

ON THE MOVE AND WORKING ALONE: POLICY IMPLICATIONS OF THE EXPERIENCES OF UNIONIZED NEWFOUNDLAND AND LABRADOR HOME CARE WORKERS. Fitzpatrick, Kathleene and Neis, Barbara

Kitzpatrick, Kathy, and Barbara Neis. (2015). "On the Move and Working Alone: Policy Implications of the Experiences of Unionized Newfoundland and Labrador Home Care Workers." *Policy and Practice in Health and Safety*, 13(2): pp. 47-67.
<https://doi.org/10.1080/14774003.2015.11667817>

Abstract

Home care work is female-dominated, generally precarious, and takes place in transient and sometimes multiple workplaces. Home care workers can engage in relatively complex employment-related geographical mobility (E-RGM) to, from, and often between work locations that can change frequently and are remote from the location of their employer. Like other precarious workers, home care workers may be more likely to experience work-related health and safety injuries and illnesses than non-precarious workers. Their complex patterns of E-RGM may contribute to the risk of injury and illness. This paper explores patterns of E-RGM and ways they influence the risk of injury and illness among unionized home care workers living and working in two regions of the province of Newfoundland and Labrador (NL) on Canada's east coast. It uses Quinlan & Bohle's pressure, disorganization, and regulatory failure (PDR) model to help make sense of the vulnerability of these workers to occupational health and safety (OHS) risks. The study uses a qualitative, multi-methods approach consisting of semi-structured interviews and a review of government and home care agency policies, as well as 20 NL home care collective agreements. It addresses two main questions: What are the work-related health and safety experiences of interviewed NL unionized home care workers? How do policies (government and home care agency) and collective agreements interact with E-RGM to mitigate or exacerbate the OHS challenges confronting these workers? Findings show that these workers experience numerous work-related health and safety issues many of which are related to working in remote, transient, and multiple workplaces. While collective agreements mitigate some health and safety issues, they do not fully address particular OHS risks associated with working alone,

remote from employers, in transient workplaces, or the risks associated with commuting between workplaces. More active union engagement with these issues could be a mechanism to improve the health and safety of these and other home care workers.

Key Words: employment-related geographical mobility; home care workers; occupational health and safety; precarious employment

Introduction

During the last three decades there has been an increase in home care work in Western countries as caring work has been relocated from hospitals and institutions to clients' homes.¹ Home care workers are employed by private or government agencies and play a vital role in the health care system as paraprofessionals caring for the elderly, those with disabilities, and those released early from hospitals. This female-dominated labour force is diverse, widely distributed throughout rural and urban areas, and performs a multitude of duties both within the private spaces of clients' homes and in public spaces. The nature of home care work means it is associated with complex and changing patterns of employment-related geographical mobility (E-RGM). E-RGM includes mobility to and from workplaces and mobility between workplaces.² Home care workers sometimes work in more than one workplace on a daily or weekly basis and their workplaces are remote from their employers' offices. Their worksites are generally transient as client resources and needs, and their employer's management objectives shift, requiring them to change workplaces. They sometimes live in the home where they work during their shifts or rotations; some commute sometimes twice a day, between their own residence, work, and travel between worksites.

Home care work is often precarious work due in part to neoliberal policies that have promoted deinstitutionalization, community care, and the quicker release of patients from hospitals. This work used to be done by full time workers inside institutions or by unpaid family members at home; it is now done by paid, part-time, and casualized workers.³⁻⁵ These workers often experience earnings insecurity, job insecurity, irregular shifts, and few fringe benefits, and work in isolation from other workers and their employer.⁶ Like other workers engaged in precarious employment, they may be more likely to experience work related injuries and illnesses than non-precarious workers.⁷ These risks are particularly substantial among temporary agency workers⁸ and workers based in a home.^{7,9}

Research on the Occupational Health and Safety (OHS) of home care workers is limited internationally.⁷ The research that exists has looked at the impacts of healthcare restructuring on the health and safety of home care workers;¹⁰⁻¹⁴ regulatory challenges associated with work located within a private residence;^{7,14} and transport and OHS challenges.⁷ This paper adds to the limited knowledge of home care OHS by documenting the work-related health and safety experiences of NL unionized home care workers in Eastern Canada, and by examining how government and home care agency policies impact unionized home care workers' OHS. It contributes to the existing literature by focusing on how complex patterns of E-RGM influence the OHS of NL unionized home care workers and the extent to which existing collective agreements may mitigate or exacerbate home care workers' OHS issues.

Home care work

The demand for home care services is increasing in most Western countries due to an aging population, increased female participation in the labour market, greater work-related mobility of family members,¹⁵ and to a restructuring of the health care system resulting in a shift

away from long term, institutional care to home care and community care.^{5,15} In Canada, home care is a provincial responsibility and consequently home care policies vary from province to province. Most of the existing research has been done in the province of Ontario, where the restructuring of the healthcare system was based on policies which resulted in shortened hospital stays, deinstitutionalization, and managed competition where both for-profit and not-for profit home care agencies bid on home care contracts.^{5,16} To date, most of the research on paid home care workers is based on research done with employees working for home care agencies^{7,12,13,17} or for provincial regional health boards.⁶ There is also Canadian research on international live-in caregivers working in Canada.^{14,18,19}

Home care work is one of the many occupations where workers experience precarious employment. Generally speaking, home care workers experience high levels of earning insecurity because their hours of work are not guaranteed and their income level is not consistent.²⁰ Often, home care workers have a limited social wage (i.e., dental, extended health benefits, sick pay, pensions).⁴ Some home care workers are exempt from employment standards protection because they are classified as independent contractors.⁷

E-RGM and home care work

Home care workers participate in a variety of different patterns of E-RGM. According to Roseman et al.² E-RGM refers to commuting to and from work and between workplaces, as well as mobility as part of work. E-RGM ranges from relative immobility (working at home) to local daily commutes to one or more workplaces, through extended commutes across regional, provincial, and national boundaries associated with often prolonged absences from home. E-RGM has the potential to positively or negatively impact the physical, mental, emotional, and

social health of workers including those in home care.²¹ Spatial and temporal dimensions of workers' mobility have been absent from the study of precarious employment.²²

OHS and home care work

As is the case for many female-dominated occupations, there is limited research on home care workers' OHS issues. Existing research shows that some of these workers are exempt from workers' compensation because they are classified as independent contractors or domestic workers.^{7,14} Recent studies examine the vulnerability of workers employed in consumer models of home care.²³ Other research examines unionized home care work done by workers employed by a home care agency.^{6,20,24} The latter research has linked OHS health and safety in home care work to changes in the organization of work due to restructuring of the health care system that have intensified work, encouraged job insecurity, and led to an increase in musculoskeletal disorders and/or work-related stress.^{6,10-12,25,26} Some of the existing research examines the workplace health and safety challenges associated with working in private homes rather than formal workplaces,^{9,27} compares agency hired and client-hired home care workers' OHS issues,²⁸ and one study compares urban and rural home care workers' OHS issues.⁷ The next section will unravel findings in the existing literature on OHS risks linked to paid home care workers; risks to home care workers related to E-RGM; and, risks to precariously employed workers that overlap with the situation of home care workers.

Risk to all paid home care workers

Paid caregivers employed in private homes work in isolation and face many OHS risks such as, musculoskeletal disorders, violence, and exposure to communicable diseases. Home care workers often experience musculoskeletal disorders because of a lack of proper equipment, poor workspace design, and the absence of co-workers to help move clients.^{7,29,30} As well, paid

home care workers experience musculoskeletal disorders when they face both physically demanding tasks and a poor psychosocial working environment.^{13,31,32} The location of the workplace within a person's home may also increase the potential risks for violence^{33,34} particularly when the client is the employer.²³ Violence in these workplaces is underreported, and is often tolerated by workers when the clients have dementia.³⁵ Besides the potential for violence, home care workers also experience exposure to communicable diseases, allergens, and dirty homes.^{36,37} These risks are greater when the home is poorly maintained.^{36,37} It is difficult for OHS regulators to inspect workplaces within private homes because of a lack of inspectors and other resources, and concerns about privacy.³⁸

Risk to home care workers related to E-RGM

While some research identifies potential and actual vehicle accidents among the OHS issues confronting paid caregivers^{36,37,39} there is only one paper that discusses the relationship between E-RGM and OHS policies for these workers.²⁷ Some of the challenges E-RGM poses for OHS include exposure to hazards related to mobility to and from work and mobility between worksites, as well as hazards while at work that are potentially exacerbated by E-RGM.²⁷ For instance, workers who work remotely from their employers, often alone, and in multiple and transient worksites, can face more challenges around knowledge of hazards and their capacity to prevent, reduce and report hazards to their employers, than those who are employed in a set workplace where the employer/management is present.²⁷ Those who change workplaces (and clients) on a regular basis may be more at risk of violence and abuse. Conversely, workers employed through programs like Canada's Live-in Caregiver Program, which brings international workers into Canada on a temporary basis, are immobilized by work permits while

in the Program. These tie them to a specific employer and this immobility makes them particularly vulnerable to violence and abuse.⁴⁰

Risks to precariously employed that overlap with the situation of home care workers

Precarious employment has been linked to increased risk of work-related health and safety issues.^{20,41} It is associated with complex and changing forms of work organization that vary between industries and create specific OHS concerns. For example, temporary agency workers are more likely to take risks and be injured on the job than those in secure, full time employment because of a fear of dismissal, lack of knowledge about OHS rights, unfamiliar transient workplaces, and assignment to the worst jobs.⁸ There is limited research on the risks to the precariously employed that overlap with the situation of caregivers. Quinlan & Bohle^{41,42} have developed a ‘Pressure, Disorganization, and Regulatory Failure’ (PDR) model to make sense of the vulnerability of workers in precarious employment. Their model identifies three intersecting factors – economic and reward pressures (work intensification, OHS compromises, and risk taking by workers), regulatory failure (difficulty monitoring and enforcing laws for workers in isolated workplaces), and disorganization of work (isolation of workers, lack of training and supervisory support, lack of collective voice, lack of safety protocols) that link precarious employment to the risk of injury and other OHS challenges.^{7,41,42} This model will be used to explain the link between precarious employment, E-RGM, and work-related health and safety issues facing NL home care workers.

The next section provides an overview of the research context and methods for a study of the work-related experiences of unionized NL home care workers and how policies (government and home care agency) and collective agreements may mitigate or exacerbate the OHS

challenges confronting these workers. This is followed by a section that presents the findings, followed by a discussion of the implications of these findings.

Research Context

In NL, the Department of Health and Community Services currently provides subsidies for home care to enable seniors, adults with disabilities, and adults released early from the hospital, to stay within their homes instead of institutions. Government-subsidized home care has increased in recent years due in part to the shift from long-term institutional care towards home and community-based care. In NL, home care is meant to complement rather than substitute for the unpaid work of family members caring for individuals. The government subsidizes most of the services provided by home care agencies. Once the Regional Health Authority determines the number of hours of subsidized care the client is eligible to receive, the client then chooses a home care agency to provide the services. In addition to caring for the elderly, the disabled, and those released early from hospitals, workers employed by home care agencies may also care for troubled teens and supervise visits with family members who have lost custody of their children as part of the Supervised Access Care Program.

Since 2004, the Newfoundland and Labrador Association of Public and Private Employees (NAPE) has been unionizing home care workers employed by agencies. By 2013 workers in more than 75% of home care agencies in NL were unionized. There is no research that describes the experiences of these unionized home care workers and very limited research looking at the experiences of home care workers in NL.⁴³⁻⁴⁵ This paper builds on research on home care workers' OHS by considering how union collective agreements, home care agency, and government policies interact with E-RGM to affect the health and safety of home care workers. The study shows that the substantial OHS risks experienced by the workers included in

this study are linked in part to working alone in transient workplaces that are spatially dispersed and remote from their employers.

Methods

The data in this paper are drawn from Kathleen Fitzpatrick's doctoral research. The findings are part of a larger comparative study exploring how different patterns of E-RGM impact working conditions of NL home care workers in St. John's, an urban area, and in southwest Newfoundland, a rural area. The data are derived from semi-structured interviews with thirteen unionized home care workers, nine unionized home care agency representatives chosen from three Regional Health Districts in NL, and five key informants (health care representatives and two union representatives who negotiate on behalf of home care workers). The interviews took place between January 2013 and April 2014. Home care workers were initially recruited through snowball sampling through the union, acquaintances, and recruitment posters. Home care agency representatives were recruited by identifying home care agencies listed in the phone book and on the Internet. Forty-five percent of the agencies that were contacted agreed to participate. Key informants were recruited by calling government department offices, union offices, local community organizations, and businesses then identifying potential participants. The qualitative software program NVivo was used to help organize the interview data according to key themes.

Government policies and legislation relevant to home care workers' employment conditions and health and safety and two procedure manuals from participating home care agencies were reviewed. The examined policies are laid out in Newfoundland and Labrador Department of Health and Community Services publications *Provincial Home Support Program*

*Operational Standards*⁴⁶ and *Close to home: A strategy for long-term care and community support services 2012*.⁴⁷ The Newfoundland and Labrador *Workplace Health, Safety and Compensation Act*,⁴⁸ *Newfoundland and Labrador OHS Regulations 5/12*,⁴⁹ the *Working Alone Safely Guidelines* website,⁵⁰ the *Occupational Health and Safety Act*⁵¹ and the *Labour Standards Regulations*⁵² were also examined. Government agency representatives were contacted to clarify policies and legislation. In addition, twenty on-line NL home care collective agreements were examined to better understand how and if collective agreements address the health and safety of home care workers. The data were analyzed using thematic content analysis informed by the literatures on precarious employment, OHS, and home care restructuring.

Home care worker characteristics

Twelve of the thirteen unionized home care workers interviewed were females. The workers ranged in age between 20 and 65 years of age.

Table 1: Unionized home care workers demographics (pseudonyms)

Home Care Worker	Age	Years as a home care worker	Marital Status
Amanda	50s	25	single
George	60s	7	Married
Pamela	30s	12	Married
Frieda	20s	2	Single
Nikki	20s	2	Single
Janet	50s	7	Married
Brenda	40s	1	Married
Vicki	40s	8.5	Married
Catherine	40s	less than 1	Divorced
Rachel	50s	less than 1	common law
Cassandra	50s	2	Married
Sherri	40s	2	Divorced
Cecile	20s	less than 1	Single

Seventy-six percent of interviewed unionized home care workers resided in the St. John's Metropolitan Area. The length of time participating workers had worked as home care workers ranged from less than one year to over 25 years. Younger home care workers tended to be single, whereas older home care workers were more likely to be married (Table 1).

Findings

This section describes the working conditions of these interviewed home care workers, linking their working conditions to precarious employment in often multiple, transient work sites and related patterns of local E-RGM. It then describes interviewed home care workers' health and safety experiences and identifies work-related health and safety issues linked with precarious work and E-RGM. Lastly, this section examines how government and home care agency policies and collective agreements affect unionized home care workers' OHS.

Working Conditions

In NL, unionized home care workers generally have the highest hourly wage and social wages among home care workers. As of July 1, 2014 all unionized home care workers received \$13.25 an hour, which is slightly more than the minimum hourly rate of \$12.25 set by the Department for home care workers caring for clients receiving subsidized care. Unionized home care workers are eligible for paid sick time, bereavement leave, and more statutory holidays than nonunionized home care workers. None of those interviewed contributed to a private pension plan or had a long-term disability plan, but all were eligible for workers' compensation in the event of a work-related injury.

Interviewed home care workers experienced somewhat precarious working conditions in the form of job insecurity, irregular hours, and earnings insecurity. They experienced job

insecurity because when the client no longer required his/her services, some home care workers could be temporarily unemployed until a new client was found. Earnings insecurity was very common among home care workers because they had inconsistent hours of work and often worked part-time. Nine of 13 worked two jobs to make ends meet.

Most interviewed home care workers preferred to work an eight or twelve hour shift caring for one client, but the majority of participants cared for one to four clients a day and were not paid for travel time between clients. The interviewed workers' patterns of daily local E-RGM were varied and complex for this reason and because their schedules were based on both client and home care agency management's needs. Their work schedules could change with little notice, along with their work location, as reflected in the comment that they are always "on call." According to Nikki, "I can get a phone call tomorrow and say well, we need you at this place at 8:00 in the morning until 12:00 and for 2 weeks only because they just got out of the hospital, and they had surgery and they only need someone for 2 weeks."

Public transportation schedules and coverage are limited in the St. John's region and non-existent in rural areas creating additional challenges. Thus, only two of the interviewed home care workers commuted by public transportation or walked from their homes to their job sites. The remainder used their own personal vehicles to travel to and from work, as well as between client's homes. Interviewed home care workers were not compensated for the cost of fuel, insurance, registration, or maintenance of their personal vehicles. Usually the home care agency scheduled thirty minutes to an hour of travel time between clients but home care workers did not receive compensation for their travel time nor did they receive mileage for traveling between job sites.

The commute patterns of four home care workers are shown in Table 2. The workday was long, particularly for home care workers who worked split shifts (working for short periods of time divided by long waiting times). Some drove to and from home more than once in the course of a day. To illustrate, over a period of 16 months Janet worked a split shift caring for a client who lived thirty minutes away from her home. She commuted a total of more than two hours a day, an hour for each three-hour shift, twice a day. Her commuting and workday extended over 13 hours but she was paid for only six hours of work and was not paid for the cost of commuting. In addition, some days she might receive a phone call after 11:00 p.m. asking her to care for an unfamiliar client, located somewhere else, that same night.

Table 2: Examples of home care workers' E-RGM

Home care worker	E-RGM
Janet	8:30 drives to client's home (30 minutes) 9:00 – 12:00 works first shift with Client A 12:00 – 12:30 drives home (30 minutes) 17:30 – 18:00 drives to client's home (30 minutes) 18:00 – 21:00 works second shift with Client A 21:30 drives home (30 minutes)
Nikki	8:00 drives to client's home (20 minutes) 8:30 – 12:00 cares for Client A 12:00 drives to client's home (10 minutes) 12:30 – 16:30 cares for Client B 16:30 drives to client's home (10 minutes) 17:00 – 19:00 cares for Client C 19:00 – 19:20 drives home (20 minutes)
Frieda	5:30 drives to client's home (30 minutes) 6:00 – 14:00 cares for Client A 14:00 – 14:30 drives home (30 minutes)
Catherine	8:00 - 8:20 rides the bus (20 minutes) 8:20 – 9:00 coffee at a local coffee shop 9:00 – 12:00 cares for Client A 12:00 -12:10 walks to the bus stop 12:20 -12:30 rides the bus (10 minutes) 12:30 -12:45 coffee at a local coffee shop 12:45 – 13:00 walks to the client's home 13:00 – 16:00 cares for Client B 16:00 – 17:00 walks to the bus stop and rides the bus

	home (20 minutes)
--	-------------------

For a short period of time, Nikki worked 90 hours bi-weekly caring for three clients (Table 2), excluding her commuting time. Her workday started at approximately 8:00 in the morning and finished almost 11.5 hours later and included a series of commutes and waiting times between worksites totaling more than 1.5 hours (Table 2). At the time of the interview, Nikki was caring for only one of the three clients so she spent less time commuting but only worked twenty-one hours a week. In a two-week period Nikki had only one day off. Her income was low: \$400 bi-weekly after deductions. Another home care worker, Brenda, said: “I could go up to about 25 hours a week or I might get no calls for work. I only get called when they are stuck to fill a shift.”

Catherine is one of the two home care workers who relied on the public transit system. Because she did not have her own vehicle, Catherine’s workday and commute extended over 9 hours but she was only paid for 6 hours of that time (Table 2). Catherine spent 60 minutes of her workday riding buses and over 1.5 hours waiting or walking. She described waiting in nearby coffee shops to keep warm and dry before the start of her shifts. Catherine mentioned that for a while she had a similar job schedule to the one outlined here, but a different afternoon client and work location. The bus arrived near the client’s home at 12:30 and her shift started at 1:00 but there were no coffee shops or retail stores nearby so she had to wait outside until 1:00 p.m. in both fair and adverse weather. If Catherine had been working in a public place, and not in a private, isolated workplace, or if she owned a car, she would have been able to travel to work at the time of her shift and would have had a dry place to sit and wait for her shift to start. For Catherine, commuting to work and between workplaces was dependent on the availability and

timing of the bus system. On average, she worked 28 hours a week Monday to Friday and also worked a second job every other weekend in the service sector to try to make ends meet.

Catherine was interested in working more hours as a home care worker but because she relied on the transit system she was unable to care for clients who did not live relatively close to a bus route and who lived a long distance from the preceding client's home. She said, "If I had a car it would be different, but I can't afford a car. I couldn't afford a car on 28 hours a week. So it's a vicious circle."

Some home care workers, like Frieda, cared for one client, full time, in one location. At the time of the interview Frieda worked from 6:00am to 2:00pm Monday to Friday.

According to their collective agreement these home care workers are entitled to every second weekend off, although many felt pressured to accept work whenever the home care agency offered it. As a result, it was common for them to work many weeks in a row without having a day off work. Home care workers reported feeling pressured to accept additional hours because of economic need, concern for their client, and 'emotional blackmail.' According to Janet "There is a lot of coercion in home care because you form a bond with a family. And if you got to be off cause you're sick, or it's your weekend off they'll [the home care agency] call and they'll say, "Well we got no one to go in. Don't you care about them? Come on now, don't you?".

Home care workers' safety and health experiences

Interviewed home care workers described multiple forms of work-related health and safety concerns including those related to commuting, musculoskeletal disorders, working in unsafe houses, harassment (sexual, physical, and emotional), insufficient knowledge about the client, and stress. OHS concerns were linked to the insecurity of their work and to their E-RGM. This section describes home care workers' experiences of health and safety issues with a

particular focus on those related to complex commuting; working in multiple and transient worksites inhabited by their clients; and, working alone in sites that are remote from their employers' worksite. All interviewed home care workers worked alone with the exception of one home care worker who recalled working in pairs while caring for a youth with violent tendencies.

Like home care workers elsewhere, the OHS concerns of these participants included musculoskeletal disorders,^{12,13,17,53} exposure to harassment and violence,^{33,34} and feeling pressured to risk their safety.⁷ Attention to their complex and changing commutes and other mobility-related aspects of their work shows that these concerns are somewhat related to their journeys to and from multiple and transient workplaces where they work alone and within which they exercise little control.

Health and safety concerns related to commuting and traveling between workplaces

Home care workers were exposed to hazards while commuting and travelling between workplaces. Some interviewed home care workers reported feeling drowsy driving home after the last shift of the day and drank coffee to stay alert. NL roads and highways can be treacherous during the winter months, and some home care workers reported feeling uneasy driving in snowy weather. They said they felt obligated to drive in severe weather to care for a client, especially when the home care agency used 'emotional blackmail' to make them feel guilty or instructed the worker to contact the client with the news that she would not be caring for the client today due to severe weather. Some talked about the need to maintain their car in order to prevent breakdowns and putting on studded tires during the winter months to create better traction when driving on snowy and icy roads. One interviewee had an accident while driving to the client's home in good weather.

Health and safety concerns related to employment in transient and often multiple workplaces

Home care workers work in isolated workplaces and their workplaces are constantly changing. Six home care workers reported that they did not have sufficient knowledge about the client prior to caring for him/her. For instance, Janet recalled, “There is no information given to us. We got a name and an address. We’re not told half of what goes on ‘til you walk into this situation and you’re probably in a mess.” It was common for home care workers to work with a new client without being formally introduced to the client by the home care agency. Because of the differences among home care clients’ needs and behaviours, home care workers reported receiving insufficient training to deal with stressful situations regarding both proper care for their clients and their own safety. Interviewed home care workers who worked with special needs youth discussed the dangers they sometimes faced. Brenda recalled, “Sometimes they were young offenders, and they would be put in hotels so I would have to go to a hotel room and stay with a young offender. One time I had the cell phone and I had the RCMP on speed dial because this one particular kid, or young man, was a known arsonist.”

Often home care workers did not have prior information about new workplaces and almost 40% described working in unsafe worksites. Some of the hazards identified included: lack of heat, house in disrepair, unclean homes, cigarette smoke, fleas, and snow on the outside stairs. Home care workers described houses that were difficult to navigate because of the piles of newspapers stacked throughout the house and filthy houses. Brenda remembered the first time she supervised a particular mother and young child in the Supervised Access Program and she said, “I didn’t eat. I didn’t drink. I didn’t use the bathroom for those 12 hours. I didn’t sit down. The place was that dirty.” A few of the interviewed home care workers worried about what they

were bringing back to their own homes, but as well they were concerned about what they were exposing other clients to when traveling between clients' homes.

Being mobile home care workers with little or no control over their work schedules created other stressors. Interviewed home care workers commented that they were stressed because they had insufficient time to provide quality care. For example, the allotted time for many clients did not take into consideration the time required to take clients shopping or to the doctor's office, to cook a proper meal, or to provide the emotional care that clients need. As well, a couple of home care workers worried about the safety and comfort of their clients when they finished their evening shift, especially when they left non-ambulatory clients alone for the night. The stress related to a lack of time to provide quality care is a common finding in research on home care restructuring in Western countries.^{1,13,53-55}

Health and safety concerns related to working alone

Home care workers experienced a number of OHS concerns related to working alone in clients' homes remote from their employer and other workers. Two of the most commonly cited issues were the risk of developing musculoskeletal disorders, and risks associated with violence and harassment. Health care workers employed in institutions also experience these two hazards but the location of homecare worksites within clients' homes and the practice of working alone exacerbate these OHS concerns.

Approximately 1/3 of the participants described symptoms of musculoskeletal disorders. For instance, according to Pamela, "you can't go into home care with a bad back, but you will leave with one." When the same work is done in an institution, there are other workers to assist personal care workers with turning clients in beds or with assisting clients to bathe or take short walks around the room. Personal care attendants also work in stable workplaces, controlled by

the employer, which are clearly subject to health and safety legislation, and where there are active health and safety committees with the right to inspect. As has been argued by others,^{27,36} working alone in the homes of often multiple clients brings with it particular vulnerabilities to these disorders. Home care workers reported that, where they existed, the lifts designated for home care clients were sometimes out-dated. One home care worker divulged that it took three requests to receive an automated lift for her client. The lift initially assigned to the client was a manual crank lift device that caused the worker shoulder discomfort. As well, home care workers reported working with clients with limited mobility who were apprehensive about the workers using a lift to move them. Home care workers also mentioned how difficult it was turning clients in bed.

Exposure to violence and harassment are OHS concerns potentially exacerbated by working alone and by the location of work in someone's home.^{33,34} Almost forty percent of participants reported experiencing harassment by one or two of their clients including physical attacks and derogatory remarks about their work and their appearance by both elderly male and female clients. Home care workers reported harassment not only by clients but also by family members. While this is not unique to home care, the duration of exposures and challenges in reporting may well be. Frieda recalls being mentally and sexually harassed by a client's son-in-law for eight months until she complained to her employer. Similarly, Nikki cared for an abusive client for eight months. Most interviewed home care workers reported that when a home care worker complained to their employer about harassment the worker was removed after a replacement worker was found. However, Nikki stated that after she wrote up an incident report detailing a harassment event no action was taken because there were insufficient workers. Some

home care workers rationalized the client's abusive behaviour as a consequence of the client's mental health.

Health and safety concerns related to job insecurity

Job insecurity was an ongoing concern mentioned by most interviewed home care workers. Home care workers experienced job insecurity when the client passed away, was placed in an institution, recovered from a hospital procedure, and when clients decided that the worker was incompatible with their needs and asked for another worker. These multiple sources of job insecurity may have prevented home care workers from reporting harassment or other threats to their health because complaints could mean they would lose the client and might, as a consequence, have limited or no income for weeks and even months while waiting for another client.

Home care workers reported taking safety risks and performing tasks requested by clients because they were afraid of losing their job. For example, Pamela recalled going outside to draw well water in -20 degree Celsius weather, and on another occasion scrubbing floors on her hands and knees. She said, "You have to give in sometimes because if not, I mean, they [the home care clients] are liable to say, "I don't want you, you won't do what I want you to do."

Homecare worker OHS, E-RGM and government and home care agency policies and practices

The work-related health and safety experiences of interviewed home care workers suggest that government and home care agency policies do not do enough to protect home care workers' health and safety. Sections 2(z) and 43 of the *Newfoundland and Labrador Workplace Health, Safety and Compensation Act*, indicate entitlement to workers' compensation is based on two requirements. First, the worker must meet the definition of "worker" under subsection 2(z) of the

Act, and second, the injury as defined under subsection 43 must be "one arising out of and in the course of employment."⁴⁸ Home care workers employed by an agency meet the definition of "worker" and are eligible for workers' compensation if injured on the job performing tasks approved by their home care agency. Home care workers commuting between home and work are ineligible for compensation, but those traveling for work are eligible for compensation.⁵⁶ It is less clear whether workers injured while traveling between workplaces would be eligible for compensation. If home care workers are injured while commuting between home and work, as is the case when they work split shifts they are not eligible for compensation. Conversely, full-time NL community nurses are likely to be eligible for workers' compensation if they have an accident while traveling directly from one client to another (between workplaces) because they are paid mileage and travel time when driving between clients' homes as outlined in their collective agreement.⁵⁷

The *Working Alone Safely Policy* acknowledges hazards facing workers in transient and isolated workplaces.⁵⁰ It recommends that the employer create a standard safety awareness checklist for employees to evaluate their risks.⁵⁰ In addition, a safe visit plan is recommended (but not required), and suggested strategies include having two workers caring for one dangerous client and active communication by the employer with the worker to keep track of the safety of the worker.⁵⁰

Home care agency representatives were not asked if they had a safe visit plan or a standard safety awareness checklist in place to reduce health and safety risks, but they were asked a general question about the health and safety of workers. Responses ranged from the employer supplying gloves to the workers and training opportunities for working with difficult clients, to comments about the importance of workers knowing their rights under workers'

compensation. Three home care agency representatives indicated they were proactive about workers' health and safety; one agency had a bulletin board with workplace health and safety information displayed at the entrance to the main office. However, none of the home care agencies volunteered that they do a risk assessment of the client before sending in a worker. Generally speaking, a pre-assessment of the client's needs was done in-person or by phone to determine what the home care client required and which home care worker was best suited to work with the client.

Most home care agency representatives suggested that workers were given sufficient information about the client to provide care. Only three out of the nine representatives had the worker meet with the client before they started to care for the individual. While three of the home care agency representatives said the agency notified home care workers if the client smoked or had animals, one home care agency representative suggested that confidentiality issues prevented her from sharing written client information with the worker unless the worker went to the office.

Over seventy-five percent of the home care agency representatives indicated they checked the clients' homes, and they described checking for uncovered sockets, clear exits, loose carpets, and dangerous slip and fall situations which could affect the safety of clients and workers. However, it seemed from their comments that the focus of these visits was on client safety. Some of the houses described by the home care agency representatives were in disrepair (i.e., rodents, holes in the wall, unsafe steps) and in some situations the home care agency representatives said that they could suggest repairs, but they did not have the power to demand that safety concerns be addressed. One home care agency representative when questioned about

whether some houses were in disrepair said, “Oh yes. Unfortunately, there is not much you can do about that. You just tell your home support worker to be as careful as they can, you know.”

A couple of home care agency representatives said that they would not place home care workers in physically unsafe houses or with clients who had behavioural problems. However, most home care agency representatives accepted challenging clients. One commented, “Everyone is entitled to the best quality care that they can receive.”

Eight of the nine home care agency representatives indicated that they offered training to workers but the training program and modules, and the frequency of course offerings varied across agencies. Sometimes home care workers received training by a more senior home care worker to help them better care for the client. Two of the agencies said they offered computer modules for home care workers to complete at home. Occasionally, home care agencies offered specific training at the office about the patient’s disease (i.e., diabetes, dementia, and Alzheimer’s), meal preparation, bathing, and transferring patients using lifts. As well, home care agencies delivered training courses about potential hazards to workers’ health (i.e., managing challenging behaviours, crisis prevention and intervention, and bad backs). One home care agency was proactive in training their employees and annually offered six to eight training sessions based on internal material and external material (i.e. Alzheimer’s Society). However, home care workers were not paid for the time they spent in training.

Collective Agreements

All the home care agency collective agreements reviewed for this project stipulate that employers must provide gloves and aprons to workers and that at least one union member representative is required to sit on the health and safety committee. Furthermore, collective agreements state that home care workers have the right to work free from personal and sexual

harassment and to refuse work with incompatible clients. Collective agreements require employers to take immediate action if a home care worker's safety is at risk. However, forty-five percent of the reviewed collective agreements did not require home care agencies to inform workers about clients with behavioral problems and none of the collective agreements required home care agencies to do an inspection of the home prior to the home care worker's first visit with the client.

Collective agreements set out the terms of employment, and they contain clauses to reduce safety and health risks facing home care workers. They address scheduling, minimum hours requiring payment, and job security. The collective agreements allow a flexible work schedule for employees. The collective agreements do not guarantee a minimum number of hours of work per day or week, however, there is a clause indicating home care workers are not obligated to accept shifts of less than 3 hours duration – the minimum laid out in s. 10 of the provincial *Labour Standards Regulations*.⁵² Home care workers are supposed to be paid overtime (time and a half) when they work in excess of 12 or 13 hours per day or 40 hours per week. The collective agreements do not explicitly mention that home care workers are protected against reprisals for OHS complaints, but this and some other basic protections such as the right to refuse work if the worker believes it is dangerous to his/her health, and the requirement that an employer have a health and safety policy are outlined in the *OHS Act*.⁵¹

Discussion

The findings of this study are similar to those arising from international research on the working conditions and OHS issues facing home care workers. In this study, home care workers tended to be older women with limited employment opportunities and low wage earners.

Likewise, home care workers in Europe, North America, and Australia are more likely to be women, tend to be older, and earn a low income.^{7,54,55} As with other research on the working conditions of home care workers,^{4,24} unionized home care workers in this study experienced irregular earnings, job insecurity, and limited social wages. Research on the restructuring of home care in Europe suggests that home care workers have experienced work intensification, but do not face job insecurity.⁵⁵ Common OHS issues described by workers in this research are similar to those found in other studies including musculoskeletal disorders,^{7,29,31,32} workplace violence and harassment,^{7,9,12,23,33-35,58,59} a lack of risk assessment,⁷ problematic access to workers' compensation,⁷ and potential or actual vehicle accidents.^{7,36,37}

While there is no other research, that examines home care workers' complex daily E-RGM, a recent study of immigrant workers in the Greater Toronto Area describes the challenges associated with daily extended E-RGM.⁶⁰ Not surprisingly, other precarious workers such as temporary agency workers also experience musculoskeletal disorders, job insecurity, a lack of OHS training and non-compliance, and regulatory oversight.⁸ The next section applies Quinlan and Bohle's PDR model to the study findings in order to make sense of the vulnerability of workers in this kind of situation to injury and illness and includes ways E-RGM contributes to the risks confronting these workers.

Pressure, disorganization and regulatory failure

Interviewed home care workers' experiences suggest they are falling through some significant cracks in provincial, and company health and safety policies and procedures as well as in their collective agreements. Applying Quinlan & Bohle's PDR model can help us see how home care work, as a form of precarious employment that is also associated with complex patterns of E-RGM, working remotely and alone, affects the health and safety of home care

workers, and the related cracks that contribute to their exposures to risk of injury and illness. Home care agencies and workers experience strong economic and reward pressures that influence their OHS. In this study home care agencies faced economic pressures from clients who had the power to decide which agency would provide their home care services. As well, agencies providing subsidized home care services experienced economic pressures from the Department, which rationed the number of hours a client was eligible to receive. While allocations of home care time were supposed to be based on need, need was determined using neoliberal policies¹⁶ that dictated that home care services were a supplement to unpaid family care.^{46,47} This policy framework contributes to the spatial and temporal fragmentation of home care work and forces workers to engage in often complex, daily patterns of E-RGM associated with split shifts. It also contributes to long working days, irregular hours, transient workplaces, and work intensification. Conversely, NL community nurses also travel to clients' homes but their work schedules are very different from those of most home care workers. According to a key informant, at the time of the study, community nurses worked Monday to Friday from 8:30 a.m. to 4:30 p.m., received mileage, and were paid to travel between clients' homes. Unlike home care workers, these community nurses had autonomy and decided the order of clients to visit during their workday. This disparity in treatment between home care workers and community nurses may result from the community nurses' better collective agreement and may also be attributable to their professional status.

Economic pressures help explain why home care workers take risks and don't always report harassment; they are concerned they might end up unemployed/underemployed for an indeterminate period if they report a problem and, as a result, lose a client. But, home care workers also took risks because they were emotionally attached to their clients. The outsourcing

of caring work from an institution to a client's home has OHS consequences that are gendered.⁶¹ Caregivers forced to choose between their own health and the health of a client may place the client's health ahead of their own OHS, especially in times of public cutbacks.⁶¹

Home care agencies in NL described economic pressures as wages rose more quickly than government subsidies for home care services and this increased the disorganization of home care work because some agencies decreased supervision and training of workers. Further, home care workers' lack of information about clients is another indication of the disorganization of work that may contribute to injury risk by placing home care workers in unsafe working environments. In this study, it seemed as though home care workers were not fully aware of their rights and given their isolated workplaces and complex E-RGM most home care workers did not speak to their fellow workers.

In this study, non-compliance by home care agencies with the OHS Act and the lack of workplace safety inspections by the government are evidence of regulatory failure. The *Newfoundland and Labrador OHS Regulations* sets out policies to protect workers and outlines employers' and employees' responsibilities for workplace safety. The *OHS Regulation 5/12 Section 15, Working Alone*, requires employers to do a risk assessment of the workplace to reduce health and safety risks associated with working in isolated and transient workplaces.⁴⁹ According to the *Working Alone Safety Guidelines*, employers should develop a standard safety awareness checklist to give employees to help them evaluate their risk.⁵⁰ None of the home care representatives interviewed talked about the recommendations outlined in the *Working Alone Safety Guidelines*. Furthermore, getting employees to evaluate their risk shifts the assessment responsibility to the worker and may place the worker in a potentially unsafe workplace during the assessment. It would be better to have both the supervisor and the home care worker

complete the safety awareness checklist together at the worksite before the first shift in order to ensure the workplace is safe. The *Working Alone Safety Guidelines* also suggest that employers develop a safe visit plan to track the safety of the worker when working at a client's premises. The safe visit plan entails using an active communication system, or employing two workers so that one worker is not alone, but these strategies require additional funding. Unless the Regional Health Authority pays for two workers to be present while caring for a violent client, it is unlikely that a home care agency will use this strategy. Supplying home care workers with smart phones that track their actual location and provide the information about the client may be an option, but home care agencies may be unwilling to invest in these phones. Employers were not directly asked if they followed the *Working Alone Safety Guidelines*, but interviews with home care workers and home care agency representatives suggested that they did not.

While the PDR model is useful for understanding how precarious work undermines OHS, improvements to labour standards and collective agreements could help to address the elements of the PDR model that contribute to risk. Currently, these collective agreements offer home care workers better working conditions than outlined in the Labour Standards Act by improving the hourly wage and offering better social wages. There are two ways the collective agreement and Labour Standards Act could be improved. Workers should be compensated for travel and wait time when traveling between workplaces and the minimum shift hours should be increased to reduce unpaid time between shifts. Also, collective agreements may be a mechanism to improve the health and safety of home care workers.

The collective agreements reviewed for this study required employers to take immediate action when an employee's safety is at risk. Most home care workers indicated that when they had told their employer about violent or aggressive clients they had been removed from these

dangerous environments but removal could result in unemployment or underemployment for workers until another client is found.

E-RGM and precarious employment may intersect to affect health and safety. For example, a home care worker caring for one client may not experience stress-related time constraints, nor the stress, uncertainty and unfamiliarity of hazards associated with working with new clients in changing workplaces. Conversely, home care workers caring for one client may be more likely to put up with harassment for longer periods of time because of the fear of losing their job or having to shift to multiple clients, transient worksites, additionally causing employment and income insecurity.

There are many similarities between this study and a recently published study by Quinlan et al. on Australian home care workers.⁷ For example, both exploratory studies reveal that home care workers' duties extend beyond caring for seniors and adults with disabilities to include work with youth. Both studies document the intersecting factors of economic and reward pressure, disorganization of work and regulatory failure. While Quinlan et al.'s 2015 study uses the PDR model and identifies OHS challenges related to working in private homes and transport issues, this study adds to the literature by identifying the importance of E-RGM and collective agreements for home care workers' OHS.

Conclusion

In this study home care workers experienced work-related health and safety issues related to three aspects of E-RGM: commuting and traveling between workplaces (traveling in severe weather and while exhausted); working alone in private homes (violence, harassment and

musculoskeletal disorders); and, being mobile workers in transient workplaces remote from their employer's office (unknown risks about clients and workplace, and stress related to client care).

Government and home care agency policies are not protecting this vulnerable group of predominantly female workers. Some policy recommendations that could help reduce the work-related health and safety risks of this workforce include: 1) ensuring that workers are eligible for compensation for injuries that occur during travel between workplaces; 2) requiring all home care agency employers whose employees work alone to follow the *Working Alone Safely Guidelines* and thus develop a safe visit plan and a standard safety awareness checklist. Home care agencies can reduce the risk of injury or illness by providing ample paid OHS training opportunities and adequate supervision of workers, by conducting safety assessments with workers when they start working with a new client or if a client's condition changes substantially, and by disclosing the client's behavioural problems and contagious diseases to the workers.

The home care workers in this research were recently unionized by a large provincial union that is more familiar with negotiating contracts for industrial and government workers who are generally located in one central and fixed workplace. Two recommendations for improving the health and safety of home care workers are to include in upcoming collective agreements a requirement for companies to carry out an on-site, risk assessment of home care clients and their homes that involves both the home care worker and the home care representative in the assessment, and implementing effective protections against reprisals to ensure workers are able to complain about unsafe working conditions without losing hours or their job. One home care worker did not know what union she belonged to and a few interviewed workers were unfamiliar with their collective agreement. It is unclear how workers who work alone in transient and

remote workplace would be able to communicate their OHS concerns to their union representative on the joint OHS committee. Active union engagement is crucial to improving health and safety of home care workers.

This study has two limitations. Firstly, the findings of this study cannot be generalized to all unionized home care workers in NL due to the small sample size. Secondly, I do not know what proportion of home care workers in NL are unionized because home care workers are employed by unionized and nonunionized home care agencies, as well as employed directly by the client. One might suppose that unionized home care workers will have better-working conditions and less health and safety issues than nonunionized home care workers. But, the union in this study is still trying to negotiate the difficult terrain of organizing home care workers employed at individual private agencies, and addressing the unique needs of these mobile and isolated workers. Still, this research identifies three areas for further research: how OHS in home care work is affected by mobility; a comparative study of urban/rural home care workers' OHS concerns; and, home care workers' knowledge of their employment and health and safety rights, and managers' knowledge of their obligations.

Home care workers are a vulnerable group of workers who provide an essential service to the healthcare system. Their health and safety should be a priority for employers, union representatives, and policy makers at all levels of government.

References

1. Aronson J and Neysmith SM. "You're not just in there to do the work" Depersonalizing policies and the exploitation of home care workers' labor. *Gender and Society* 1996; 10 (1): 59-77.

2. Roseman S, Neis B and Barber PG. Towards a feminist theoretical framework for analyzing employment-related geographical mobility. *Studies in Political Economy* in press.
3. Armstrong P, Armstrong H and Scott-Dixon K. *Critical to care: The invisible women in health services*. Toronto: University of Toronto Press, 2008.
4. Armstrong P and Laxer K. *Precarious work, privatization, and the health-care industry: The case of ancillary workers*. Montreal: McGill-Queen's University Press, 2006.
5. Armstrong P. Relocating care: Home care in Ontario. In: Morrow M, Hankivsky O, Varcoe C. (eds) *Women's health in Canada: Critical perspectives on theory and policy*. Toronto: University of Toronto Press, 2007: 528-553.
6. Sharman Z, Tigar McLaren A, Cohen M and Ostry A. "We only own the hours": Discontinuity of care in the British Columbia home support system. *Canadian Journal on Aging* 2008; 27 (1): 89-99.
7. Quinlan M, Bohle P and Rawlings-Way O. Health and safety of homecare workers engaged by temporary employment agencies. *Journal of Industrial Relations* 2015; 57 (1): 94-114.
8. Underhill E and Quinlan M. How precarious employment affects health and safety at work: The case of temporary agency workers. *Industrial Relations* 2011; 66 (3): 397-421.
9. Quinlan M and Bohle P. Under pressure, out of control or home alone? Reviewing research and policy debates on the occupational health and safety effects of outsourcing and home-based work. *International Journal of Health Services* 2008; 38 (3): 489-523.
10. Cloutier E, David H, Ledoux E, Bourdouxhe M, Gagnon I and Ouellet F. Effects of government policies on the work of home care personnel and their occupational health and safety. *Work* 2008; 30 (4).

11. Cloutier E, Ledoux H, Bourdouxhe M, David H and Ouellet F. Restructuring of the Quebec health network and its effects on the profession of home health aides and their occupational health and safety. *New Solutions: A Journal of Environmental and Occupational Health Policy* 2007; 17 (1-2): 83-95.
12. Denton M, Zeytinoglu IU, Webb S and Lian J. Occupational health issues among employees of home care agencies. *Canadian Journal on Aging* 1998; 18 (2): 154-179.
13. Zeytinoglu IU, Denton M, Webb S and Lian J. Self-reported musculoskeletal disorders among visiting and office home care workers. *Women and Health* 2001; 31 (2-3): 1-35.
14. Hanley J, Premji S, Messing K and Lippel K. Action research for the health and safety of domestic workers in Montreal: Using numbers to tell stories and effect change. *New Solutions* 2010; 20 (4): 421-439.
15. Tarricone R and Tsouros AD. The solid facts: Home care in Europe. 2008
http://www.uquebec.ca/observgo/fichiers/60612_E91884.pdf. Viewed 10 July, 2015.
16. Armstrong P and Armstrong H. Women privatization and health care reform: The Ontario case. In: Armstrong P, Amaratunga C, Bernier J, Grant K, Pederson A and Willson K. *Exposing Privatization: Women and health care reforms in Canada*. Aurora, Ontario: Garamond Press, 2001.
17. Denton M, Zeytinoglu IU, Davies S and Lian J. Job stress and job dissatisfaction of home care workers in the context of health care restructuring. *International Journal of Health Services* 2002; 32 (2): 327-357.
18. Oxman-Martinez J, Hanley J and Cheung L. Another look at the live-in caregiver program: An analysis of an action research survey conducted by PINAY, the Quebec Filipino Women's Association with the Centre for Applied Family Studies. 2004;IM No. 24

http://s3.amazonaws.com/migrants_heroku_production/datas/198/Oxman-

[Martinez_Hanley_Cheung_2004_original.pdf?1312424790](http://s3.amazonaws.com/migrants_heroku_production/datas/198/Oxman-Martinez_Hanley_Cheung_2004_original.pdf?1312424790). Viewed 10 July, 2015.

19. Pittman T. The living and working conditions of live-in caregiving program workers in Newfoundland and Labrador. 2012. (unpublished).
20. Lewchuk W, de Wolff A, King A and Polanyi M. The hidden costs of precarious employment: Health and the employment relationship. In: Vosko LF (ed) Precarious employment: Understanding labour market insecurity in Canada. Montreal: McGill-Queen's University Press, 2006: 141-162.
21. Temple-Newhook J, Neis B, Jackson L, Roseman S, Romanow P and Vincent C. Employment-related mobility and the health of workers, families, and communities: The Canadian context. *Labour/Le Travail* 2011; 67 (Spring): 121-156.
22. MacDonald M. Spatial dimensions of gendered precariousness: Challenges for comparative analysis. In: Vosko, LF, MacDonald M and Campbell I. (eds) *Gender and the contours of precarious employment* London: Routledge, 2009.
23. Hanson GC, Perrin NA, Moss H, Laharnar N and Glass N. Workplace violence against homecare workers and its relationship with workers health outcomes: a cross-sectional study. *BMC Public Health* 2015; 15 (11): 1-13.
24. Cohen M, McLaren A, Sharman Z, Murray S, Hughes M and Ostry A. From support to isolation: The high costs of BC's declining home support services. 2006.
http://www.heu.org/sites/default/files/uploads/support_to_isolation_1.pdf. Viewed 10 May 2015.

25. Denton M, Zeytinoglu IU and Davies S. Organizational change and the health and well-being of home care workers. 2003; SEDAP Paper No. 110
<http://socserv.mcmaster.ca/sedap/p/sedap110.pdf> Viewed 10 July, 2015.
26. Zeytinoglu IU and Denton M. Satisfied workers, retained workers: Effects of work and work environment on homecare workers' job satisfaction, stress, physical health, and retention. 2005. http://www.cfhi-fcass.ca/Migrated/PDF/ResearchReports/OGC/zeytinoglu_final.pdf. Viewed 10 July, 2015.
27. Lippel K and Walters D. Employment related geographic mobility and occupational health and safety policy. 2014; December 15, 2014. (unpublished).
28. Quinn MM, Markkanen PK, Galligan CJ, Sama SR, Kriebel D, Gore RJ, Brouillette NM, Okyere D, Sun C, Punnett L, Laramie AK and Davis L. Occupational health of home care aides: Results of a safe home care survey. *Occupational and Environmental Medicine* 2015; doi: 10.1136/oemed-2015-103031: 1-9.
29. Meyer J and Muntaner C. Injuries in home health care workers: An analysis of occupational morbidity from a state compensation database. *American Journal of Industrial Medicine* 1999; 35 (3): 295-301.
30. Ono Y, Lagerstrom M, Hagberg M, Linden A and Malker B. Reports of work related musculoskeletal injury among home care service workers compared with nursery school workers and the general population of employed women in Sweden. *Occupational and Environmental Medicine* 1995; 52 (10): 686-693.
31. Hannerz H and Tuchsén F. Hospitalizations among female home-helpers in Denmark 1981-1997. *American Journal of Industrial Medicine* 2002; 41: 1-10.

32. Johansson J. Psychosocial work factors, physical work load and associated musculoskeletal symptoms among home care workers. *Scandinavian Journal of Psychology* 1995; 36 (2): 113-129.
33. Barling J and Rogers A. Behind closed doors: In-home workers' experiences of sexual harassment and workplace violence. *Journal of Occupational Health Psychology* 2001; 6 (3): 255-269.
34. Geiger-Brown J, Muntaner C, McPhaul K, Lipscomb J and Trinkoff A. Abuse and violence during home care work as a predictor of worker depression. *Home Health Care Services Quarterly* 2007; 26 (1): 59-77.
35. Sharipova M, Borg V and Hogh A. Prevalence, seriousness, and reporting of work-related violence in the Danish elder care. *Scandinavian Journal of Caring Science* 2008; 22 (4): 574-581.
36. Craven C, Byrne K, Sims-Gould J and Martin-Mathews A. Types and patterns of safety concerns in home care: staff perceptions. *International Journal for Quality in Health Care* 2012; 24 (5): 525-531.
37. Sims-Gould J, Byrne K, Beck C and Martin-Matthews A. Workers' experiences of crises in the delivery of home support services to older clients: A qualitative study. *Journal of Applied Gerontology* 2013; 32 (1): 31-50.
38. Bernstein S, Lippel K and Lamarche L. Women and homework: The Canadian legislative framework. 2001 . <http://www.publications.gc.ca/collections/Collection/SW21-55-2000E.pdf>. Viewed 10 July, 2015.
39. Cheung K. Close calls for low-back injuries. *The Canadian Nurse* 1999; 7: 47-50.

40. Fudge J. Global care chains, employment agencies, and the conundrum of jurisdiction: Decent work for domestic workers in Canada. *Canadian Journal of Women and the Law* 2011; 23 (1): 235-264.
41. Quinlan M, Mayhew C and Bohle P. The global expansion of precarious employment, work disorganisation, and consequences for occupational health: A review of recent research. *International Journal of Health Services* 2001; 31 (2): 335-414.
42. Quinlan M and Bohle P. Overstretched and unreciprocated commitment: Reviewing research on the occupational health and safety of downsizing and job insecurity. *International Journal of Health Services* 2009; 39 (1): 1-44.
43. Botting I, Neis B, Kealey L and Solberg S. Health restructuring and privatization from women's perspectives in Newfoundland and Labrador. In: Armstrong P, Amaratunga C, Bernier J and Grant K. (eds) *Exposing privatization: Women and health care reform in Canada*. 2001: 49-94.
44. Kelly M. Women, home care and social change in a rural Newfoundland community. 2005. [Master of Arts thesis]. St. John's: Memorial University of Newfoundland, 2005.
45. Morris M, Robinson J, Simpson J, Galey S, Kirby S and Martin L. The changing nature of home care and its impact on women's vulnerability to poverty. Ottawa: Status of Women Cat. no. SW21-42/1999E; 1999.
46. Government of Newfoundland and Labrador Department of Health and Community Services. Provincial home support program operational standards. 2005.
http://www.health.gov.nl.ca/health/publications/home_support_manual.pdf. Viewed 10 July, 2015.

47. Government of Newfoundland and Labrador Department of Health and Community Services.
Close to home: A strategy for long term care and community support services. 2012.
http://www.health.gov.nl.ca/health/long_term_care/ltc_plan.pdf. Viewed 10 July, 2015.
48. Government of Newfoundland and Labrador. Workplace Health Safety and Compensation Act, RSNL 1990, Chapter W-11. <http://www.assembly.nl.ca/legislation/sr/statutes/w11.htm>. Viewed 10 July, 2015.
49. Government of Newfoundland and Labrador. Newfoundland and Labrador Regulation 5/12: Occupational Health and Safety Regulations, 2012 under the Occupational Health and Safety Act. 2012. <http://assembly.nl.ca/Legislation/sr/Regulations/rc120005.htm>. Viewed 10 July, 2015.
50. Government of Newfoundland and Labrador. Working Alone Safely. 2014.
http://www.servicenl.gov.nl.ca/ohs/safety_info/si_working_alone.htm. Viewed 10 July, 2015.
51. Government of Newfoundland and Labrador. Occupational Health and Safety Act. RSNL 1990 O-3. <http://www.assembly.nl.ca/Legislation/sr/statutes/o03.htm>. Viewed 10 July, 2015.
52. Government of Newfoundland and Labrador. Labour Standards Regulations, Consolidated Newfoundland Regulation 1996.
<http://www.assembly.nl.ca/legislation/sr/annualregs/CNR1996/Cr960781.htm>. Viewed 10 July, 2015.
53. Larsson A, Karlqvist L, Westerberg M and Gard G. Perceptions of health and risk management among home care workers in Sweden. *Physical Therapy Reviews* 2013; 18 (5): 336-343.

54. Delp L, Wallace S, Geiger-Brown J and Muntaner C. Job stress and job satisfaction: Home care workers in a consumer-directed model of care. *Health Services Research* 2010; 45 (4): 922-940.
55. Doniol-Shaw G and Lada E. Work schedules of home care workers for the elderly in France: Fragmented work, deteriorating quality of care, detrimental health impact. *Work* 2011; 40: S31-S46.
56. Workplace Health Safety and Compensation Commission. Client Services Policy Manual Newfoundland and Labrador Chapter 19: Entitlement.
<http://www.whscc.nl.ca/policiesandprocedures.whscc> (EN 19). Viewed 25 September, 2015.
57. Registered Nurses Union Newfoundland and Labrador Collective Agreement. 2014
<http://www.rnunl.ca/uploads/file/NLNU%20-%202012-2016,%20Provincial%20Agreement.pdf>. Viewed 10 July, 2015.
58. Menckel E and Viitasara E. Threats and violence in Swedish care and welfare - magnitude of the problem and impact on municipal personnel. *Scandinavian Journal of Caring Science* 2002: 376-385.
59. Viitasara E, Sverke M and Menckel E. Multiple risk factors for violence to seven occupational groups in the Swedish caring sector. *Relations industrielles/Industrial Relations* 2003; 58 (2): 203-231.
60. Premji S. Health impacts of work-related geographical mobility among precariously employed immigrants in Toronto. Paper presented at: Canadian Association for Research on Work and Health, 2014 October 19-22, Saskatoon, Canada.

61. Lippel K and Messing K. A gender perspective on work, regulation, and their effects on women's health, safety and well-being. In: Nichols T and Walters D. (eds.) *Safety or profit? International studies in governance, change and the work environment*. Amityville, New York: Baywood Publishing Company, Inc.; 2013: 33-48.