

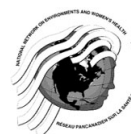
# **BURNED OUT AND TIRED:**



## **THE IMPACT OF RESTRUCTURING AND WORK REORGANIZATION ON WORKERS IN LONG TERM CARE**

By Pat Armstrong and Irene Jansen with the assistance of Erin Connell and Mavis Jones  
**February 2004**

National Networks on Environments in Women's Health  
Canadian Union of Public Employees



---

This project was funded by the National Network on Environments and Women's Health (NNEWH). NNEWH is financially supported by the Centre of Excellence for Women's Health Program, Women's Health Bureau, Health Canada. The views expressed herein do not necessarily represent the views of NNEWH or the official policy of Health Canada

Pat Armstrong is currently Canadian Health Services Research Foundation/Canadian Institutes of Health Research Chair in Health Services and Nursing Research at York University in Toronto. At the time this study was conducted she was Chair of the School of Canadian Studies at Carleton University in Ottawa.

Irene Jansen is currently a Senior Officer in the Union Development Department at the Canadian Union of Public Employees in Ottawa. At the time this study was conducted, she was a researcher at the Hospital Employees' Union, CUPE's Health Care Division, in British Columbia.

Erin Connell is a graduate student in Sociology at Carleton University.

Mavis Jones is a graduate student at Simon Fraser University.

For more information on this study, contact Pat Armstrong at (416) 736-2100 or Irene Jansen at (613) 237-1590.

---

# Table of Contents

---

<b>Introduction</b>	1
Long Term Care: Transforming Conditions	2
Downloading	2
Reorganization	3
<b>Missing Women: Occupational Health Hazards</b>	7
No Sex Please; We're workers	7
Gendered Analysis	8
Methodology	10
Identifying Health Issues	12
Workload	12
Training	18
Shifts and Scheduling	20
Control and the Right to Care	21
The Long Arm of the Job	27
Insecurity	30
Social Relations	31
Violence	34
Physical Space and Physical Demands	36
Because You're a Woman	39
Conflicting Interests	40
Similarities and Differences	41
<b>Conclusions</b>	43
<b>Policy and Research Implications</b>	45
Government policy in long term care	45
Workers' Compensation	45
Workplace Health and Safety Committees	46
Research	46
<b>Appendix I</b>	47
<b>Endnotes</b>	51

---

# Introduction



Health care work is hazardous. Across Canada, those employed in health and social services lose more work time due to illness than any other employees.<sup>1</sup> According to the Workers' Compensation Board of BC, "the health care industry is associated with more days lost per claim and a higher injury rate than the provincial average for all BC industries combined". Practical nurses, aides and orderlies are particularly at risk.<sup>2</sup> Given that over 80 per cent of health care employees are women, given the tendency to see women's work as clean and safe and given the restricted definitions of injury, such figures may understate the health impact of working in care delivery.<sup>3</sup> Moreover, recent reforms and demographic changes have altered conditions in health care institutions, especially in long term care facilities, in ways that may well increase the risks. It is these two issues; namely the invisibility of hazards in women's health care work and the health impact of changes in long term care, that are the focus of the research set out below. The objective is to help point to the gaps in knowledge about and recognition of the health hazards women face under changing conditions in long term care.

The focus of this research is long term care facilities in Ontario and British Columbia, two provinces that differ to some degree in their approach to both health care reforms and Worker's Compensation.<sup>4</sup> Our interest is in the full range of employees who work in these institutions, most of whom regard themselves as care providers whatever their official occupational title. Conducted jointly by partners in the National Network on Environments and Women's Health and funded through that Centre of Excellence program, the project was designed to bring together perspectives from an academic at York University and a researcher from the Canadian Union of Public Employees, along with those from the union members who do the work in these facilities and from graduate students in the universities. The primary research is based on group interviews with 40 health care providers in BC and Ontario, and then confirmed with another 40 providers in these provinces. Those participating in the interviews included a wide range of workers in long term care.

The report begins with an outline of changes in long term care and the approaches to women's workplace health hazards, setting the stage for the analysis of the interviews that provide the basis for recommendations on data collection and policy.

## Long Term Care: Transforming Conditions

### Downloading

“On October 4, 1998, Calgary’s Bow Valley Health Centre, a city hospital, blew up”. Thus begins the Canadian Institute for Health Information report on *Health Care In Canada 2000*<sup>5</sup>, a report that signals just one of the reforms that leave the context for work in long term care dramatically changed. The report goes on to say that:

Over the last decade, the number of hospital beds, the number of admissions and the length of hospital stays have dropped, year after year. Compared to 1984/85, hospitals in 1997/98 had about 25% fewer beds<sup>6</sup>

Although the closure of B.C.’s Shaughnessy Hospital in 1992 was the first indication of things to come, Ontario then had the lowest hospital patient days to population ratio. The ratio was over 20% lower than that of British Columbia, the next lowest jurisdiction.<sup>7</sup> Since then, British Columbia has continued to reduce utilization rates but not to close major hospitals. In Ontario, however, 33 public hospitals have been slated for closure, along with six psychiatric hospitals and six private hospitals.<sup>8</sup> Over the last decade, Ontario has reduced the number of acute care beds by 36%; more than either the national average or B.C.<sup>9</sup>

This huge reduction in hospital beds can be partly explained in terms of what the Canadian Institute for Health Information describes as “the inappropriate use of acute care beds for long-term stay patients”.<sup>10</sup> Hospitals have been redefined to include only the most short-term and interventionist treatment for both acute care and psychiatric patients. Patients once treated in hospitals have been downloaded into long term care facilities and many of the kinds of patients once residing in long term care facilities are now living somewhere else. The result is a very different kind and mix of patients in long term care, and a higher death rate among residents.<sup>11</sup> It is difficult, however, to determine the extent of change because most of the research on the consequences of reforms has concentrated on hospitals and homes.

The shift to long term care facilities is not surprising for at least two major reasons. First, the Canada Health Act clearly prohibits charges for any necessary services in hospitals, including room, board and supplies but there is no similar prohibition in long term care. Thus, moving care from hospitals to long term care facilities reduces government costs because fees can be charged for at least part of the services. Second, care is cheaper in long term facilities. It is cheaper in part because people are assumed to require fewer hours of care, because they are assumed to require less skilled care and because those who provide the care are often paid less than those in hospitals. The difference is clearly evident in the earnings data. The average weekly earnings, including overtime, in institutional health and social services other than hospitals was \$466.63 in 1999 com-



pared to \$598.21 in hospitals.<sup>12</sup> The differences may well be smaller in British Columbia where care aides and Licenced Practical Nurses make the same wage regardless of location but overall wage packages are still lower in long term care.

However, long term care facilities have for the most part been structured on the assumption that such facilities are providing custodial and supportive services rather than medical and treatment ones. Both the facilities and the caregivers date from this earlier time and earlier patient load. The demands on the workers' time and skills have thus changed significantly even if the number of people cared for has not.<sup>13</sup> And facilities may not be up to the task.

## Reorganization

Long term care facilities may be operated by private for-profit or not-for-profit organizations, or by local governments. Whatever their ownership, many are heavily subsidized from governments that pay a per diem rate for the health care services provided, theoretically based on the level of acuity. Such rates clearly play a role in what services are provided. Governments also influence conditions through their regulation of the facilities.

In Ontario, more than half the beds are in for-profit facilities and these are increasingly owned by large corporations, many of which are foreign-owned.<sup>14</sup> Ontario is licencing new beds in long term care and is operating an open bidding process that may mean an even higher proportion of beds are operated by for-profit and foreign owned firms. There is very little research in Canada on the consequences of ownership in this area but what is available suggests that for profit companies are more likely to move or close and more likely to reduce care in order to increase profits.<sup>15</sup>

In B.C., only a third of the facilities are owned by for-profit firms. However, restrictions on government spending for new beds, combined with the promotion of public-private partnerships, threaten to increase the role of for-profit firms. A recent report from the U.S. Department of Health and Human Services found that "staffing levels were much higher at non-profit nursing homes than at for-profit homes", and that the problems were particularly evident in large chains of the sort coming into Canada.<sup>16</sup> Although such changes in ownership may be less visible than blowing up hospitals, the consequences for the health of providers may be equally significant.

Both BC and Ontario have specific Acts and accompanying regulations that govern long term care facilities and Ontario has provincial formulas for funding care.<sup>17</sup> The emphasis in both provincial legal frameworks is on the rights of the residents, with virtually no attention paid to those of the workers. Regulations provide considerable detail on what residents must be provided in terms of physical space, nutrition and supplies. They are much less specific about what kind of care must be provided and what training providers must have. In B.C. for example, the regulations say that "there must be a sufficient number of health care professionals on duty at all times who have appropriate experience and training and qualify to meet the identified needs of the residents".<sup>18</sup>

Ontario did have regulations on minimum hours of care but effective June 1, 1996, the government revoked the requirement that nursing homes provide a minimum of 2.25 nursing hours per resident per day. Instead of requiring a registered nurse be present, the request for bids says that "In most long term care facility settings, at least one registered nurse is on-site for each shift on a 24 hour basis".<sup>19</sup> Meanwhile, the U.S. Department of Health and Human Services is recommending not only a substantial increase in staff in such homes but also a minimum of 2 hours care by a nurses' aide each day for each patient.<sup>20</sup> The absence of care minimums in the context of the changing care needs of residents and changing ownerships may have negative consequences not only for the residents but also for those employed in long term care.

Governments in both provinces seem to leave the protection of employees' health mainly to other statutes and related health and safety committees. In British Columbia, the Workers' Compensation Board is responsible for occupational health and safety while in Ontario there are now separate statutes, the *Workplace Safety and Insurance Act* and the *Occupational Health and Safety Act*. Yet here too there are changes underway that may further limit the capacity of such legislation to address the health of workers. As Katherine Lippel has shown in her extensive research on Worker's Compensation, the emphasis has traditionally been on i) injury and illness that can be "objectively" measured and substantiated by medical experts; ii) injury and illness that can be clearly and causally linked to paid work and not to an individual's personal life; and iii) unusual circumstances.<sup>21</sup>

Yet research has demonstrated the link between "work organization, job control and worker support, and health outcomes such as depression, anxiety, high blood pressure and coronary heart disease". Workers "in high strain jobs have been shown to have higher rates of a wide variety of diseases than their counterparts in low-strain jobs". Nevertheless, provinces have only recently begun to allow claims based on chronic illness or mental stress of the sort created by the changes in long term care. Indeed, Ontario has ignored this research and reversed the move to recognize such workplace-caused illness by restricting mental stress covered under Worker's Compensation to "an acute reaction to a sudden and unexpected traumatic event arising out of and in the course of his or her employment".<sup>22</sup> In spite of the evidence, or perhaps because of it, The *Workplace Safety and Insurance Act* is quite explicit about rejecting work organization, job control, worker support, job strain or job insecurity as an occupational health issue.

The worker is not entitled to benefits for mental stress caused by his or her employer's decision or actions relating to the worker's employment, including a decision to change the work to be performed or the working conditions, to discipline the worker or to terminate employment.<sup>23</sup>

In contrast, the 1999 B.C. Royal Commission's report on Workers' Compensation recommends the recognition of "non-physical conditions arising from non-physical and non-traumatic stimuli or stressors" and that such conditions be compensated. However, the principle is severely restricted by the requirement that there be "clear and convincing evidence" that the condition has "arisen out of and in the course of employment"<sup>24</sup> and that

the stressors leading to the psychological disability are not related solely to generic work processes, such as labour relations issues, disciplinary actions, demotions, layoffs, termination or transfer, when done in good faith and in a lawful and non-discriminatory manner.<sup>25</sup>

Just as Lippel has pointed out, the emphasis remains on a specific kind of evidence that makes claims difficult to establish, a clear link to employment that may be equally difficult to establish and eliminates some factors for compensation even though the evidence indicates they are often work-related illnesses.

Even if Workers' Compensation regulations remained the same in both provinces, the changes in long term care would make them inadequate. Given the explicit rejection in Ontario of mental illness as a basis for claims, Workers' Compensation cannot deal with the consequences for workers' health. Even if B.C. does implement the recommendations of the Royal Commission, there is little room to handle the kinds of health issues the research demonstrates are workplace related.





---

# Missing Women: Occupational Health Hazards

---

Karen Messing presents, in *One-Eyed Science*, an eloquent and comprehensive analysis of both the institution in the research on the health of women workers and of women's workplace health hazards.<sup>26</sup> She identifies two major problems in the research that are of relevance here. First, women have been invisible in the research either because they have not been participants in the research or because the research that does include them fails to analyze the data by sex. Second, when women are included as participants and in the description of the results, the analysis too often fails to recognize the impact of workplace segregation and the specific conditions of women's lives. These problems are particularly evident in research on health care work.

## No Sex Please; We're Workers

In spite of the fact that women now make up nearly half the labour force and the majority of workers in a number of occupations, much of the research on occupational health hazards is about men. This is perhaps not surprising in construction and mining work, given that men dominate these industries. And it may not be surprising that construction, policing and mining have received considerable attention in occupational research, given the high rate of visible injuries. But such research often reflects and perpetuates the notion that men's work is dangerous, especially in contrast to women's work. Moreover, this research may provide the basis for policy in areas such as Workers' Compensation that recognizes only the kinds of injuries common in male work. Thus men who fall in a construction project are much more likely to be fully compensated while women with migraines caused by the excessive workloads and the stress of working without social support in caring for dying patients is not. Indeed, any chronic illness resulting from continuous conditions in health care workplaces is unlikely to be recognized by compensation.

Even according to these criteria for injuries and illness, however, health care work is clearly dangerous. In 1998, the number of recognized accidents reported by Workers' Compensation in Ontario was only slightly lower in health care than it was in construction. And in BC the number of days lost from injuries was higher in health care than in construction.<sup>27</sup> With different criteria - criteria based on women's work - the rate may have been significantly higher.

While the absence of women in research on construction work may be understandable, it is more surprising in the famous Whitehall Studies that revealed how white collar work could be particularly stressful and health damaging for those at the bottom of the hierarchy with the least control over their work.<sup>28</sup> Although women are more likely than men to do such work, the more than ten thousand British civil servants involved in the study were all men. The failure to include women here can mean either that it is assumed that women experience job stress in ways that are the same as men or that women do not face such stress at all.

When women are included in studies and when the data is broken down by sex, important similarities and differences emerge. An analysis of 1994-95 population health data found “more women reported high work stress compared with men at all age groups and education groups”.<sup>29</sup> Women reported less job control and less support from co-workers than did men. While men in administrative and professional jobs reported low work stress, women in such jobs reported both higher levels of job strain and of physical demands.<sup>30</sup> Such findings suggest that research done on men cannot be generalized to women even in the same occupational categories.

## Gendered Analysis

While it is important to analyze and collect data by sex, it is not enough to reveal the nature and extent of workplace health hazards women face. Both the methods used to collect data and those used to analyze results must take the specific locations, perspectives and needs of women into account. Research needs to begin by recognizing that women and men do different work in different workplaces and that they often bring with them different ideas about the work they do. Moreover, as the research on job evaluation in particular has made clear,<sup>31</sup> women frequently understand words and concepts in ways that are different from men. Surveys and research methods standardized on and developed for men may miss or misrepresent women’s work. Assumptions about women may influence the structure of the questions, the collection of data and the analysis of the results.

Long term care provides a useful example of the need for gender-based analysis. Health care is women’s work. More than four out of five of the people who do such work are women, and more than one in ten women work in health care. The proportion of women is even higher in long term care.<sup>32</sup> Especially in long term care, many of the skills and much of the effort involved are similar to those required in the home and it is too often assumed that women are simply doing what they would naturally do at home. Many of the conditions and demands of work remain invisible in long term care even if some health care work is seen as endangering health in part because it is seen as ‘just’ the same kind of custodial work women do at home.



A recent study in cancer care offers a case in point. The research emphasizes that “doctors, in particular, are feeling the emotional strain of caring for people with the often deadly disease”.<sup>33</sup> The stress for doctors involved in treating this disease seems obvious. Yet it is mainly nurses, almost all of whom are women, who spend the most time with those dying of cancer and who are most often there at the death. And, in long term care facilities, virtually all the patients die, many after long, painful and heartbreaking diseases. Because it is mostly women who are there with them every day and because they are providing care of the sort associated with women at home rather than treatment associated with high technology, the strain is less obvious and less studied than the strain for men.

Similarly, the constancy of demands by a resident who always feels like they have to go to the bathroom combined with another who has not been fed and a third who has just hit you may simply seem like running a household full of children. They may not seem to provide as much dramatic tension as cancer care. Control issues may also be perceived differently in women’s work, based on the assumption that women do not have the same need to control the pace and nature of their work as do men. Indeed, nursing work has often been described as a labour of love: an act of devotion that implies submission rather than control. Moreover, the women who do the work may feel compelled to make up for the extra demands both because they feel responsible for the people who go without care and because they have learned from an early age to take on such responsibility.<sup>34</sup> In the process, they may hide the real pressures from workloads even while they feel powerless in ways that threaten their health.<sup>35</sup>

Equally important, many of the manifestations of workplace stress may be interpreted as the result of women’s biology or social responsibilities or attitudes, rather than as a consequence of their paid work. So, for example, the fact that the number of women with paid work reporting migraine headaches is triple that of men may be dismissed as a result of biology rather than of workplace demands.<sup>36</sup> Similarly, the strong link between low co-workers support and both psychological distress and increased odds for injury among women may be seen as simply reflecting their social needs rather than their workplace conditions. And the greater work stress levels reported for women in couples with children compared to men in such couples can be interpreted as linked to their domestic work and thus not a workplace issue at all.<sup>37</sup> As a result, it is easier to justify women’s claims for compensation as personal rather than work related and little attention is paid either to workplace conditions or to the impact of the work on domestic life.

Methodologies developed and standardized on male work can also understate or misrepresent women’s work. Direct and multiple choice questions may miss significant aspects of women’s work, in part because they begin with assumptions about the nature of work in goods production or even other service work, and because they use words that make more sense in male workplaces. Moreover, in surveys it is the researcher who determines what is important, leaving out significant aspects that those who actually do the work understand as critical to their health and work.

There are, then, at least two major issues of visibility in research on health hazards in long term care; one related to the changing conditions and the other to female dominated health care work. Both are of concern here.


## Methodology

This project began with a survey of existing research and methods for data collection related to long term care facilities and to the women who work there. Literature from academic, union and government sources was searched. We were particularly interested in literature that investigated the impact of reforms within these facilities and that recognized gender as a critical component in research design.

The purpose of the survey was two fold. First, we sought to determine the range of organizational issues identified as health hazards resulting from changing conditions in long term care facilities. Second, we wanted to assess the methods used in light of critiques put forward by those promoting a gender-based analysis.

The resulting annotated bibliography, printed as a separate document, then provided the basis for the development of an interview schedule. As a result of our literature search, we were particularly interested in changes related to work organization, to workloads, to violence and to household relations. The schedule (Appendix I) was designed as a guide for group interviews; a starting point for discussions that were participatory and that would allow those in the group to identify their own issues. This approach is based on several assumptions. First, those who do the work are in the best position to describe how, and under what conditions, that work is done. Two, group discussions allow people to stimulate each other in their thinking at the same time as they help ensure that the views presented have some resonance with other workers and represent some shared experiences. However, group discussions may also limit what can be asked. Because these were group discussions, we decided not to raise questions in these mixed groups about the impact of, or on, their reproductive capacities, or about sexual harassment, although in retrospect this may have been an issue that we should have raised at the end of the sessions.<sup>38</sup>

Organized with help from the Canadian Union of Public Employees and its B.C. Health care Division, the Hospital Employees' Union, the group interviews included a total of 40 participants and lasted anywhere from two to four hours. These interviews were taped and transcribed with consent forms signed. In addition, another 40 providers engaged in a two hour discussion that followed a brief presentation by Pat Armstrong outlining what the research suggested were the issues. Erin Connell, a graduate student who was part of the research team, recorded detailed notes from this session. All participants were informed about this process and verbally agreed to participate, although consent forms were not required. This session allowed us to explore the ideas raised in the smaller groups, seeking either confirmation or challenges, and to add to the issues that came out of the group discussions.

---

As is the case in the group interviews, all participants are union members who volunteered to participate. Although this means that only unionized institutions were included in this research, it should be noted that this is a highly unionized sector. And although participants were recruited by the union, they were not necessarily union activists and the union staff who did the recruiting were not present at the interviews. Interviews took place in various locations, including unions offices, conference rooms and participants' homes. Participants were free to end the interview at any time, although none of them did. Indeed, many wanted to continue the conversation long after the promised finishing time.

The purpose of the interviews was to have participants identify health issues for women created, or exacerbated by, changes in long term care facilities. It was therefore important to include the entire range of facilities. Participants came from small and large, rural and urban, publicly owned, private for-profit and not-for-profit facilities. Most participants were women, although a few men were included in order to ensure that the groups reflected the actual composition of the work-force in long term care. All participants had at least 5 years experience in long term care facilities and most had more than a decade, an important characteristic given the focus on the impact of reforms.

Those involved were care aides, resident attendants, physio assistants, laundry workers, cooks, housekeepers, personal support workers and Registered Practical Nurses or Licensed Practical Nurses\*. In other words, they covered the full range of providers in long term care facilities, with the exception of Registered Nurses. RNs are a small minority of those employed in long term care and they are not, for the most part, members of the Canadian Union of Public Employees. The concerns of RNs are clearly important and may be different in some respects given their location near the top of the long term care hierarchy. Only additional research would reveal the extent to which they share issues with the range of workers interviewed here.

The analysis of these interviews, presented in the next section, forms the basis for the policy advice offered in the conclusions. Before preparing the final draft, we went back to some providers to get their feedback on what we had missed, what they thought we had captured appropriately, and what we had misrepresented. As was the case with the bibliography, there is a dual purpose: to identify issues and methods not only for academic research but also for practices in worker's compensation, health and safety, and in government policy making.

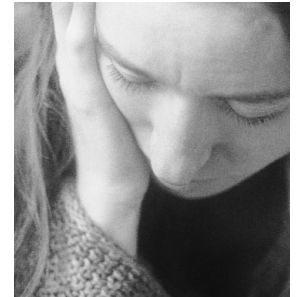
---

\* In Ontario, the term Registered Nursing Assistant has been used while in B.C. the term is Licenced Practical Nurse.

## Identifying Health Issues

### Workload

Workload has long been recognized in the research as a health issue.<sup>39</sup> However, increases in health care workloads are often less visible than those in goods production or in many other forms of service delivery.<sup>40</sup> This invisibility, in part at least, is related to women's dominance of health care work and to the traditional association of such work with women. The skills and effort involved in caring work are often hard to see and even harder to measure with commonly used techniques, especially given many assumptions about caring labour and its association with domestic work. Workload increases may also be less visible because they happen over time, allowing people to adjust, and because they happen in multiple small ways rather than in sudden changes in production processes. Women may also work hard to compensate for the caring deficit because they do not want the patients to suffer. As a result, both the increases in workloads and their consequences can remain unrecorded in official calculations of workplace health.



#### **Increases Through Changes in Staff/Patient Ratios.**

The most obvious form of workload increase, and one identified by everyone interviewed, is the reduction in staff to patient ratio. Although all those participating in this study reported increases in workload, there was considerable variation in the extent of the increase, both within and between provinces. There was general agreement, however, that workloads increased less in not-for-profit workplaces, and estimates of increases were consistently higher in Ontario than in B.C.

The appearance of greater reductions of Ontario staff is not surprising, given that the provincial government has removed the regulation requiring a minimum of 2.5 hours per day of care per patient. According to those we interviewed, long term care facilities have taken advantage of this reduction in "red tape" to increase significantly the number of patients cared for by each provider. For example, a health care aide had been responsible for five residents in her four hour shift but now must care for 10 residents in that same time period.

And that's not only dressing them. That's going in the morning, that's getting them up, that's feeding them breakfast and doing their care for the day before you go home.

To get 40 hours of work, these providers must work 10 four hour shifts within a seven day period. Another aide reported that after 8:30 at night, there are only five of them to look after 46 residents. Yet another described how they put condom catheters on most of the male residents at night because there are only four providers for 75 residents. It is not only night or short shifts that have been affected.

If they would give us back the 2.5 hours per day. We've lost two people on days alone. We used to have 12 on the floor. Now we have 10. And those two people, one at each end, makes a hell of a difference.

In B.C., the staff reductions may take the form of eliminating entire job categories such as bed-making. The increases in workloads take a toll, according to an Ontario aide. "So people are getting run-down. People are getting sick." In B.C., more than one RPN said, "I'm off on stress leave for 3 months because of it, because I've had enough."

### **Increases Through Non-replacement of Absent Staff**

Workloads also increase when staff who are sick or absent for work-related reasons are not replaced. In B.C., when attendants take patients for medical appointments, there is no one to replace them on the floor. One Ontario institution worked 57 shifts short-staffed in July alone. "If you're on short, they won't call in anybody. Or say, if two people called in [sick], they will pay time and a half for one person to come in, but they won't pay for two." These providers linked the short-staffing directly to the pressure to make money in this for-profit facility. One result, they say, is "too many injuries", injuries sometimes made visible by fines employers pay to workers' compensation programs. As more than one worker said:

We had a lot of people on Workers' Compensation. They don't seem to realize, the more you work short, the more people are calling in or their back is hurting

### **Increases Created by a Shortage of Providers**

Even if the employer is willing to call in casual or part-time staff to replace absent workers, there is no guarantee that they will find providers willing and able to work. Those interviewed offered their reasons for this shortage. First, full-time workers are far too exhausted from their increased workloads or their regular shifts to take on extra work. Second, part time or casual employees are already doing two or three jobs and thus have neither the time nor the energy to fill in the gaps. And third, others not fully employed are off on sick leave or are too "fed-up" to continue as care providers.

### **Increases Created by Unprepared Replacements**

In the view of Ontario workers, not all programs designed to fill the gaps are useful. According to one participant, new government policies are pushing people into care work.

We have people that shouldn't be there. I blame that on the government because the health care aide and the PSW [personal service worker] courses are ones that mother's allowance covers, unemployment insurance covers. And if you don't fit in the computer course, "well we'll throw you in the health care aide course." And a lot of them are not suited.

Another added, "Some thought they were actually going to be somebody's companion. We have a lot of them."

Ontario interviewees also pointed to workfare programs as problematic in these terms. Forced to take work in order to qualify for welfare, the workfare participants often do not have the kind of aptitude required for health care provision. Although the government seems to assume that any woman can do this work, the providers say you need to really want to care for these people if you are going to develop the skills and stamina necessary to provide appropriate care. Many of those there by force "leave crying the first day."

### **Increases Through Reliance on Part-time and Casual Employees**

Equally important, those who are called-in may be unfamiliar with the workplace and the patients. Such substitutes often mean more work for the regular employees, because they have to teach and supervise these new and temporary recruits.

That's another added stress, because you've got to make sure that those residents are taken care of, and if you're working with somebody, you know, who is not fully competent at doing their job, you're backtracking, and checking up on them, which you don't like to do because you're supposed to be able to work with that person. And sometimes there are confrontations right on the floor, when I say look, you did that wrong. "Well, what are you telling me that for? I've been here long enough." "Well, you're a casual, you haven't worked that much." I'm just trying to explain it and that adds a lot of stress.

Reliance on such temporary workers can be disruptive to team work among providers, team work that comes from long years of working together. Moreover, new faces can be disruptive for the residents and create additional work as a result.

Employees in both B.C. and Ontario talked about the increasing reliance on part-time and casual labour, even for regular, daily work. Indeed, those employed at an Ontario for-profit home say that only part-time employees are now hired.



## Increases Through Growing Patient Needs

A less obvious workload increase results from changes in the definitions of care levels and in who is admitted to residential care. In both provinces, significant reduction in acute care beds mean that many people who were once cared for in hospitals are now placed in long term care. Residents who experience acute care problems can no longer count on hospital care. One participant explained that:

The hospitals won't keep people who should be in the hospital. We had someone sent back from ICU the other day right back to the nursing home, right back from ICU.

According to another, "We have people too [that] the nurse will send by ambulance to the hospital and they'll send them right back". As a result, long term care facilities are now providing much more of what was until very recently defined as acute care. Now patients have catheters and colostomies, oxygen masks and IVs. "We never used to have any like that. They weren't allowed to bring them in." But now such complicated care is provided by the same people who did extended care; care that was frequently described as custodial.

The new emphasis on home care also means it is more difficult to get admission to long term care. As a result, those who are admitted require more intensive care.

People are staying home longer. When we get them, they're either a dementia patient or chronic care. We very rarely get what we call a higher functioning resident. Even our high functioning residents are what at one time we may have called the low chronic care residents.

This shift to more chronic and dementia patients is apparent in both provinces. More and more long term care facilities have locked units for psych-geriatric patients or provide care in unlocked floors. This increase in the number of such patients significantly changes the work, as the following exchange makes clear.

C: I have to say I find extended easier than the ones that have dementia [oh yeah intervenes another aide] because, I mean, you can get them ready for bed, you turn around and they're up and dressed or in somebody else's bed, and that is very, very - well, draining.

A: It's draining.

C: It is because you get them all ready, and then you turn around, they're up in somebody else's room or they're waking somebody else up. Whereas in extended you do them, put them in bed and they're there.

A: And they stay there. So personally, I don't find that as difficult.



All interviewees produced examples of the kind of care demands related to psychiatric patients increasingly residing in long term care.

We have some that are like children. Like it's like dealing with a four year old. Like [a female resident], she throws things and screams and cries really loud and goes and punches you, and says she hates you and sticks her tongue out at you.

### **Increases Through Changing Resident Mix**

This shift also means “there’s a lot of men.” “It used to be the opposite. There used to not be that many men. It used to be nearly all women.” “The locked floor is nearly all men.” “They were little old ladies; they were intermediate care grannies” who required levels of support that are now defined as appropriately provided by “home-helpers.” Men are stronger, heavier and more difficult for women providers to deal with, adding yet another source of workload increase. The increase in this kind of workload has been particularly evident in Ontario where many chronic care and psychiatric facilities are being closed.

Not only are more of the patients chronic care and psych-geriatric but more of them are also from a broader age range and experience a wider variety of health problems. In B.C., providers report that “we’re getting people in younger” and more of them are suffering from drug abuse. In Ontario,

with the closures of a lot of programs for younger people, we have tried to integrate them...It’s very difficult. It’s like having one program but you’re running dual activities because they don’t have the same interests. There is nothing in common other than they both require special care. And we even have the developmentally challenged now that they are trying to integrate in with the Alzheimer’s program and that is even more difficult to manage than, say, higher level functioning people that just don’t have common interests, because at least they can understand the differences. You get into Alzheimer people trying to understand the behavior of the developmentally challenged and the developmentally challenged trying to understand that the other has a problem or that they have a problem. So that creates a bit of higher risk. There’s the potential for more outbursts. It puts you in a difficult position because you could constantly be separating people if you have something going on over there...especially at noon time...when they get tired and their tolerances are less, then you have to start separating them because the elderly person is at high risk physically. And they can easily be knocked over.

The B.C. care providers suggest that the stress on both the workers and the residents could be relieved by “more staffing and a better mixing of residents” that would “like, get the dementia together, get the Alzheimer’s together.”

### **Increases Through New Formulas For Care Needs**

What care is necessary for these more varied and dependant patients has also been re-defined and re-calculated. In one Ontario institution, “the auditors come in and they go through the charts of residents and they assess each resident on how much care they need. Our CMI [Case Mix Index] went down 7% which is a total of \$225,000.” The employer’s response was to cut the number of care providers. In addition to the problem of accountants assessing care needs, these aides and RPNs saw a major problem even with nurses doing the calculations when both the formulas for care needs and the timing for assessment of care needs serve to underestimate the care required.” By the time they get the assessments done, it’s for last year...so you’re dealing on last year’s thing when the reality is today...And as a rule, our residents don’t improve.” Moreover, the charts themselves often fail to record behaviors that would justify more complicated care. For example, “we have people that normally hit all the time so to them it’s the norm, so we don’t document.” To write down every incident would be a waste of time. Yet unless recorded hits or other behaviour cannot be included in the formulas for care. Equally important, care categories have been re-defined in ways that underestimate care needs.

Self-care at one time in our facility was you looked after yourself. Now they consider self-care somebody who will still need help dressing, make sure that they’re shaven. If you don’t have to answer a bell, they’re self-care, even if they need help to transfer from chair to toilet.

### **Workload Increases Have Health Consequences**

The consequences of these increases in workloads are multiple but often unrecognized by employers or official data collection services. One result, these providers said, is “too many injuries,” injuries made visible in at least one case by the fine the employer paid to the Worker’s Compensation Board.

We had a lot of people on Worker’s Compensation. They don’t seem to realize the more you work short the more people calling in or their back hurting

Providers scramble to make up for the cutbacks in care time, frequently camouflaging the overall impact of speeding up.

A lot of people get frustrated with themselves because they’re used to leaving at the end of their shift and having everything done so therefore they’ve worked three times as fast or three times as hard to make sure it’s all done. And they still want the same quality. But now you don’t have the time frame or the same amount of people that’s doing it.

An RPN asked

What productivity are they really getting out of you at that level? Probably not a lot. [It would] probably make more sense to hire more people and you would increase everyone's productivity whereas this way, after so many hours, are you really of any value? Are you producing? You can't look after yourself hardly so how can you possibly give any quality care?

Workload alone is not the issue. When workers have control over their work and a sense of accomplishment for a job well done, the workload itself may not be a health problem. As one part-time worker who also farms explained

It doesn't really matter...like with me and farming. I can go from 8 [in the morning] and come in at 9 when it's dark. And come in and sit down and go "whew, that was a good day." It's not the same thing.

The workload is not the same issue when it is combined with other pressures, such as limited control and fear of job loss. With workloads increasing in multiple ways, in a context that leaves providers with little choice, the results may be ill health.

## Training

### Lack of Training for New Patient Needs

Training is also increasingly recognized as a health issue, at least in the research. Like workloads, however, training deficits may be less visible in health care because the skills required are often invisible as a result of their long association with the women who do the work. Caring, feeding, bathing, changing, cleaning and toileting may be seen as unskilled tasks that any woman can do. Similarly, the changes in organizational structure within health care create less visible changes in demands on providers' skills than is the case in much of goods production. Reorganizing an assembly line is more likely to raise clear issues around demands on workers. Yet psychiatric patients require different skills than "intermediate care grannies," and so do those returning quickly from acute care.

What is clear is that training has not been a priority in spite of the major changes in the long term care residents. Provider after provider offered comments very similar to one by a nursing aide in B.C.

We're getting a lot of [dementia patients] which is really starting to bother me because none of us are actually trained for people coming out of [psychiatric care].



This group went on to explain that the only training they had been given was a 40 minute session on how “to get out of holds.”

That’s the only one we had. She did do repeats on that but still, I mean, if somebody comes up behind and grabs you by the back of the hair...So you had one training 10 years ago? I mean, I think by rights there should be updating.

An Ontario provider summed up the situation in four words: “no training, no staffing.” She went on to say that “if you want training you can go on your own or you can request it” but in either case employees lose wages as well as the cost for tuition. Asked about training for colostomies, the response was “the only training we get is from another health care aide.” And RPNs who once had training for such work find their skills are rusty from lack of practice of their acute care skills and outdated by new technologies. Several maintained that, in earlier periods, employers “would pay for the course,” but those days are gone now. Without training, the providers may be risking their own health and that of their residents, many of whom now require quite complicated care.

### **Training That Does Not Fit Current Work Organization**

Several of the providers also raised questions about the nature of training that is available. It does not, in their view, prepare people for current conditions. In school programs students are “assigned one person each” compared to “10 to 12 residents like in the real world.” Time pressures, and cost cutting, leaves only the minimum time for each task. “If you did everything the course said to do - a bed bath, my God you’d be there for an hour.” And there is no longer an hour for bed baths.

As one nursing aide put it, “even with training, it’s sort of like with training for Alzheimer people. All the things you learn are various things you don’t do in actual care.” Part of the problem is that each task is taught as a separate function, while in real life people come with a complex set of problems “You don’t have 40 activities going on at once” in training but you do in long term care. Another problem is the cut back in staff combined with patients requiring more care. What they learn is “not feasible within the workplace” and this too can lead to frustration on the part of those who take the training and those who don’t. “One lady was crying last week. She couldn’t handle it and she was only there as a student.” There is little opportunity to use the skills they have acquired through education and experience. “There’s a higher risk of burn-out and you’re frustrated with all our knowledge...We’re going backwards instead of forwards.”

Although one aide agreed that

We have got to learn how to change the way we are trained, cause we are still turning out people who think they are only going to do two residents a day. And they walk into our facility, and I don’t know where there’s a facility where you have one health care aide for two residents.

Another suggested that “maybe then they’ll demand that there be more staff.” Neither solution seems to be in the offing right now.

---

Not all the interviewees had negative stories to tell about training. One RPN who works in a municipally-owned facility offered the following positive example.

With one of our residents who was psychiatric, we had a team come in, a psychiatrist and two of his assistants. And they interviewed her and us to see if they could help her. She refused all help. So we had an in-service and they set up things for us to do for this particular personality disorder so that we could at least have an idea of an approach...And that at least gave us a base to start from...to know this and this. And that really helped...So if you've got a little bit of support...Our facility has been fairly good about bringing in outside help to offer expertise where they felt that we'd tried everything and we weren't coming up with answers.

Even the occasional support from experts is “a help to you,” and may reduce the level of frustration in dealing with new demands. For this provider, training falls into an obvious category. “It’s a health and safety issue,” but one that may not be addressed. New patients and new work organization mean new skills are required but few of those interviewed had the opportunity to learn the new and appropriate skills formally or to use what they had learned both on the job and in school.

## Shifts and Scheduling

There are obvious health consequences to the shift work that is standard practice in health care. Less obvious is the impact of assignments to particular areas, assignments that are part of scheduling and the problems created by a lack of choice in assigning shifts. New issues arise along with the changes in resident profiles.

Assignment to locked wards or dementia patients is particularly draining. One facility in B.C. began assigning providers permanently to these wards in order to ensure that patients “see the same faces around.” In an Ontario facility, “they unitized it.” This means providers “work one shift; one shift only and one unit only.” There is no movement, like that in the B.C. case, from area to area. “If you want to trade a shift with somebody, you have to try everybody who is on the unit first.” According to these workers, the strategy is problematic because the workloads have become so heavy and because so many more of the residents are psychiatric that continuous assignment to one group of patients is too stressful. The B.C. workers said “we burn out because we cannot take those kind of people for a two week stretch.” For example, “you get people there that’ll ask you 15 times what time it is or what time lunch is...because obviously they can’t remember.” In another facility,

In an 8 week rotation, I was on that locked ward for 6 weeks. And that’s a long time to be locked up on that floor with those people. And...I think I was the first one to completely say “to hell with it. Enough’s enough.” I mean, it’s dangerous. I mean it’s not safe. It’s not healthy.

It is not only constant assignment to the locked ward that is problematic. Being assigned to any ward for a long period, given the new workloads and residents, can be exhausting. “If you get someone who’s really quite difficult to deal with, you’ve got them every shift.” Providers complain of “walking out of there burned out and tired.” After six weeks on one floor, an RPN said they “were snapping at staff a lot quicker.” Another reported that she was “more tired, whatever you like to call it, stressed out or whatever when we have two weeks in one spot.” Because “we ranted and grumbled,” the shifts have been changed to a one week rotation and those interviewed found this much less exhausting than assignment to one strenuous ward for long periods.

Shortages in staff also create scheduling issues that can influence health. Providers in both provinces report that people are pressured, or even forced, to work extra shifts and to work on odd schedules designed to fill in the gaps. Lack of choice can also exacerbate the situation. “We have to work anything. The only thing that they have to give you is every second weekend off. You have to work whatever they book you.”

## **Control and the Right to Care**

Much of the research demonstrating that a lack of control over work processes can have a significant negative impact on health has focused on men and male dominated work. The famous Whitehall studies revealed that those at the bottom of the hierarchy, with the least control, faced the greatest health risks. But, as Patricia Kaufert<sup>42</sup> so eloquently points out, the 10,000 civil servants participating in the study were all men. Yet decades ago, Patricia Marchak<sup>43</sup> clearly showed that women in female dominated workplaces have less control over their work than do men. Although some research has been done recently in the area,<sup>44</sup> the limited attention paid in health research to women’s control over their work may be linked to traditional ideas about female passivity. In long term care, emphasis on control may seem incompatible with an emphasis on care. For those we interviewed, however, having control over their work was essential for both their health and that of the residents.

### **Reductions in Control Through Time Pressures**

In answer to a direct question about whether they can make decisions about what you do and the way you do it, most of those interviewed answered with some version of “On your wing, you choose which resident you look after and that sort of thing. You have to have your work done at the end of the day.”

But it became quite clear in response to later questions that this control over personal care is increasingly limited by both cutbacks in staff and by new rules. This is particularly the case in what they see as the right to provide the care people need.

When I first worked there, you were able to talk to a lot more people. [Yeah, says another:] You were able to go into work and chat with the patients. You had a lot of things that you had in common with them.

All the participants offered some version of the following. Listen to several aides from B.C.

B: I think one of the biggest problems there is that there's no one on one. "Hey, how're you doin'?" "You can't do that there... There's no possible way where you can sit down and say - oh "How're you feelin' today?" You know, chit chat. A little hug for them, because they need it.

A: [I] always feel guilty.

C: If someone comes in, and sees you sitting, they think that maybe you haven't got anything to do.

Both the obviously necessary caring work and the less visible, but equally necessary, caring work are compromised.

A: I'd like them to have more baths a week...

B: I would like more time to be able to wash them at a comfortable speed because it's more stress.

C: And also do the extra things. To do their nails...

B: ...the nails, to shave...

C: ...do their hair...

B: Sometimes if you're rushed you don't get the shaves done... At one time I used to be able to heat up the curling iron...

C: ...oh yeah...

B: ...and have my little section down there where I would curl their hair. Do you think that I can do that now?

The same kind of issue was raised in Ontario.

Na: When it comes down to it, when you get that much stress, that much additional work and stuff like that, you're no longer [caring].

Nb: Exactly. You're no longer putting your parents or your grandfather... in a home where they're going to be cared for. Basically, it's... a warehouse.

Nc: Yeah.

Nd: Yeah.

Nb: You get them up, you feed them, you dress them, you feed them, you put them to bed. That's it... You have no time to socialize... You have no time to do anything.

Nd: No time to care.



This is not some utopian dream about some perfect working conditions never possible in the real world. These aides have experienced different times.

Nb: When we first started, we used to have time to sit down and talk to residents, read to them, write letters for them. It was nothing to spend 20 minutes. And now you don't have 20 minutes to read, much less sit down to talk to somebody.

In another Ontario group, everyone agreed care had "gone down the hill."

N1: We have no time to spend with them.

N2: No no. You're washed and dressed and I'll see you.

N3: You're going as fast as you can.

N4: There is no time for a chit-chat with them or even clip their nails or anything really.

An RPN made it clear why their concerns were not just about physical tasks.

I mean, it's like you're at home. Is the most important thing in your day when you shower? Or is it if somebody asks you how you are and it's nice to see you? And I don't find we do that anymore. We're just what you have to do...just task oriented.

Those interviewed report a sharp contrast with both their earlier experiences and their training. The result of this conflict between what they think they should do and what they are able to do creates "a frustration level that wasn't there before." They "feel bad," "stressed," "short-tempered" and "angry," although some claim "you get hardened." Morale suffers.

N1: We were just saying that a couple of weeks ago that like you say when we first started, for each department or each unit at Christmas time, the staff would organize a pot luck supper. And we had a lot of fun with the residents and the whole building and everything. Everybody was always wanting to be involved. Now...I'm here 40 hours and that just kills me. I can't possibly stand the thought of coming back here any more than I have to.

N2: Nobody volunteers for anything anymore.

N3: No. No...It's not 'cause they don't want to. It's just that they don't have enough left if you...You need time to recover to survive the next number of shifts.



## Reductions in Control Through New Rules

It is not only workload increases that limit the workers' right to care. It is also new rules coming from provincial and regional authorities, as well as from employers and supervisors.

In Ontario, the interviewees report, the Ministry of Health has introduced a variety of regulations and guidelines that mean the facility is micro-managed from afar.

In our case, I'm talking about routine and whether we can establish it or it's established for us. We have to work around the Ministry of Health, [that routine] pertaining to meals is a good example. Breakfast can only be served from this time to this time. Then there is morning nourishment. Lunch is served from this time to this time. There's an afternoon nourishment...So you're actually working around the Ministry guidelines. So the routine isn't set up by us.

The problem, they say, is compounded by conflicting guidelines. In the case of meals, the time lines do not fit with housekeeping schedules. "So there's no thought as to where things were to be done and how they were to be done and who was there."

Supervisors and administrators add their own set of rules, often without consultation or even, the workers claim, without much knowledge of the situation.

I refer to the residence as Stalag 13...For instance, who is compatible to sit with who at meals. Okay? We don't have a say in that. Just the supervisors get to make the decision...Everyone is assigned to their own seat in the dining room. If a lady is sitting there by herself, - she's someone you can carry on a conversation with - and there's another lady behind her at the table, they should sit together and they should talk. If we were to sit them at the same table, the [supervisor] would come, they would find us and say so and so is not sitting in the right chair. You have to move her. And so many times we said "This is stupid. Let's think about it for a while. Why can't they just sit there and talk to each other?"

This aide went on to say that "It's the little things like that" that leave them without a sense of control and with frustration. "When the staff who are actually dealing with these residents are treated like you don't know anything...your opinion doesn't count for anything." In other words, they have no control.

In another facility, an aide explained, they have "hard and fast rules. This is the way the policy is and this is the way its going to be followed." She offered the example of rules that require certain times for toileting and changing diapers; rules that do not allow the providers to use their own "common sense."

Sick leave policy was repeatedly used as an example of rules that both limit choices and create health risks. One facility introduced a new policy to reduce absenteeism.

People are afraid to be calling in because of their policy because you can go so quickly in this policy...If people are coming in sick, these residents are very susceptible and...when our policy started...two years ago...our mortality rate skyrocketed...It's certainly my feeling that people are coming in sick and people in very low condition...pick this up. To us it's harmful enough.

For workers in both provinces, the problem is made worse by the high turnover in administrators. Our B.C. group reported having four administrators in four years and so did an Ontario one. Indeed, several others said administrators last an average of a year now. And "each person has her different way" of doing things and each person "puts their own paperwork in, and changes everything." The problem is compounded by the more frequent changes in ownership, especially in the for-profit facilities. Providers point to sudden shifts in policy after new administrators are hired, shifts that seldom take providers' views into account. Many of them, according to one group, "don't have an idea in hell about caring" and some do not even know about Canada. In one Ontario facility, the new manager has been brought in from the United States by the American owners and, according to these interviewees, has introduced changes that conflict not only with Canadian practices but with Canadian laws. "Their interpretation of the contract is definitely not what ours is." The union was able to stop many of these policy changes but the constant change in administration rules "gets on your nerves." Similarly, a new owner of a private for-profit facility in B.C. introduced "a lot of stressful changes in a short time." The changes meant "we have to work faster, do the impossible and take the flack from the families and residents."

This conflict between what they see needs to be done, what they want to do, and the severe limits placed on their time by the workload increases and new rules constituted the major control issue in long term care. However, it is a control issue that is camouflaged by a direct question about control in patient care because these providers still often make some decisions about the ordering of direct personal care.

### **Reductions in Control Through Reduced or Irrelevant Consultations**

Various providers pointed to the real difference between consultation and control. "It's sort of like they let you make these meaningless decisions to give you a sense of control." This worker, like others, talked about being asked for her views on very minor matters while other areas are reorganized in ways that fundamentally limit her power. For example, she talked about how charting now follows new rules that severely limit what they can write down about patients and how they can describe their responses. "You cannot say so and so was angry. He displayed emotions of anger. He displayed anger-like symptoms. Well shit, anger is anger no matter how you look at it." She made it clear that she can decide some personal care issues "but when it comes to the structure of the floor and how it's [being run]...they never listen to us."

Groups in both provinces offered examples of consultations that had no impact on decisions. For instance, workers are often asked for an opinion even though the employer has “already purchased a piece of equipment and it’s too late to send it back.” The frustration of fake consultation may be greater than a clear acknowledgment that management decides. As one resident attendant explained:

That is a greater insult to me than not asking in the first place. Even if they didn’t ask and they said they went ahead. Well, okay. They did. But they went ahead anyway and they gave you this little bit of satisfaction thinking that you had some input. That’s a bigger slap in the face than if they didn’t ask you in the first place.

Another worker described the consequences of this kind of approach:

You know, it’s perfectly horrible. Like when you’re an adult, when you’re in your own home...and you’re making your own decisions...and you’re employed and you go out to work and you’re being treated like maybe your child would be when they go to school. I mean it’s very demeaning. It really is. And that affects all the people working there. Like that really affects your attitude towards management and towards any new program they want to try. Maybe some programs are good, maybe they are helpful but there’s so much negativity because of where it comes from.

The emphasis on costs, especially in for-profit facilities, is often used as a justification for both controlling providers and for disregarding their advice. Cost controls also reduce the possibilities for care, further reducing workers’ control.

N1: If it’s not one thing it’s another. Like the other day, [the residents] had open sores. She went to go to the pharmacy to buy a little bottle. It cost \$5.00. You try spreading that around 10 people.

N2: And then you get shit ‘cause you used a mouth swab and they’re so expensive.

When these providers are asked a direct question about consultation on a range of issues, they have to answer that they are consulted. However, further probing reveals a much more complex process at work, one that reveals the real and growing limits on their control over their work and workplace. Some, however, said that there is not even a pretense of consultation. In one for-profit facility, “the new owner doesn’t even have staff meetings because she doesn’t want feedback.”



## **Reductions in Control Through Changing Relations With Relatives**

It is not only administrators' rules and workloads that restrict workers' ability to make decisions about providing care. It is also the relatives of the residents. While relatives have always sought to influence the way care is provided, cutbacks in staff, equipment and supplies mean relatives see the care deficit and seek to overcome it by placing pressure on the workers to provide more care. And in for-profits especially, the providers say "they must please the families more than the residents." This means a significant power shift between providers and relatives. Workers in both provinces offered examples ranging from families demanding immediate care to families trying to get providers fired for not delivering adequate care.

Na: Because families know their rights now and they have a lot of leverage...and what we do is always wrong.

Nb: You get these families that are always complaining, trying to tell you that their husband said this and he hasn't spoken in 50 years. You know, obviously it wasn't him that said it.

And families have more and more to complain about, say these providers, and it is the front-line workers who take the blame. Aides are "the ones the family sees every day...so we get the brunt of the complaints."

It is also important to note that families do not only act as controls on workers. Several interviewees said "families are actually really supportive" and that "we get recognition from families." Like these B.C. workers, Ontario providers reported that families can be allies, especially if there is time to educate them about current conditions.

I find families are more understanding when you explain. Like we have a neighbour whose mother went in and they were very upset when she broke her wrist. And I explained how few people work there. How many people are on your list. And they just...they couldn't believe it.

Lack of control, then, can take many forms, and many of these forms will not be revealed by direct questions about control, consultation or autonomy.

## **The Long Arm of the Job**

When Worker's Compensation Boards or workplace health and safety committees pay much attention to households and communities, it is usually in order to explain health problems in terms of private lives rather than to look at the impact of paid work on households and communities. Yet there are many reasons to believe that changes at work are felt in the home and beyond.<sup>45</sup> While obviously both men and women may bring their work home in this sense, the evidence indicating that women bear the primary responsibility for domestic work and for childcare suggests that the consequences will be different. And because health care involves communities and requires emotional engagement

on the part of those who provide care, it would not be surprising if the links among health care work, communities and households are greater than they are for goods or much of other service delivery.

Many of the women, and men interviewed for this research, talked about the ways tensions at home increased along with those at work. A B.C. aide was far from alone in reporting “I’m fighting with my husband all the time.” Like this woman who was always “short-tempered” at home, a male resident in Ontario told us about the impact on his family.

I have three kids and ...and..I’m pretty laid back - I was finding, the more you’re working, the more stress from work, the more your hours are being cut, there’s no way [you can leave tensions from work when you get home]. You know it’s easy to say...“Whenever you come in the door you leave your family problems at the door.” They tell you that at work. And when you get home...work stays at work. It doesn’t work that way...Like I found myself being upset with the kids...and things like that.

He was applying for other work, even though he enjoyed many parts of his paid caring work, because the tension at home “was just starting. It was a direction we didn’t want to go in.”

Both women and men found they cannot leave the stress at the long term care facility door.

I find you get home too and you’re thinking about all the things you didn’t get done. You try, like in a sense maybe you’re trying to organize for the next day...You wake up at 2 in the morning, like out of a deep sleep, and say “Oh geez, I haven’t got this done.” Like it just goes [continually.] It doesn’t stop even when you hit the front door. You’re forever thinking of something.

More than one worker said “you dream about your work.” Both women and men said “you’ve got no energy left.”

Our job is physical. It’s very physical. It’s heavy. Your old body gives out long before it should from repetitious lifting. And it’s mentally a strain and it’s emotionally draining and so you’re done...By the end of the day you don’t want to do anything else.

This exhaustion is particularly problematic for women because most of them go home to another job. “It’s brought my family life down” said one provider, and went on to explain that this meant she could not “even get up to do my housework...I can’t do any vacuuming anymore because you can’t do this motion...like washing windows.” Another drew a direct parallel between the work she did for pay and the work she did at home. Her tasks were similar in both workplaces, but at home she could at least object. “If there’s any demands on you, you’re like “Don’t bother me, I’ve just been taking orders for eight hours.” The women also talked about how the pressures changed as their chil-

dren aged. Everyone in that group agreed “it’s hard on weekends” when they work shifts. This is especially the case when their daughters are teenagers and they are unwilling to leave these daughters alone at home.

More than one woman reported that her inability to provide the care she thinks necessary at her paid work leads her to

Over compensate at home. I do that because I am a caregiver at work so therefore it spills over into my family life. Like I cater to them...I do too much...But it’s easier sometimes. It’s easier just to keep on doing it, right? Because I have two older daughters and a son and I work in the kitchen all day, then I go home and I start making supper...Then my husband says: “Let the girls do the dishes”. It’s just easier for me to do it. You know. And then...we get into this...

It was only women who said that the changes at work had a negative impact on their sex life. “Sometimes you’re really wiped out...My whole body is aching. And I’m tired. You don’t want to lift another body.” “If anyone needs anything from you, it’s like being at work.” Not only are they too tired for sex but they often get into arguments that make sex unappealing.

If I come home from work and my husband and I started to discuss something, you know, a bill or anything, we’d end up in a big fight. So now we know. I come home and I have my hour or my hours nap or I sit and read a book or watch the news or whatever.

However, not all women can find or spare the recovery time.

The women also reported that the deterioration in conditions within long term care spills over into the community and they are often held responsible. One told about being accosted at her church. During coffee after the service, “this lady comes up to me. She says ‘Oh, you work at [the facility] don’t you?’” The parishioner then complained that one of the residents came to church “with her clothes absolutely filthy. Everybody turns around and looks at me, as if it’s my fault and I’d gotten her ready.” Another said she is the first person anyone calls when there are problems with the care their relatives are receiving. Others nodded, and talked about how often they get calls at work from relatives of people they know from their various communities. Such calls and questions increase the pressures on the workers, especially given that they already “feel guilty” about the levels of care, levels they can do little about.

According to these workers, then, new managerial strategies combined with cutbacks are significantly reducing the providers’ control over their work and thus also reducing their possibilities for healthy work.

## Insecurity

Security is a determinant of health, although not in the eyes of statutes covering workers or most health and safety committees. In the rapidly changing health care sector, however, a sense of security is hard to achieve. Both Ontario and B.C. recognized the problem by setting up an organization to help with labour force adjustment in health care. While the organization continues to function in B.C., Ontario abolished theirs and left workers to fend for themselves. This does mean that B.C. workers have more job security than their Ontario counterparts, although this does not mean that no B.C. workers fear job loss. Asked if their jobs were secure, B.C. workers replied “As long as the place stays open and we don’t do anything wrong” or “unless they sell it, then they will shut it down.” Indeed, none of the workers we interviewed felt their jobs were secure.

The fears are quite justified, given the changes in ownership and the cutbacks in care. In one Ontario for-profit facility, providers were particularly concerned.

when you get people like our owner. [For him] everything is his profit margin. Like nothing is going to affect that. And he’s going to cut your supplies or your people or whatever, if it comes to that. So the people are going to suffer. So there doesn’t seem to be any control over it. Like nobody seems to be able to stop him from doing that.

Moreover, the groups had witnessed first hand people being fired, laid off or disciplined for offenses that would not have been offenses in the past. Again, this was more common among Ontario workers. In sick leave absences, for example, the policy in many Ontario facilities has changed in ways that severely restrict eligibility. According to a group of Ontario workers, one provider ended up being reprimanded for missing three days in a four month period. “And every single letter you get from management...says ‘Can lead up to and including, termination.’ And that’s a threat.” “There’s no leeway anywhere.” Policy has also been altered in relation to how patients are treated, limiting what providers can do and how they can do it. And providers find it difficult to follow the new rules, especially now that there are patients they never had to deal with before.

More than one Ontario worker said “a worker is in a position of helplessness right now.”

N1: Well, it’s not a fair playing field. You don’t have a lot of options. You put up with it or get out.

N2: Most people can’t afford to get out so you jeopardize everything else.

N1: When you have financial responsibilities...you just try and shut up and bear it. That only increases the stress because you know it’s not right in your mind. So [the fear of job loss] is always sub-consciously in there.



This fear not only means that workers put up with conditions that create stress. It can also mean, these workers claim, a failure to report injuries and thus inaccurate data on injuries at work.

We have a problem right now where people who are injured or there is a potential hazard for injury but won't fill out incident reports because they're afraid of being called up in front of management for it.

The fear, some said, meant people were less active in the union and less prepared to take grievances or complain when the contract is violated. Here, too, the problem may be worse in Ontario because there is less job security. One provider explained that she did not get active in the union because "I can hardly do what I have to do now and if they start harassing me [about union involvement] then I'll really go over the edge." This "makes your job harder and more vulnerable." And it can affect their health. Job security, they say, was once common in their workplaces and there was comfort in the knowledge that unions could protect workers from unreasonable demands. Neither is the case any longer.

## **Social Relations**

Social relations can be supportive or undermining.<sup>46</sup> Either way, they are an important factor in health even though they have not appeared prominently in deliberations of those deciding the compensation for workers or in health and safety committees. However, the B.C. Workers' Compensation Board is now participating with unions and the Health Benefits Trust to develop research and pilot projects on issues related to social support. Social support may be particularly critical in care provision because so much of the work is emotional.

### **Less Team Work, Fewer Friendships and More Interpersonal Conflict at Work**

One group of B.C. nurses talked at length about their friendship networks from work that spilled over outside the long term care facility. "We're in good groups," they said. Asked about her relationships outside work, one woman responded that "most of my outside friends work with me...We go out for lunch or dinner with a couple of other girls from work." However, they worry that the tensions created by the changes will threaten these friendships.

Several in Ontario groups said this has already happened. "Oh, it's like a time bomb." "You don't know when you're going to blow up."

It's the little things that set you off. If the shift before you hasn't filled the laundry bags,...put out new laundry bags. Sounds petty, but when you've got a load of laundry and you're walking down and there's no bags in the laundry cart...

The constant shortage of supplies and equipment creates tensions that workers may end up taking out on each other. Each member of this group added to the list: no swabs, no mouthwash, no toothpicks, no face cloths, no disinfectant to spray the tubs, no cream, the list went on. Although they tried to address the problem as a labour/management issue, they were told this was a management right.

The team spirit that once prevailed, they said, has been eliminated by even more explicit management strategies. In the lunch room,

We used to all sit together. Now we have maintenance in one corner, domestics in another corner, health care aides in the centre, RPNs, sometimes they sit with us [care aides]. And RNs, I don't know where they eat.

According to this group, management has told RNs that they cannot socialize with the other workers. "They said it clouds their ability to discipline you."

Na: People sure don't have the fun they used to.

Nb: We get work done but we enjoyed it.

Nc: ...a lot of fun. Yeah, we enjoyed doing it.

Na: And everybody cared about everybody they worked with.

Nb: We were like a family.

Na: We used to be so close that we knew what was going on in each other's families and if there was a problem in somebody's family, everybody helped.

These workers may only remember the best parts of earlier times, but it is clear that the move to many more part-time and casual employees means "now I work with people that I can't even tell you their name some of the time." But the problem is more than turnover in staff. "You're afraid to say something to somebody because they could end up making a federal case out of it," especially under all the new rules and with less job security.

This is not to suggest that the Ontario interviewees produced no examples of supportive social relations. Some reported continuing social supports, supports that were highly valued and ones that they worked hard at maintaining.

We have a lot of team work too at our places because I find there are people there you have a rapport with and other people will have more of a hard time with. Well, when I work I switch with them. It's less stress for the residents, less stress for us, and there's lots of team work like that where we are.

### **Less Recognition or Management Support**

Stress can also result, the participants say, from working extra hard with no recognition. All the groups commented on what they saw as a lack of respect and appreciation from management for all their extra work. “If I’m stressed, I’m angry maybe at management or I feel there’s no way I’m going to get this done and I’m starting to rush, and I come in [to face] that perceived attitude...It takes so little.” “They don’t care whether you have a home life or anything else.” Indeed, one provider reported that her administrator said “morale is not my concern.” Another added “They don’t care if you’re losing hair and are sleep deprived.” In spite of their efforts to make people comfortable and provide the care they think residents need, several providers feel that their work is undervalued. “A lot of the attitude [is] if you work in a nursing home, you’re nothing.”

### **Fewer relationships With Residents and Less Support in Grieving after a Death**

Another important set of social relations are those with residents. These providers often spend long years caring for the same people. “They’re family.”

You get attached to them. They’ve been there for 20 years and you’ve been there for 20 years. It’s like part of your family.

This attachment can be repetitious but it can also be rewarding. When patients die, the residents often go through a grieving period. Several participants described various supportive processes to handle their grief. For example

Something nice we used to have is when they sent a thing up to each unit and there were different things about the person...If you as an employee wanted to add something to it, their favourite expression - whatever, anything special to you - and then put it in a profile. Then people come in and there’s a book of people who have passed away and lots of things about them. And at least the workers had a...sense of closure.

However, the increase in workload has eliminated such practices in many workplaces. Beds have to be quickly cleaned, belongings packed up and shipped off as quickly as possible in order to handle the next person on the waiting list. “The hardest thing is putting their belongings into the garbage bag.” “Sometimes, they’re not even out of their room and they’re moving [another resident] in.” Moreover, the increase in the acuity levels of patients means that more deaths occur each day, and so do the occasions for grief. The participants said there was no time to grieve and, in some cases, the grievance teams that had once helped in the process have disappeared.

Interviews in both provinces reinforced the importance of strong social relations at work, but interviewees in both places also suggested that it was becoming more difficult to create or maintain such relations.



---

## Violence

In recent years, violence has been recognized as an issue in women's health both in the home and in the paid workplace. Surveyed in 1993, members of the Canadian Union of Public Employees indicated a high level of violence in the social service sphere. "A staggering 65% were subjected to some form of violence from aggressive acts."<sup>47</sup> Violence has always been part of health care provision, especially in psychiatric wards. As one physio attendant explained

Violence in the workplace is not acceptable. It's not part of my job to get bit, spit at and everything else. That was part of my job 20 years ago. We used to get all that. And that was just part of the job. Now we know it's not.

However, according to these workers, a number of factors are contributing to escalating violence in long term care.

### More Violent Residents

First, residents have different health problems now. Cutbacks in psychiatric hospital services and in homes for those with drug problems, especially in Ontario, have increased significantly the number of violent patients in the facilities.

We may have had the odd person who'd get drunk or whatever, but they'd end up going to bed. Now we're getting the type that gets drunk and abusive. We've had about 4 or 5, and some that we've had to call the police. I'd say it's increased a good 50%.

At the same time, more of the elderly have dementia or Alzheimer's. "Like they're punching each other or kicking and hitting each other," and the caregivers often get caught or hurt in the middle. Housed with developmentally challenged and physically disabled, the patients produce a volatile mix. More men, and more younger patients, also means that the caregivers are facing patients who are very strong as well as very stressed. Aides, attendants, housekeeping staff and RPNs all report increases in violence. They are punched, hit, bitten, grabbed by the hair, spit at and slapped in the face by patients who are often "just fighting all the time." The constancy of such violence strains the nerves of the providers, as one incident clearly reveals.

I got hit by [a resident] when he knocked me right to the ground because I didn't bring the right soap for his shower. I'd already taken him out of the shower and he was in a shower chair...on wheels. And I walked out and left him sitting there with nothing on because...it was either that or I was going to do something I shouldn't have.

This was a "big, big man," and the aide was reprimanded for leaving the patient alone.

---

While those interviewed have experience dealing with elderly patients requiring care, this new mix means new problems. “And not everybody is equipped to deal with the behaviours. They can do the physical care but then you have to deal with the behaviours.” Often the physical space makes dealing with this violence more difficult, especially if there is no locked facility.

### **Violence Resulting From Cutbacks**

Second, cutbacks increase the level of tension in the facilities and this creates an atmosphere that is conducive to violence. Patients cannot get the care they need when they need it, or they do not get the appropriate medications on time and their anger erupts. For example, in one B.C. facility, a high turnover in RNs means “the residents refuse to take their meds which makes their behaviour worse.” Equipment fails more often and supplies are short, with the same consequences. Activities have also been cut, activities that can help reduce tension, and those that remain are not diverse enough to interest the new mix of residents. Some facilities have no gardens or outside spaces that would allow patients physically to let off steam. And reductions in staff can mean that there is only “one attendant on the locked ward,” vulnerable to violence from the many residents in their care.

### **Violence From Working Alone**

Third, fewer providers mean there are fewer possibilities for together dealing with problem patients. Residents are often more easily calmed by a variety of techniques used by several people and, if that fails, there is strength in numbers to subdue violent patients. Providers say they feel safer in another sense if they work in teams.

Many said they are often blamed for the violence, adding to their stress.

If the patient slaps you across the side of the head, they say well, you have to understand. She’s had a stroke. All of a sudden, she doesn’t have a mind. But if she says you abused her [they hold the worker responsible].

The consequence is that violence becomes invisible.

If somebody gets punched in the face or choked...It’s our fault because we approached them wrong. People just get discouraged from reporting a resident because it ends up being your fault. So it’s a way of them not having to deal with it.

One B.C. aide “was punched in the breast yesterday...but I didn’t fill out anything because nothing gets done.” But even formal complaints may not provide protection.

If a patient gets violent and we file a complaint, it takes so long to get through the system that we still have to work with a violent patient for a long time before anything gets done. One resident needed 3 people to do him. He got transferred to another place where he punched a woman in the head and she is now on permanent disability with head trauma.

Their only defense, several said, was to ensure they worked in pairs at least so there was a witness to defend the provider’s claims.

For those interviewed, the link between increasing violence and changes in long term care are obvious. However, the way violence is managed may conceal this escalation. As one interviewee put it, the way data is collected can hide the actual health hazards workers face. “It’s just like how to lie with statistics.” Research based on such data may thus understate the extent of the hazards workers face.

## **Physical Space and Physical Demands**

Physical conditions and physical effort are, and have been for a long time, recognized as a factor in health. As research conducted for pay equity purposes in particular point out, many of the harmful working conditions women face are invisible in the evaluation of jobs. And the physical effort involved is often ignored.<sup>48</sup> Yet, as these interviewees graphically demonstrate, bathing, feeding, toileting, walking, changing and cleaning up after residents is quite physically demanding work, work that has become more onerous under current conditions.

### **More Crowding**

Crowded, inadequate facilities are common, according to those interviewed here. In both provinces, long term care services are often located in buildings designed for other purposes. This is particularly the case in the for-profit facilities. But even the newer homes designed for long term care are often inadequate for the increase in the number of residents when combined with a change in the physical capacities of those patients. In some facilities, virtually all patients are in wheelchairs that cannot be maneuvered in the confined spaces.

One Ontario therapy assistant pointed to the example of the activity rooms.

One of the areas in our facility where I find a risk or a hazard is...[in] these activity areas...I’ll bet you they’re not as wide as this room. And they’ll have a big table like this in them, maybe a stove in one corner and a few planters and that. They’re obviously not designed for wheelchairs, and a hundred per cent of our people are in wheelchairs. So there is more of a risk for injury trying to get them into the tables. If anyone has to go to the washroom - the ones you know will always have to go to the washroom - you

try and stick them near the door all the time but they can't get the best view. It's a bad risk. Our tea room has become the auditorium, the activity room, the pub. Families often try to come in and be with the resident and can't. There's no room for them.

Similar conditions were reported by a B.C. provider; this time in her description of the dining area.

We're squishing everybody back this way. Nobody wants to listen...The kitchen staff can't pour over the top of the residents. They have to be beside them. But [is it] going to take for somebody to get burned or somebody to get injured before they realize that you've just confined everybody into a closed area where nobody can move?

Another person from the kitchen staff added that there are two tables beside a hot tank, in contravention of Worker's Compensation Board guidelines.

The resident rooms are equally problematic, creating "some real problems when we're trying to manoeuvre lifts and even for domestics to clean. We have a really hard time in some rooms." Bathrooms are often too small for even two people, let alone two people with a wheelchair and a lift. Some rooms in a B.C. facility are so small that there is not "enough room to have many people accomplish tasks."

### **More Physically Demanding Residents**

Not only are the homes more crowded, they are also increasingly populated by more heavy men and more severely disabled people who have to be lifted in and out of bed, off and on the toilet, in and out of the bath. The introduction of lifts and shower chairs has helped in some circumstances. However, often the lifts cannot be fit into the areas where they are needed. Perhaps more importantly, providers said they are so rushed they often do not have time to use the lifts. Moreover, there are not enough lifts to fill the growing need and those that are available often cannot handle the load or are in disrepair.

Take the example of the 300 pound man using the lift.

He was kind of flipping out and had broke the belt and hit against the wall and the chair flew out. It's on a pole and he landed inside the tub, so she had to hurry up and drain the water.

### **Inadequate Supports and Supplies**

Similarly, the participants often do not use gloves for their work. Part of the problem is the inadequate supply and part is the workload that leaves no time to stop and search for gloves. Aides also find it difficult to do many of their necessary tasks if they have gloves on. In the past gloves were less necessary both because the providers had more time to wash their hands and because most of their residents were old, rather than ill. Now gloves are more and more essential to the job, but the heavy workload and the shortage of supplies make it difficult for workers to use them.

### **Inadequate Ventilation and Repairs**

Heat was also a problem for most of the participants. Few of the facilities have air conditioning and the heat can get quite oppressive, especially given the speed up in the work, the additional physical effort required and the lack of time to take breaks. Some report vomiting from the heat and many report increased levels of exhaustion.

More facilities are in poor repair. Leaks, broken stairs, cracked ceilings and beds that did not work were only some of the problems identified by these workers. Such problems may not be new but they are more frequently overlooked, the participants said, in these cost cutting times.

### **Inappropriate Facilities**

Another consistent complaint about the physical space was the contradiction between evidence indicating what should be done and the practice. According to those interviewed, many of the facilities were constructed in ways that all the research and policy advice suggested was inappropriate. One aide put it succinctly: “the course is saying everything we have, we’re not supposed to have.” Age of the buildings is not the only issue.

Our facility is only 13 years old and we have all the things they say we should not have. We have carpet, we have tile with a pattern that they just put in, we have a tub that they say you should never have, especially for Alzheimer’s and yet we bathe people in it.

Part of the problem is that the residents have changed faster than the facilities. And part of the problem is the employer’s failure to respond to rules and orders from the bodies responsible for ensuring safety, at least in the view of these providers.

In general, participants said their work had become more physically demanding and more pressured.

N1: You’re lifting heavier things. Like the chairs are heavier. They’re harder to push, some of them. And just stress for time, for time, for time.

N2: And you’re moving twice as fast.

Their “arms, legs, hips and knees ache.” They get repetitive strain from doing the same motions over and over, and back injuries from lifting heavy loads. While such aches are not new, the extra workload makes them both more common and more constant.

What these respondents suggest is that physical conditions are getting worse and physical demands are increasing, and this is happening just as “we are getting older.”



## Because You're a Woman

Does it make a difference that the overwhelming majority of those who work in long term care are women? According to many of these women it does, and the result is a dismissal or camouflaging of many of the health hazards they face.

Several women maintained that management made certain assumptions about women. Because they are women, "management also realizes that you're not going to leave somebody unattended somewhere." They know "You'd never leave your own child", and they assume that women will absorb the extra demands without complaint and without taking it out on the residents. Women will make up for the shortages in supplies and time. They also assume women know how to do the work, and thus feel less pressured to provide them with training. "I think they know you will be more attentive," said women in one group. Another used almost the same words: "They seem to feel that women are going to be more attentive to someone's needs." This assumption translates into rising workloads unaccompanied by supports for the workers.

More than one woman also claimed that their concerns were dismissed as female complaints, problems that resulted from their biology rather than from actual conditions. In one case, for example, providers' concerns about the smell of carpets were repeatedly ignored. The most outspoken of the women was told that she was smelling this "because of her age," clearly implying that menopause, not carpets, was the cause. Women say they can expect similar treatment when they complain about violence or injury. Interestingly, management may ignore workers' home lives when they increase demands but use workers' home lives as an excuse for women's ills.

However, participants did think that women felt more responsible for patient care than men, that women were more likely to take on the extra workload without complaining, that "no matter how short staffed you are, [you] keep the residents feeling secure." "I think it's because women have this...maternal thing." Women are also more likely to bring in soap and supplies for patients when the facilities run short, to curl hair and wash faces to make people feel better and to take the brunt of the blame from people they know in the community when care is not provided.

But what we're saying is that the issue is your compassion, which is why you work here. I mean, and that's wonderful but yet it can also be detrimental I think.

Women's extra efforts, combined with their reluctance to complain, hide the increasing workloads and inadequate care time. "But...if it was guys that were mostly working in the home and they said you're going to do this, they'd say 'Yeah, right. We're not doing that.'"



These particular women also felt that women are more likely to have their work stress spill over into their homes and are more likely to put in extra hours to ensure the work is done.

A: Men if they had to be out at 3, they would be out at 3.

B: And they can let it go and go home.

C: Men totally disassociate that. When it's time to go home, they have a clear conscience. I find most men do anyway.

Yet these women see a turning point. They see less acceptance by women of the increasing demands.

I think we've grown so much though. We demand the training now. We've learned ourselves that we're only hurting ourselves.

And they thought the younger women would be "a little more aggressive" in demanding change.

## Conflicting Interests

All groups raised concerns about conflicts between patients' rights or their assumed interests, and providers' rights. Patients' rights have become increasingly important and these workers did not object to patients having rights or reject the need for such rights. They did, however, feel that such rights were often promoted at the expense of, or without thought given to, the rights of providers.

One example from Ontario is smoking. Residents have the right to smoke "because it's the resident's home and . . . because they can't do it themselves, they need to be supervised". Although the providers are allowed to supervise through a window, "you still have to go into the room to light maybe eight, ten smokes at one time". This right for patients "eliminates your rights completely". Through their union, these workers have developed a strategy that allows some compromise. They can trade the task with a provider who smokes, if there is one on the shift. But cutbacks in staff mean that there is often no smoker on the shift.

Another example was temperature. Group members complained that their facilities were too hot and that even those with air conditioning had them turned off. This practice was justified in terms of patient rights. Management held that "fans are too chilly for the residents". The workers challenged this claim maintaining that management was simply using the patients as a way to justify cost cutting strategies.

A third example was the new shift schedules. Management explained the assignment of providers to the same patients and wards in terms of the patients' need to "see the same faces". However, the constancy of the demands and the rising level of demands from many of these patients, as we have seen earlier, can increase the stress on providers if they face the same demands day after day. It is not the same as acute care, where patients will be staying only a short time. In these facilities, residents are often there for years and, while providers frequently grow attached to these individuals, they do not always want to see them every shift.



---

These conflicts were raised by group participants as health issues, although they were not part of the original questions in the interview schedule. For them, resident rights have become a means for management to limit providers' rights to a healthy workplace.

### **Similarities and Differences**

Many of the same issues were raised in both provinces, although the analysis of B.C. providers' interviews suggests that conditions are somewhat better there and that more strategies are being developed to address the health hazards identified here. The interviewees in both provinces see significant differences between for-profit and not-for-profit facilities. According to them, workloads are much lighter in not-for-profit facilities and team work is more common. Whether or not these differences exist across provinces, regions and facilities, and the extent to which they exist is, like other issues addressed in this study, a matter for further research.

## Conclusions




The literature review revealed very little research focused on the health of those who work in long term care and even less that was gender sensitive and concerned with the impact of changes on women's health. Nevertheless, some evident patterns emerge. Both the general research and the few studies that examine long term care emphasize the importance to health of control over work, and indicate that work reorganization is reducing women's sense of control over their work.

Increases in workloads that happen through a variety of visible and invisible processes, especially when combined with lack of control and women's responsibilities for households, add to the unhealthy stress. And so does job insecurity. Social support from other workers, from management, from unions and from relatives of residents can help relieve this stress. Conversely, the tensions that grow in the wake of reorganization can significantly reduce social support. Such tensions may add to the stress in invisible ways or erupt in more obvious violence. The most recent research also suggests that this stress becomes visible in women's reproductive health, in back and musculoskeletal injuries, in allergies, fatigue and substance abuse.

This research was designed to explore most of these issues within the specific context of the changing conditions in long term care and through a gender sensitive lens, with the intent of providing direction for further research and policy development. Left out of our interviews were direct questions about women's reproductive health and specific injuries, in part because we have more extensive research on these matters. There was room for participants to address these concerns but they did not come up in our discussions perhaps because we did not ask.

In general, the interviews echoed other research. What is new here, though, is the exposure of the multiple, varied and often invisible ways workloads are expanding not so much through explicit change within facilities as through changes outside the institution that have a cumulative impact on health. These changes in turn create the need for new kinds of training and new approaches to scheduling if workers' health is to be maintained. Similarly, the interviews expose some of the hidden and different ways employees' control over their work is undermined, especially when it comes to providing the kind of care women in particular see not only as necessary but also as their responsibility.

Violence too, is revealed as multi-faceted and changing with new kinds of residents. This is related in turn to the exclusive focus on providing protection for residents, without an equal concern with the protection of and social support for the workers in long term care.



Finally, much attention has been paid to the impact of women's domestic responsibilities on their paid work, often as a means of explaining away their pain. But this research suggests that it is time to look at how workplace demands are undermining the home lives of both women and men. While both women and men described the ways changes in long term care are negatively affecting their household relations, it is women who feel the greater tension because they have more responsibility for household labour and household relations. Furthermore, women reported an impact that went beyond households to communities, communities that held them responsible, and to which they felt responsible, for care deficits.

Although there is a growing consensus in the research, it has had only a limited impact on compensation for workers. Indeed, Ontario has explicitly rejected as a compensable workplace illness the mental stress that is much more common in women's work in general and in health care work in particular. While B.C. is exploring the possibility of extending compensation in ways that would take workplace stress into account, the recommendation that would restrict this recognition to those not related to generic work processes would severely limit the impact because so much of what is described here results from just such processes. In both provinces the emphasis on unusual circumstances would make much of this stress ineligible for compensation, given that all the women interviewed described similar conditions. Moreover, both provinces tend to privilege evidence that is based on traditional science, science that often fails to make these stressors visible.

This leads to the final concern in this study, the issues it raises for current research. In recent years there has been considerable growth in the research on population health. The National Population Health Survey, for example, follows some people over time and thus allows some assessment of changes.<sup>49</sup> It can therefore provide an overview of changes in health status and some comparative data for each sex. However, it is limited both by the structuring of questions that permit only specific kinds of responses based on researchers' definitions of the problem and by the focus on individuals rather than on hazards groups face in particular kinds of workplaces. This study, like others focused on women's concerns, indicates the need for participatory research which allows workers to identify and expand on issues and for research which seeks to expose processes and practices that have been invisible in female dominated workplaces. Moreover, it indicates the need for research that takes the general legislative, regulatory and ownership context as well as the specific workplace into account. New research needs to explore the differential impact on women within these workplaces, a matter we were not able to explore in any depth here but one which did emerge in the discussion. Very little of the current research takes such context, and such differences, into account

---

# Policy and Research Implications

---

In many ways, this research confirms what has already been written about the health hazards women face at their paid work. Where it departs from that research is in the emphasis on context, contributing to some more specific implications for long term care:

## Government policy in long term care

All policy needs to be examined for the health impact on employees at the workplace level. In terms of current issues in long term care, provincial governments should:

- Develop and enforce minimum care standards to relieve workload stress.
- Develop and enforce minimum training standards and provide new training to relieve workload stress.
- Include workers' rights in long term care legislation.
- Develop and enforce physical facilities requirements that meet the new resident profiles.
- Allocate residents to facilities or at least to locations within facilities in ways that meet their needs and those of the employees.
- Fund long term care in ways that recognize the current skill and care requirements.
- Consult workers on facility physical structures and supply requirements.

## Workers' Compensation

Workers' Compensation needs to be linked to the research on health hazards in order to both compensate for conditions that are beyond workers' control and to encourage employers to develop different workplace conditions.

- Assess Workers' Compensation regulations for their gender and workplace specific impact.
- Take the research on the impact of work organization into account in developing regulations, paying particular attention to the health impacts of shared workplace stressors and to the issues raised by the women who provide most of the care.
- Extend compensation coverage to those facing significant workload increases, whatever the cause.
- Include violence against workers by residents, relatives or patients as a compensable condition.

## Workplace Health and Safety Committees

The offspring of Workers' Compensation, these committees should be developing programs based on the research and have the power to implement changes in workplace organization and structures, changes that the research on work organization demonstrates influence health. As is the case with Workers' Compensation Boards, such committees should not only be representative of the gender distribution in the workplaces but should also be trained in gender-based analysis.

- Assess the impact of work reorganization and develop strategies to alleviate the stress it causes.
- Consider the gender impact of work reorganization, especially in terms of the right to care, control over care work and violence against workers.
- Develop preventative programs to address the ways workplace tensions influence household and community relations as well as social support, and do so in ways that assess the differential impact for women and men.
- Make job security a priority in workplace health and safety.
- Make the physical and social organization an issue for workplace health and safety.

## Research

Research, to be gender sensitive, must do more than count women or analyze data by sex.

- Make group interviews and other participatory research strategies a critical component and pressure Workers' Compensation Boards and other policy makers to recognize their value.
- Do not rely solely on direct questions about workplace hazards. Issues need to be explored in ways that are designed to make the invisible visible to researchers and to those who do the work.
- Ask about the consequences for households and relationships.
- Develop comparative data bases that examine different workplace strategies, different kinds of ownership and different government policy on care formulas and training.
- Take context into account.
- Collect and analyze data in ways that recognize the cumulative impact of changes and their interaction.

# Appendix I



## Interview Schedule

- What is your job title?
- What exactly do you do?
- How long have you worked in long term care?
- Do you work full-time, part-time, casual?
- Do you have a second job?

---

## Work History/Context

- How long have you worked for your employer (main job)?
- What shift(s) do you work?
- How many extra hours per week do you work? (Paid overtime?)
- How secure is your job? (i.e. people in jobs like yours being laid off or unemployed)

---

## Work Intensification

- How do you think the work has changed over time?  
NOTE, TO BE ASKED OF EACH ISSUE RATHER THAN AS SEPARATE QUESTION  
(i.e. interruptions, disturbances in job)
- Do you work faster? (i.e. and make mistakes)
- Do you work longer? (i.e. work more than 6 consecutive days, asked to begin work earlier or later)
- Do you work harder? (i.e. pressured/required to work overtime - choice?)
- Do you get your work done?
- Do residents require more/different care? (removal of 2.5 hour minimum)
- Are there more residents to care for?
- Are there different people caring for them?
- Are the tasks you perform physically demanding? Which ones? (lifting)



## Skills and training

- Do you use all the skills you have learned? (i.e. do you use your education and training)
- What are they and how are they used/ not used?
- Do you do work for which you are not trained?
- Are there teaching/training sessions for new workload? (i.e. new equipment, technology, protocols, skills)
- Do you get explanations about tasks which you are asked to do?
- Are there opportunities to discuss problems related to organization?
- Are those you work with experienced enough/skilled enough/ prepared enough for the job?

## Work Organization

- Do you work in teams? (distribution of tasks; responsibility for other persons, equipment; cooperation; demands from others)
- Are problems created amongst co-workers as a result of varying levels of experience, training, ages?
- Have your tasks changed?
- Do you have multi-tasking? (variation in tasks; team work)
- Does this make the work harder or easier? How? (challenge of work tasks; reorganizing work programme during day; interruptions; conflicting demands; too much to do; doing tasks that aren't a part of your job)

## Control

- Do you have control over what tasks you do? (autonomy; institutional policy; training/values conflicting with institution; office politics and red tape; lack of power/consultation/communication; management (mis)understanding work-related problems; clarity of job; conflict; doing things against own judgement)
- Do you have control over how long you do tasks for? (setting work schedule; having authority to make decisions on own)
- Do you have control over who you do tasks with? (ability to get job done; supervisor's lack of competence)



## Social Impact

- Do any of these changes influence how you feel at work everyday?
- Do you find yourself responding differently to residents and coworkers? (reactions, interactions)
- Do any of these changes influence how you feel when you go home? (mood)
- Do any of these changes influence how you get along with other people at work? (climate/ atmosphere; social relations; ability to work as a team; support; liking supervisor)
- Do any of these changes influence how you get along with other people at home? (household relations because you're a woman)
- Do any of these change influence how well you sleep or eat? (exhausted)
- Do any of these changes influence how often you get angry/upset/irritable?
- Do any of these changes influence how satisfied you feel about the care you give? (how measured: enough time to talk to patients/answer questions; doing work you consider to be significant; being needed by others; accomplishment/competence; impacting other lives; helping; how is it/isn't it different)
- Do you experience discrimination/harassment (because you're a woman)? (pay, job opportunities; discrimination based on gender/ethnicity/race; chilly climate; sexual harassment)

---

## Health Impact

- How does your job affect you emotionally, physically?
- Is your supervisor supportive/ have (un)realistic expectations of your work?
- What about relatives, family? (juggle conflicting tasks/duties; homework time; any new responsibilities at home?)
- Does your work have an impact on your relations at home; on what work you do there and how you do it? Does your family have an impact on your paid work?
- Have changes in health care had an impact on your home, family?
- Do any of these changes have an impact on your health or safety? (physical effort; physically demanding/strenuous; exposure to illness; physical conditions of job; workers' comp.; physical space: does it hurt/help your health)
- What would help improve your health and well-being? (more secure income, job change, more time with family/friends, learning to relax more/worry less)
- Do you get more pain in your legs, back, arms, head?
- What about your eyes, hands?
- What about infections, viruses,
- Are there more violent incidents from patients or staff? (hostility)

- Are there job-related allergies?
- What about stress? (define stress/how it manifests itself; dealing with emotionally difficult situations, unreasonable deadlines, duties unclear, no autonomy/control, no feedback, conflict)
- Have you experienced activity limitations due to your health? (affecting social activities; sick days, injuries, disabilities; affecting housework, exercise; resulted in accomplishing less; emotional problems)

---

### **Unions**

- Does the union help with health and safety issues?
- How? (programs available, grievances)
- What more could it do?
- How well does the health and safety committee work to help with your health issues?

---

### **Material Benefits**

- Is your income adequate? (considering efforts/achievements, benefits, sick leave)
- Do you feel appreciated, respected? (supervisors, support, concern for welfare, paying attention to what you have to say, recognition, motivation, feedback, equal treatment, loyalty)
- Is your job monotonous? (tedium, dull, lack of variety, lack of appreciation; challenge, stimulation)
- How does work affect your domestic responsibilities? (work-home overflow, job (in)flexibility, social relations)

---

### **Future/questions**

- What do you think the future holds? (i.e. I have experienced/expect to experience an undesirable change in my work situation; restructuring: small/large, profit/not-for-profit)

---

# Endnotes

---

1. E. B. Akyeampong, "Missing Work in 1998 - Industry Differences", *Perspectives on Labour and Income*, Autumn 1999:30-36.
2. Workers' Compensation Board of British Columbia, *WorkSafe Focus Report on the Health Care Industry*, December 1996. Author: Richmond, BC, 1996, p.5.
3. Calculated from Statistics Canada, *Labour Force 15 Years and Over by Detailed Industry and Sex, for Canada, 1996 Census*  
<http://www.statcan.ca/english/census96/mar7/occupa/table3/00p.htm>
4. see Workplace Safety and Insurance Board, *Your Guide to Independent Living*, Toronto: Workplace Safety and Insurance Board, July 1999.
5. Canadian Institute for Health Information, *Health Care In Canada 2000: A First Annual Report*, Ottawa: Canadian Institute for Health Information, 2000, p.1.
6. Canadian Institute for Health Information, *Health Care In Canada 2000: A First Annual Report*, Ottawa: Canadian Institute for Health Information, 2000, p.5.
7. Health Services Utilization Task Force, *When Less Is Better: Using Canada's Hospitals Efficiently* Ottawa: Health Services Utilization Task Force, 1994, p.52.
8. K. Bezanson and L. Noce, *Costs, Closures and Confusion: People in Ontario Talk About Health Care*, Toronto: Caledon Institute of Social Policy, 1999, p.6.
9. Ontario Ministry of Health, *Daily Census Summary*, July 21, 2000.
10. Canadian Institute for Health Information, *Health Care In Canada 2000: A First Annual Report*, Ottawa: Canadian Institute for Health Information, 2000, p.5.
11. Statistics Canada, *National Population Health Survey, Cycle 2-residents of Health Care Institutions, 1996/97*, Ottawa: Statistics Canada, 1999
12. Statistics Canada, Cansim,  
<http://statcan.ca:80/English/Pdbd/People/health/health23.htm>, 22/07/00.
13. According to Statistics Canada, the number of people living in health care institutions in 1996.97 was virtually unchanged since 1994/95. Statistics Canada, *National Population Health Survey, Cycle 2-residents of Health Care Institutions, 1996/97*, Ottawa: Statistics Canada, 1999.
14. For a more extended discussion on long term care in Ontario, see Pat Armstrong and Hugh Armstrong, *Women, Privatization and Health Care Reform*, Toronto: National Networks on Environments and Women's Health, 1999.
15. V. I. Tarman, *Privatization and Health Care: The Case of Ontario Nursing Homes*, Toronto: Garamond, 1990.

16. R. Pear, "U.S. Recommending Strict New Rules At Nursing Homes", *New York Times*, July, 23, 2000, p.1.
17. Government of British Columbia, *Community Care Facility Act. Adult Care Regulations, 1998*; Government of Ontario, *Nursing Homes Act, Charitable Institutions Act, Homes for the Aged and Rest Homes Act and Long Term Care Facility Program Manual, 1998*.
18. Government of British Columbia, *Community Care Facility Act. Adult Care Regulations, 1998*, section 6.7(i).
19. Government of Ontario, Ministry of Health, Request for Qualification to Operate Interim Care Beds, RFQ 98-013, July 1998, p.20.
20. Robert Pear, "U.S. Recommending Strict New Rules At Nursing Homes", *New York Times*, July, 23, 2000, p.1.
21. K. Lippel, "Watching the Watchers: How Expert Witnesses and Decision-makers Perceive Men's and Women's Workplace Stressors", pp.265-291 in K. Messing, B. Neis and L. Dumais (ed.), *Invisible. Issues in Women's Occupational Health*, Charlottetown: Gynergy, 1995.
22. Government of Ontario, *Workplace Safety and Insurance Act, 1997*, Chapter 16, Schedule A, 13.(4).
23. Government of Ontario, *Workplace Safety and Insurance Act, 1997*, Chapter 16, Schedule A, 13.(5).
24. Royal Commission on Workers' Compensation in British Columbia, *For the Common Good*, Victoria: Royal Commission on Workers' Compensation in British Columbia, 1999, recommendation 195, b).
25. Royal Commission on Workers' Compensation in British Columbia, *For the Common Good*, Victoria: Royal Commission on Workers' Compensation in British Columbia, 1999, recommendation 195, c).
26. K. Messing, *One-Eyed Science. Occupational health and Women Workers*. Philadelphia: Temple University Press, 1998.
27. Ontario Workplace Safety and Insurance Board, *Annual Report. Statistical Supplement, 1998*. Toronto: Workplace Safety and Insurance Board, 1999, table 2; British Columbia Workers' Compensation Board, *Worksafe Focus Report. Health Care Industry, 1998*, p.8.
28. M.G. Marmot "Social Inequalities in Mortality: The Social Environment", Pp. 21-33 in R. G. Wilkinson (ed.), *Class and Health: Research and Longitudinal Data*, London: Tavistock, 1986.
29. Canadian Institute for Health Information, *Statistical report on the Health of Canadians*, Prepared for the Federal, Provincial and Territorial Advisory Committee on Population Health, Ottawa: Health Canada, 1999, p. 52.
30. K. Wilkins and M.P. Beaudet, "Work Stress and Health", *Health Reports*, Winter Vol. I (3):47-62: 1998.

31. For a summary of this literature see Pat Armstrong, "Equal Pay for Work of Equal Value". A Paper Prepared for the Canadian Human Rights Commission, Ottawa, March 2000.
32. Calculated from Statistics Canada, *Labour Force 15 Years and Over by Detailed Industry and Sex, for Canada, 1996 Census*.
33. R. Daly, "Cancer Workers Face Burnout", *Toronto Star*, July 25, 2000, p.A3.
34. see P. Armstrong et al., *Managing Reform: Managing Care: Perspectives from B.C. Nurses*. Ottawa: National Federation of Nurses Unions, 1999.
35. M. Estry-Behar et al. "Stress at Work and Mental Health Status Among Female Hospital Workers", *British Journal of Industrial Medicine* January, 47(1):20-28, 1990.
36. K. Wilkins and M.P. Beaudet, "Work Stress and Health", *Health Reports*, Winter Vol. I (3):47-62: 1998, p.52.
37. Canadian Institute for Health Information, *Statistical Report on the Health of Canadians*, Prepared for the Federal, Provincial and Territorial Advisory Committee on Population Health, Ottawa: Health Canada, 1999, p.53.
38. It is clear from research done at CINBIOSE that women's menstruation, menopause and reproductive capacities are influenced by working conditions, although feminist researchers have often hesitated to make the link for fear such research will be used to limit women's employment. See K. Messing, *One-Eyed Science*. Philadelphia: Temple University Press, 1998.
39. J. Auman and B. Draheim. "The downside to downsizing." *Benefits Canada*, May, 31-3, 1997.  
  
J.A. Schaefer and R.H. Moos. "Relationship, task and system stressors in the health care workplace. Special Issue: Work stressors in health care and social service settings." *Journal of Community & Applied Social Psychology*, 3(4):285-298, 1993 Nov.  
  
J.A. Engels et al. "Work related risk factors for musculoskeletal complaints in the nursing profession: results of a questionnaire survey." *Occupational and Environmental Medicine*, 53:636-41, 1996.
40. R. Bourbonnais et al. "Job strain, psychological distress, and burnout in nurses." *American Journal of Industrial Medicine*, 34(1):20-8, 1998 July.
41. See A Yassi et al. "The epidemiology of back injuries in nurses at a large Canadian tertiary care hospital: implications for prevention." *Occupational Medicine*, 45(4):215-220, 1995.  
  
M. Estry-Behar et al. "Stress at work and mental health status among female hospital workers." *British Journal of Industrial Medicine*, 47(1)20-8, 1990 Jan.
42. Patricia A Kaufert. "The Vanishing Woman: Gender and Population Health," Pp. 118-136 in Tessa M Pollard and Susan Brin Hyatt (eds). Cambridge: Cambridge University Press, 1999.

43. Patricia M. Marchak. "The Canadian Labour Farce: Jobs For Women," pp. 202-212 in Marylee Stephenson (ed), *Women in Canada*. Toronto: New Press, 1973.
44. M.L. Ferguson-Pare. "Registered nurses' perception of their autonomy and the factors that influence their autonomy in rehabilitation and long term care settings." *Canadian Journal of Nursing Administration*, 9(2):95-108, 1996 May-June.
- R. Bourbonnais et al. "Job strain, psychological distress, and burnout in nurses." *American Journal of Industrial Medicine*, 34(1):20-8, 1998 July.
- J.A. Schaefer and R.H. Moos. "Relationship, task and system stressors in the health care workplace. Special Issue: Work stressors in health care and social service settings." *Journal of Community & Applied Social Psychology*, 3(4):285-298, 1993 Nov.
45. N.G. Swanson et al. "Occupational stress and women's health." In Sheryle J. Gallant et al (eds), *Health Care for Women: Psychological, Social and Behavioral Influences*. Cincinnati: National Institute for Occupational Safety & Health, 1997.
- D.Tierney et al. "She ate not the bread of idleness: Exhaustion is related to domestic and salaried working conditions among 539 Quebec hospital workers." *Women and Health*, 16(1): 21-42, 1990.
46. Hospital Employees' Union. *The Workplace Anti-Stress Guide*. British Columbia: Hospital Employees' Union [Marcy Cohen, Project Coordinator], Canadian Union of Public Employees, 2000.
- G.K. Ahlberg-Hulten et al. "Social support, job strain and musculoskeletal pain among female health care personnel." *Scandinavian Journal of Work Environ Health*, 21:435-9, 1995.
- B. Bearwood et al. "Complaints against nurses: A reflection of the 'new managerialism' and consumerism in health care?" *Social Science and Medicine*, 48:363-74, 1999.
- C. Cott. "'We decide, you carry it out': A social network analysis of multidisciplinary long term care teams." *Social Science and Medicine*, 45 (9):1411-21, 1997 Nov.
47. Canadian Union of Public Employees. *Overloaded and Under Fire. Report of the Ontario Social Services Work Environment Survey. Executive Summary*. Ottawa: CUPE, 2000, p. 3.
48. A.M. Trinkoff and C.L. Storr. "Work schedule characteristics and substance use in nurses." *American Journal of Industrial Medicine*, 34(3):266-71, 1998 Sep.
49. Statistics Canada, Health Statistics Division, 1996-97 National Population Health Survey, Content for Main Survey, Ottawa, no date.

opeiu491