their performance?
3. Can you talk to me about the role you play in structuring the work day for the home support workers. How do you organize their day (ie scheduling, payroll, work assignment)? Tell me about the challenges you encounter.
4. Tell me about the process involved in the workers receiving their schedules or negotiate time off? How is information conveyed to your staff? By this I mean communication regarding schedules, changes in policy, payroll.
5. Talk to me about the job descriptions of the home support workers. What are their responsibilities in a typical work day? Can I see some of these job descriptions?
6. What policies or operational standards (either on site or in the larger home support operational standards) have been developed to structure their job descriptions/ expectations?

7. Tell me about the policies surrounding health and safety training and the orientation of new staff? Considering health and safety in the workplace, tell me about the considerations you make, if any, for males and females or younger workers vs. older workers.

8. Tell me about what happens or the policy in place when someone makes a report about an unsafe work incident or if an injury is reported. What happens? What paperwork is completed? Once the paperwork is filled out what happens? What do you do with the information?

Appendix E

Interview Guide for Policy Makers

1. Could you describe how decisions are made within your department in relation to standards of practice or operational guidelines for the home support sector?
2. Think about the last time you were involved in the process of developing a policy or changing a policy in the home support sector. Walk me through that process. Who did you connect with or consult with?
3. Why did you make the change that you did? Did you consider differences in males and females or older worker vs younger workers in the development or revision of that policy?

Appendix F

ICEHR Ethical Approval Letter

June 1, 2010

ICEHR No. 2009/10-129-ME

Ms. Sue Ann Mandville-Anstey
Faculty of Medicine
Memorial University of Newfoundland

Dear Ms. Mandville-Anstey:

Thank you for your submission to the Interdisciplinary Committee on Ethics in Human Research (ICEHR) entitled *"Mapping social relations of older workers' employment: using institutional ethnography to explore the meaning and organization of work, health and safety of aging workers in the home support sector"*.

The Committee has reviewed the proposal and appreciates the care and diligence with which you have prepared your application. We agree that the proposed project is consistent with the guidelines of the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS)*. Full ethics clearance is granted for one year from the date of this letter.

Although clearance has been granted to your project, the Committee would like to suggest that particular attention be given to the competency of potential home care clients consenting to the ethnographic observational dimension of the study. Similarly, while you have provided adequate acknowledgement of the issues of risks, harms, anonymity and confidentiality, the reviewers would like you to be attentive to issues of anonymity and confidentiality, especially relating to the audiotapes as well as identifying information in transcripts and reporting of results.

If you intend to make changes during the course of the project which may give rise to ethical concerns, please forward a description of these changes to Mrs. Brenda Lye at blye@mun.ca for the Committee's consideration.

The TCPS requires that you submit an annual status report on your project to ICEHR, should the research carry on beyond June 2011. Also, to comply with the TCPS, please notify us upon completion of your project.

We wish you success with your research.

Yours sincerely,

Lawrence F. Felt, Ph.D.
Chair, Interdisciplinary Committee on
Ethics in Human Research

LF/bl

cc: Supervisor – Dr. Diana Gustafson, Faculty of Medicine

Telephone: (709) 737 2561 / 737 2861

Fax: (709) 737 4612

Appendix G

Informed Consent Form

Title: *Mapping social relations of older workers' employment: Using institutional ethnography to explore the meaning and organization of work, health and safety of aging workers in the home support sector*

Researcher(s): Sue Ann Mandville-Anstey, Doctoral Student, Division of Community Health and Humanities sanstey@cns.nf.ca (777-8170)

Supervisor(s): Dr. Diana Gustafson Phd RN., Division of Community Health and Humanities Diana.Gustafson@med.mun.ca (777-6720)

You are invited to take part in a research project entitled: *Mapping social relations of aging workers' employment: Using institutional ethnography to explore the meaning and organization of work, health and safety of aging workers in the home support sector*

This form is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any other information given to you by the researcher. Please contact the researcher, Sue Ann Mandville-Anstey, if you have any questions about the study or for more information not included here before you consent.

It is entirely up to you to decide whether to take part in this research. If you choose not to take part in this research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you, now or in the future.

Introduction

My name is Sue Ann Mandville-Anstey and I am a Doctoral student in the Division of Community Health and Humanities, Faculty of Medicine, Memorial University of Newfoundland. As part of my Doctoral dissertation, I am conducting research under the supervision of Dr. Diana Gustafson.

Through interviews, I would like to speak with aging workers to discuss their working lives in the home support sector including topics such as the meaning of work, health and safety, employment practices and how aging workers go about doing their daily work. Additionally, I want to speak with managers and policy makers who have important roles to play in the day to day activities of the front line workers. I propose that by understanding the work, effort and intent that is involved in being an aging worker along with the economic, social, political and social forces that organize your everyday work may influence policies that will positively impact recruitment and retention in this field.

Purpose of study:

The purpose of this research is to explore the working lives of aging workers, age 50 + providing home support services using a method of inquiry called Institutional Ethnography (IE). From the standpoint of these workers, I want to gain a greater understanding of how their work lives are organized by exploring factors such as the meaning of work, health and safety needs and practices, work environments as well as policies and government systems regulating the work of aging workers in this sector.

What you will do in this study:

Participating in this research study will involve an interview with the researcher lasting approximately 30 to 60 minutes. The purpose of these interviews is to gather a greater understanding of how workplace policies and job descriptions structure the work that you do. The focus of the research is on gaining a greater understanding of how you go about your daily work and how being an aging worker is influenced by policies and standards that govern the home support sector.

Withdrawal from the study:

You may withdraw from the research study at any time without any reason.

Possible benefits:

The benefits of this research for you as a participant are that you get the opportunity to express your views about work in this sector. While there may not be any direct benefit to you, this research has the potential to contribute to a growing body of knowledge. In the future, the results of this research may have an impact on policy changes and employers' responsibilities towards addressing the needs of aging workers.

Possible risks:

There will be the inconvenience of committing your time for an interview. However, if at any time you wish, you may withdraw from the study and you are permitted to do so.

The only other perceived risk for the front line workers could be a fear of a risk of loss of job or other ramifications of speaking out about your work as well as the health and safety issues in the workplace. I assure you that I have the support of the owner and management in conducting this research and management is interested in understanding the challenges and needs of the aging workers in their agency. Privacy and confidentiality will be maintained at all times during the data collection and analysis process.

Confidentiality:

As the principal investigator, I will ensure privacy is maintained for all participants by ensuring that their identities are confidential. Interview transcripts will be coded with a letter name (ie Participant A) and all information including the transcriptions, digital recorder and coding will be locked in a personal filing cabinet in the Research Office at the Centre for Nursing Studies. I will be the only person with access to this cabinet.

Anonymity:

No names or identifying information will be used neither in the write up of the research nor in the dissemination of research findings. No names or specific employers will be identified in any reports or publications.

Recording of Data:

The interviews will be audio taped and transcribed for analysis. The tape recorded interviews will be transcribed by a professional with experience in data transcriptions and this person will have no access to the assigned codes, consent forms or names of participants. No identifying information will be reported in the interview transcriptions.

Reporting of Results:

The information collected during this research will be used to form the basis of the write up of my doctoral dissertation. Presentations to local groups with a vested interest in this area of research will be conducted. A written report will be formulated and distributed to research participants including employers and employees. Additionally, key stakeholders such as government officials with the Department of Human Resources and Employment, Eastern Health and seniors

groups will be presented with the research findings. I also plan for peer-reviewed presentations of research process via conferences, presentations, local meetings and peer-reviewed publications.

Storage of Data:

All information including the transcriptions, digital recorder and coding will be locked in a personal filing cabinet in the Research Office at the Centre for Nursing Studies. I will be the only person with access to this cabinet.

Assigning code numbers to interviews and transcriptions of the interviews will further ensure confidentiality and anonymity. The identification numbers will correspond to tape recordings and consent forms and there will only be one copy of this confidential information kept. The consent forms, taped interviews, written transcripts coding notes and the researcher's field notes will be locked in a safe place and electronic transcripts and all notes pertaining to the research will be password protected. However, consent forms will be separate from the transcriptions to further ensure confidentiality.

Questions:

You are welcome to ask questions at any time during your participation in this research. If you would like more information about this study, please contact Sue Ann Mandville-Anstey BN., MN., PhD (c) 777-8170 or sanstey@cns.nf.ca

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-737-8368.

Consent and Signature Form

Your signature on this form means that:

- You have read the information about the research
- You have been able to ask questions about this study
- You are satisfied with the answers to all your questions
- You understand what the study is about and what you will be doing
- You understand that you are free to withdraw from the study at any time, without having to give a reason, and that doing so will not affect you now or in the future.

If you sign this form, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

Your signature:

I have read and understood what this study is about and appreciate the risks and benefits. I have had adequate time to think about this and had the opportunity to ask questions and my questions have been answered.

I have read and understand the information sheet explaining the purpose of the research

I consent to participate in the research project understanding that my participation is voluntary and that I may end my participation at any time.

I agree to be audio-recorded during the interview

I understand that I am free to withdraw from the study at any time without giving a reason

A copy of this Informed Consent Form has been given to me for my records.

Signature of Participant

Date

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of Principal Investigator

Date

