in focus backgrounder

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Leading knowledge exchange on home and community care

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Ontario Personal Support Workers in Home and Community Care: CRNCC/PSNO Survey Results

In 2009, the CRNCC collaborated with the Personal Support Network of Ontario (PSNO) and the Ontario Community Support Association (OCSA) to conduct a survey of Personal Support Workers (PSWs) to gauge their attitudes on issues of importance to the profession. This survey asked participants a broad range of questions about demographic backgrounds, education, training and career opportunities; challenges to meeting client needs; attitudes toward cultural competency; their feelings about what is most important in their job; employer relations; and, incidences of workplace violence, harassment, and bullying as a particular form of harassment.

Using a web-based survey tool "Survey Monkey" (http://www.surveymonkey.com/), the CRNCC, PSNO and OSCA sent survey questions to PSWs recruited through OCSA/PSNO mailings lists. Results were analyzed using survey monkey-based software, and SPSS, a quantitative data analysis software. This report presents the survey results of 364 PSWs from across Ontario. Since the sample is not random, hence, not representative of the population of PSWs, this is an exploratory study which makes no claims to generalizations. Nonetheless, the preliminary results can guide the direction of a larger, more vigorous survey and can serve to generate hypotheses which can be tested in subsequent follow up research.

I. Personal Support Workers in Ontario

PSWs make up a substantial proportion of Ontario's health care workforce and provide much needed assistance with daily activities in hospitals, long-term care and educational facilities, adult day programs and at home in the community. According to Lilly (2008), the Canadian Home Care Human Resources Study Survey of Formal Caregivers estimates that PSWs carry out most (70–80%) of all paid home care work in the country. Yet, we know relatively little about them (Aronson and Neysmith, 1996; Ontario Association of Community Care Access Centre et al., 2000; Toronto District Health Council 2002; Twigg, 1999).

PSWs typically provide non-professional services involving personal assistance to older people, people with disabilities and/ or chronic health conditions and, in some cases, children (Personal Support Network of Ontario, 2010; Keefe, Martin-Matthews & Légaré, 2009).

Generally, PSWs assist with activities such as:

- Home management including shopping, housekeeping, meal preparation;
- Other instrumental activities of daily living (IADLs) including transportation and medication management;
- Social and recreational activities;
- Personal care including bathing, toileting, dressing, personal hygiene, eating, mobility (OCSA/MOHLTC, 1997).

II. Survey Results

1.0 "I best describe my position title as…"

Depending on the province or territory or even the work setting, people who provide the bulk of non-professional work in home and community care go by different job titles (Lum et al., 2010). In this survey, the majority of respondents, about 80%, describe themselves as PSWs; however, close to 20% do not.

- 82% call themselves PSWs;
- 7% call themselves Home Support Workers;
- 4% are Personal Attendants;
- 1% are Homemakers;
- 5% of participants identify as "none of these job titles" or "other."

2.0 Demographic Background

2.1 Gender and Age

In Canada, women predominantly make up the home support labor force, and a high proportion of these women are immigrants and visible minorities (Aronson, Denton & Zeytinoglu, 2004; Neysmeith & Reitsma-Street, 2003). In long-term care settings for example, overwhelmingly, the majority of care workers are female, and many are 45 years and older. This trend is present in countries other than Canada, such as the US, Denmark, France, the Netherlands, and Australia (Korczyk, 2004).

Table 1: Percentage of PSWs by Age Groups

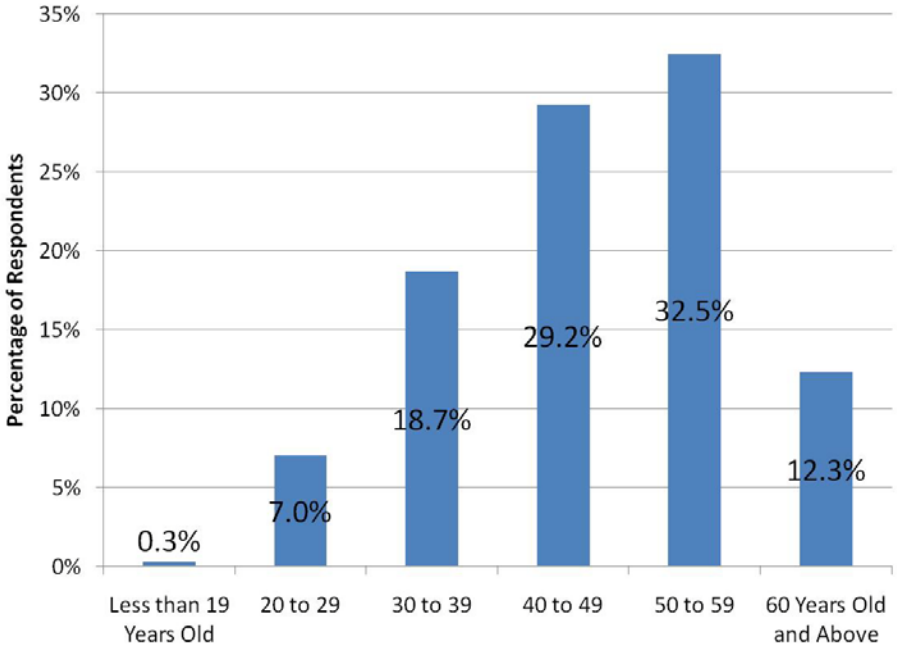
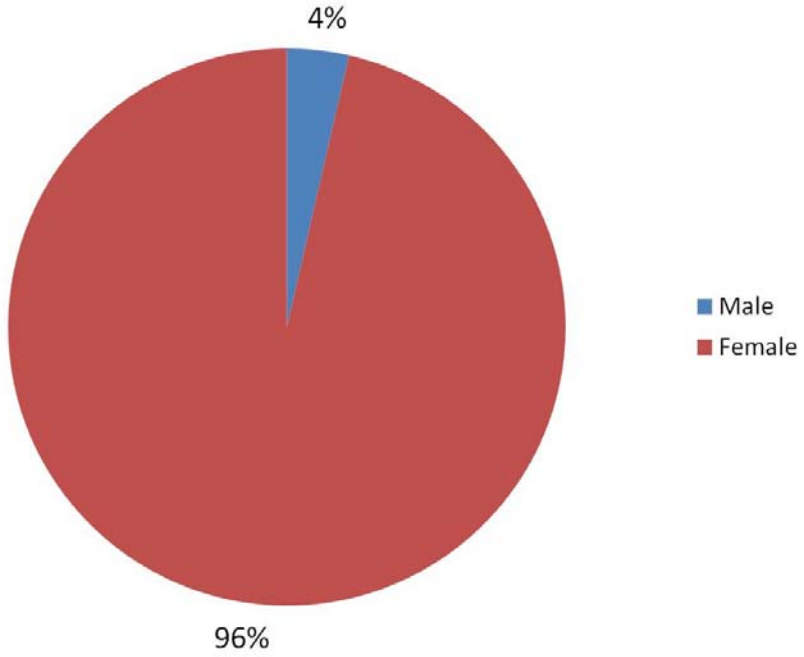


Table 2: Percentage of PSWs by Sex



The average age of a PSW in community support services is 45.6 years old (OCSA, 2010) and nearly three-quarters of care workers in Canada are 35 years or older, compared with 61% of workers in the overall workforce (Korczyk, 2004). The gender and age of PSWs who responded to this survey reflect comparable trends. As Table 1 and 2 above show:

- Almost all (96%) of respondents are women;
- Approximately three quarters (74%) of respondents are 40 years of age or older;

- Almost half (45%) of PSWs are 50 years of age or older.

2.2 Race, Ethnicity and Visible Minority Status

Between 2001 and 2006, Ontario's visible minority population increased more than four times faster than the provincial population as a whole: 27.5% vs. 6.6% (Statistics Canada, 2009a). Given immigration patterns for Canada and Ontario, this number will likely continue to grow.

Broadly, PSWs reflect the ethnic and racial diversity of Ontario. The overall visible minority population of Ontario is estimated at 2.7 million, almost 23% of Ontario's total population. Table 3 shows Ontario's visible minority populations based on 2006 census data (Statistics Canada, 2010). In comparison, visible minorities are over-represented among PSWs, making up 42% of this labour force. Table 4 represents the breakdown of visible minority representation for our PSW respondents.

Table 3: Ontario Visible Minority Population (2006)

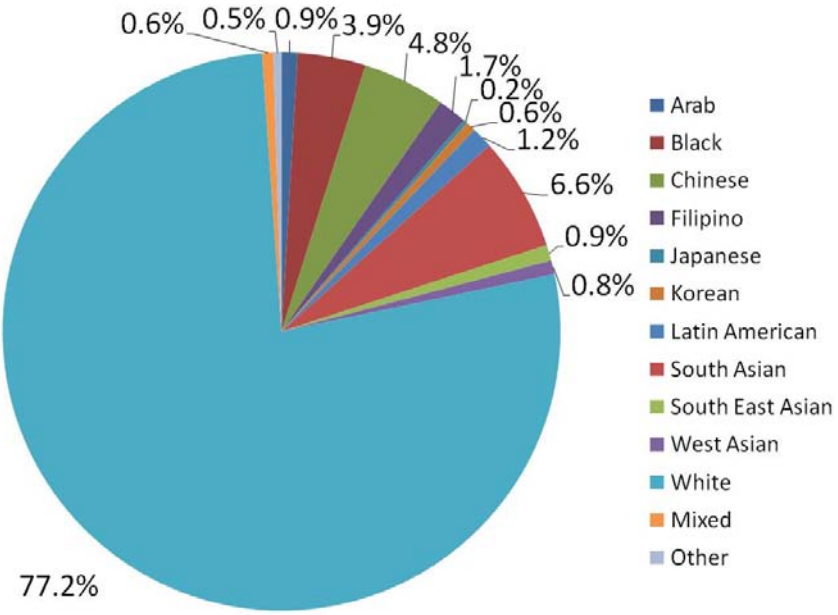
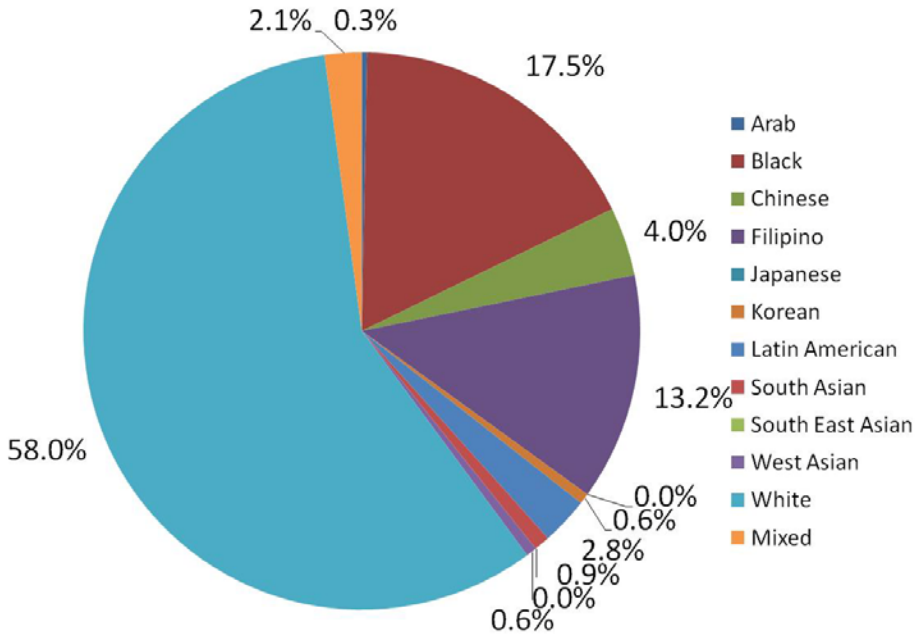


Table 4: PSW Visible Minority Status



Within the 42% of respondents who self-identified as visible minority:

- 18% self-identified as Black;
- 14%, as Filipino;
- 4%, as Chinese;
- 3%, as Latin American;
- 1%, as South Asian; and,
- Less than 2% self-identified as Korean (0.6%); West Asian (0.6%); or Arab (0.3%).

2.3 Aboriginal Status

In the 2006 census, 242,495 people or 2% in Ontario self-identified as Aboriginal, representing an increase of 28.8% between 2001 and 2006, which is a rate faster that of Canada as a whole (Statistics Canada, 2009b). However, 5% of our PSW respondents self-identified as Aboriginal. With increasing life expectancy of Aboriginal peoples, there will be growing numbers of older First Nations people who will require culturally sensitive care.

3.0 Where do PSWs work?

PSWs work in a wide range of settings including home care, long-term care facilities, adult day programs, community support services, supportive housing, group homes, private homes, hospitals, educational facilities to name a few (PSNO, 2009). As shown in Table 5 below, almost 64% of PSWs in this survey work solely in the home and community care sector:

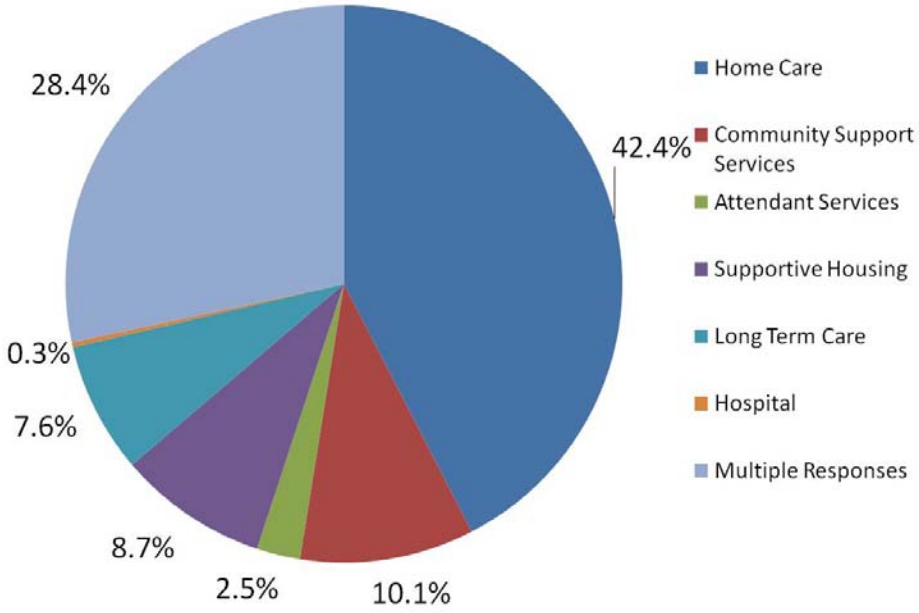
- 42% provide homecare;
- 11% provide community support services;
- 8.5% work in supportive housing;
- 3% provide attendant services.

Less than 8% work solely in institutions:

- 7% work in LTC facilities
- <1% work in hospitals

Almost 29% of PSWs have multiple jobs and report working in more than one setting.

Table 5: Work Settings



Unfortunately, it is difficult to say with any accuracy how the distribution of these figures compares with the distribution of PSWs generally in Ontario. For example, Health Canada estimates that in Ontario, approximately 100,000 people work as personal support workers or perform similar roles. Of these, over 6,000 home support workers work in hospitals, 34,000 in home care and community support and 57,000 in long-term care facilities (Health Professionals Regulatory Advisory Council, 2006).

The problem however is that Health Canada does not classify PSWs as stand-alone job categories and may group them with related occupations such as Patient Service Associates, Attendant Care Workers and Visiting Homemakers. As well, employer records of staff employed may be inaccurate as employers may add up hours worked and report on FTE positions rather than on staff positions. Because many employers rely on part-time or casual workers to meet variable demands for services, FTEs may underestimate the number of PSWs employed (Lum et al., 2010; Health Professionals Regulatory Advisory Council, 2006).

4.0 Years Working as PSW

Table 6 shows the number of years our respondents report as having worked as a PSW. About half (44%) state that they have been support workers for more than 10 years, suggesting that they are committed to their work as a career path as opposed to a short term job.

Table 6: Years Working as PSW

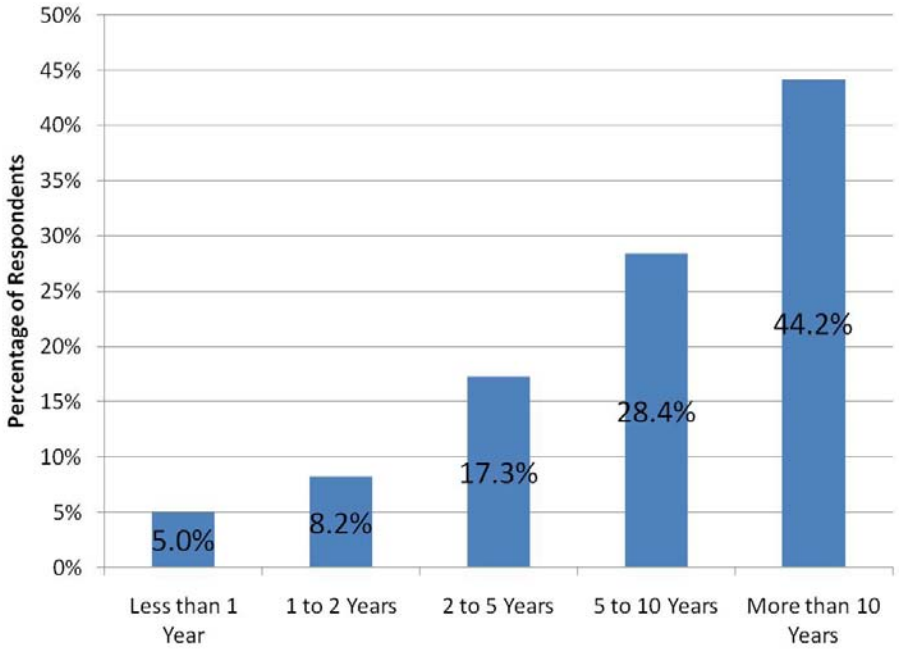
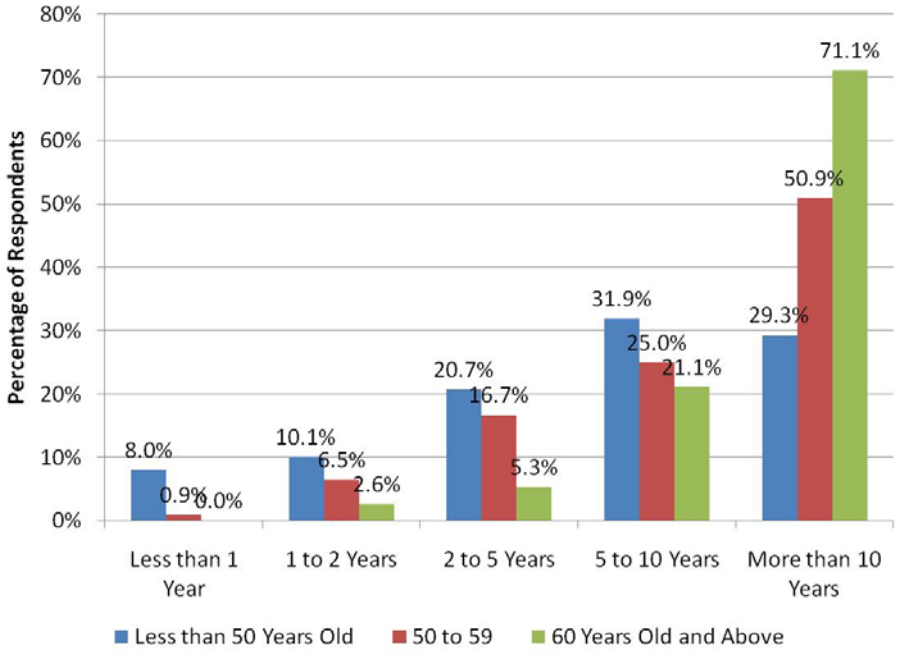


Table 7 below presents our findings when we compared the PSWs less than 50 years old, 50 to 59 years old and those who are 60 years or older with their number of years of experience as PSW. Of significance, we noted that:

- About 61% of PSWs under 50 years old have 5 or more years of experience;
- Almost 76% of the 50-59 age group have 5 or more years of experience;
- Over 92% of the 60+ age group have 5 or more years of experience.

Table 7: Years Working as PSW by Age Groups



5.0 Education, Training and Job Readiness

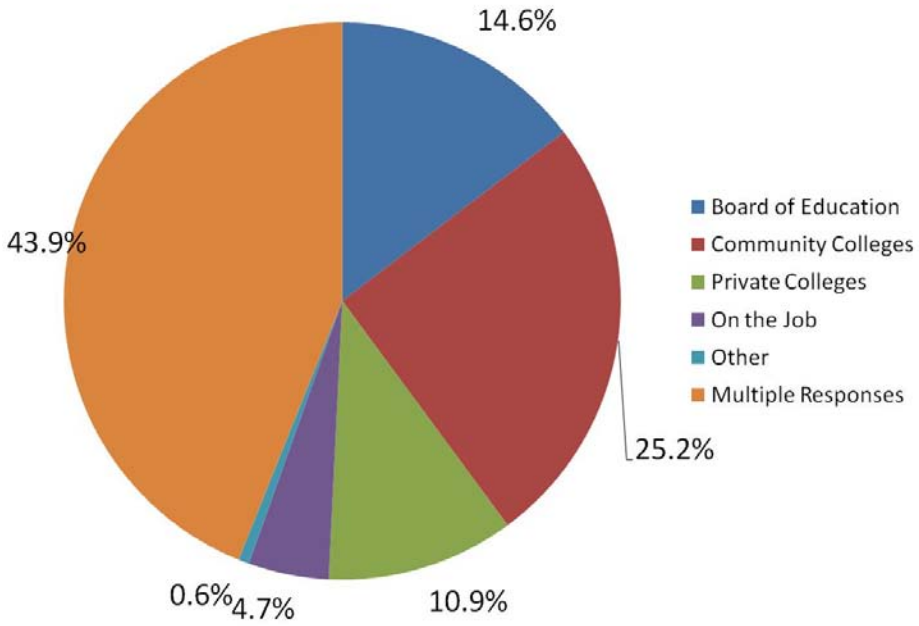
5.1 Where do PSWs receive their training?

Of the estimated 7,000 annual graduates from PSW Certificate Programs in Ontario, only 20% are from MTCU recognized community college programs. Almost 45% of graduates attended private career colleges with the balance (35%) having attended Board of Education adult learning programs or programs sponsored by non-profit organizations (PSNO, 2009).

As shown in Table 8 below, the majority of PSWs in our study say that they received training through many different sources (44%). Of the remaining PSWs who report only one source of training:

- 25% received training through publicly funded community colleges;
- 15% received training through Board of Education programs;
- 11% attended private training colleges;
- 5% received on the job training from employers;
- 0.6% indicated some other training alternative (without specification).

Table 8: Training Programs in Ontario



5.2 Certification

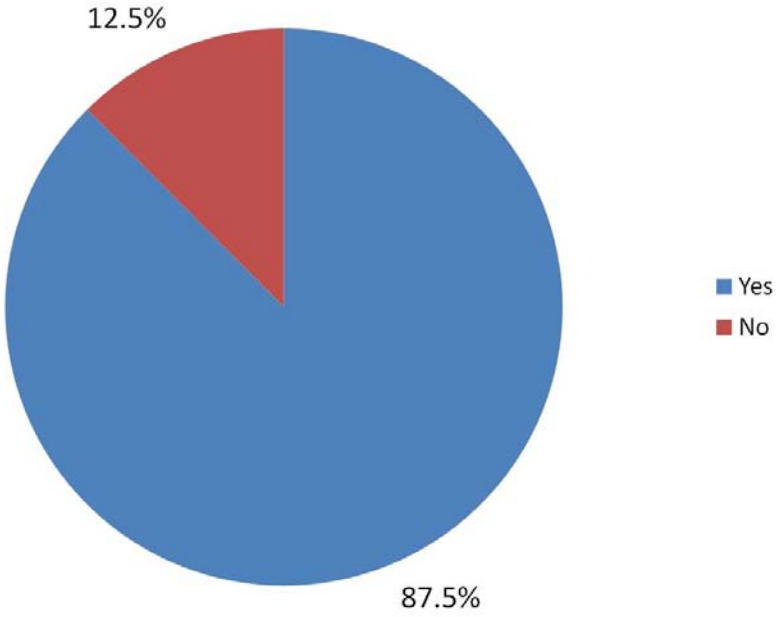
Personal Support Workers do not need a PSW certificate to work as a PSW in Ontario (PSNO, 2010 - check), although as of July 1, 2011, with changes to the new *Long-Term Care Act*, a PSW certificate will be a mandatory requirement for all new PSW hires. Various training institutions issue certificates. They include:

- Community colleges;
- Private vocational schools;
- Boards of Education;
- Not-for-profit organizations.

All organizations providing training base their programs on the document “Personal Support Worker Training: Outcomes and Module Outlines” which was published by the Ontario Community Support Association (OCSA) in January 1997(OCSA, 1997).

About 88% of PSWs indicate that they have a “PSW certificate,” compared to 12% who indicate they do not (Table 9).

Table 9: Do you have a PSW Certificate?



However, what does a PSW certificate mean? In Ontario, obtaining a PSW Certificate does not translate into a designation such as Certified PSW or Registered PSW because PSWs are essentially unregulated health care workers. In other words, there is neither an officially recognized “certification” nor “registration” process. Nor is there a PSW regulating body (PSN0, 2010). In sum,

- PSWs are unregulated health care workers.
- There is no certification” nor “registration” process.
- There is no PSW regulating body.
- Some confuse a college PSW certificate with professional certification. A college PSW certificate merely shows one has completed a course of study. It is not the same as “certification” or “registration” as health professionals understand the term.
- Some private career colleges misleadingly use the terms “certification” and “registration” their advertising (PSN0, 2010).
- End-of-course examinations are not required in order to receive a PSW Certificate. However, some private career colleges offer a “national exam” or a “provincial certification exam.” Such exams are neither recognized nor required to work as a PSW (PSNO, 2010)

In short, the terminology around certification for PSWs in Ontario is not standardized. As a result, there is much confusion around what a PSW certificate means.

5.3 Training Standards

Since health is under provincial jurisdiction in Canada, there are no national standards, programs, exams for personal support workers. Each province sets its own training and performance requirements and standards. Ontario requires Personal Support Workers to receive training according to the original standards approved by the Ministry of Health and Long Term Care in May 1997.

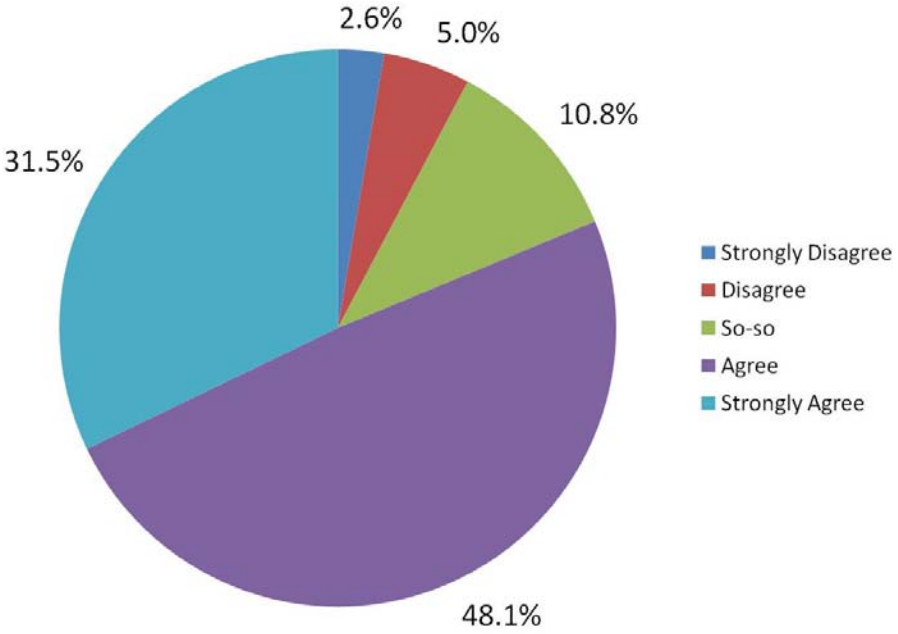
PSW roles fall under limits defined the *Regulated Health Professions Act*, which specifies which health professionals may do certain "controlled" acts. PSWs do not diagnose conditions, do not deliver clinical care except under specific circumstances, or provide acute care beyond emergency first aid (OCSA, 2009). There are only a few circumstances where PSWs may perform some of these acts. There are also specific guidelines to follow if they are asked to do one of these acts (Personal Support Network of Ontario, 2010). PSNO identifies three PSW training standards in Ontario: the Ontario Ministry of Health and Long-term Care Standards (MOHLTC), the Ministry of Training, Colleges and Universities Standards (MTCU), and the National Association of Community Colleges (NACC) training standards.

6.0 What do PSWs say about their work?

6.1 Do you have enough training to meet your work responsibilities?

Do PSWs feel that they have enough training to meet their work responsibilities? As shown in Table 10 below, 79% indicate they receive enough sufficient training (31% strongly agree; 48% agree) while only 8% of respondents disagree.

Table 10: My training is enough for my level of responsibility at work



6.2 What training do you need to help do your job better?

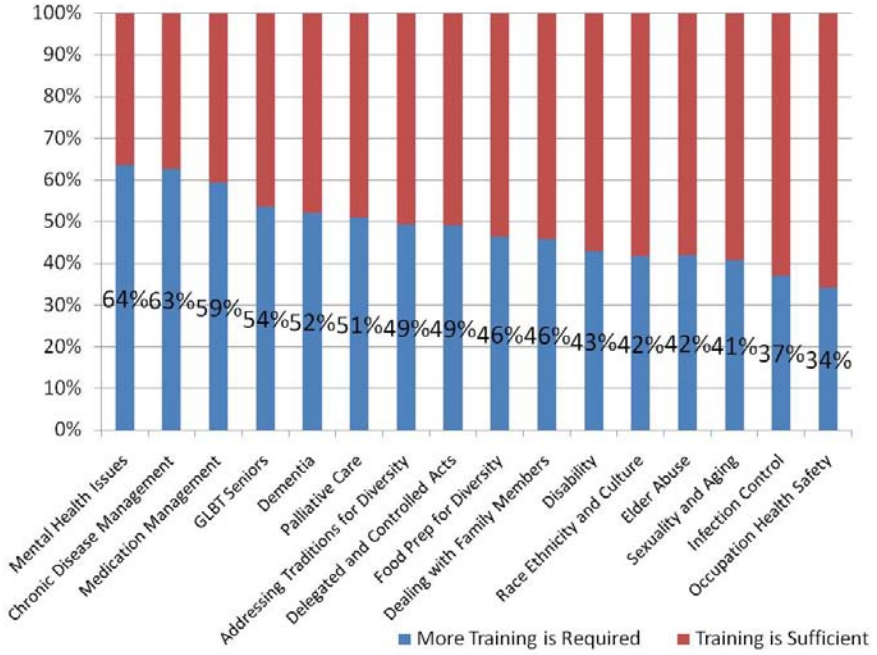
Although most PSWs feel that they have enough training to meet their current work responsibilities, we still asked what kinds of training would help PSWs better meet their work responsibilities, and then, to indicate more specifically the areas in which they feel enhanced training would be beneficial. Note that this is in addition to their current skills training associated with IADLs and ADLs.

We asked about a number of areas including:

- specific client conditions such as mental health issues, chronic diseases and dementia;
- cultural competency training such as cultural traditions, food preparation for diverse clients, and understanding issues of race, ethnicity and culture;
- professional competencies such as medication management, palliative care, dealing with families, and delegated and controlled acts;
- emerging issues in care such as GLBT seniors, elder abuse, sexuality and aging; and,
- occupational health and safety and infection control.

Table 11 summarizes the results.

Table 11: What training do you need to help do your job better?



Over 2/3 of PSWs indicate more training is needed in areas of mental health (64%) and chronic disease management (63%). Over half indicate more training is required in medication management (59%), GLBT seniors (54%), dementia (52%), and palliative care (51%).

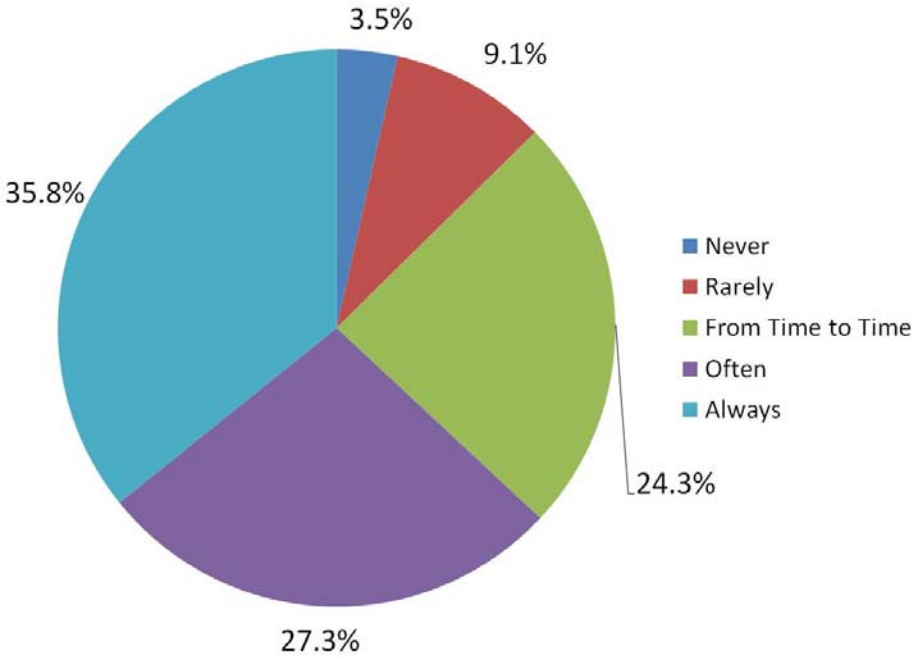
Alternatively, PSWs point out that they do not need additional training in areas such as occupational health and safety (66%); infection control (63%); sexuality and aging (59%); race ethnicity and culture (58%); elder abuse (58%); disability issues (57%); food prep for diversity (54%); dealing with family members (54%); delegated and controlled acts (51%); and addressing traditions for diversity (51%).

6.3 Is your schedule flexible enough to meet clients with different care needs?

An important aspect of PSW work is to provide more or less care as clients' needs change. AS shown in Table 12, over half of our respondents (53%) feel that their schedules are always (36%) or

often (27%) sufficiently flexible to meet their clients' changing needs. Just over one in ten respondents (13%) indicate that their schedules are never (4%) or rarely (9%) flexible enough to meet the broad and diverse range of client needs.

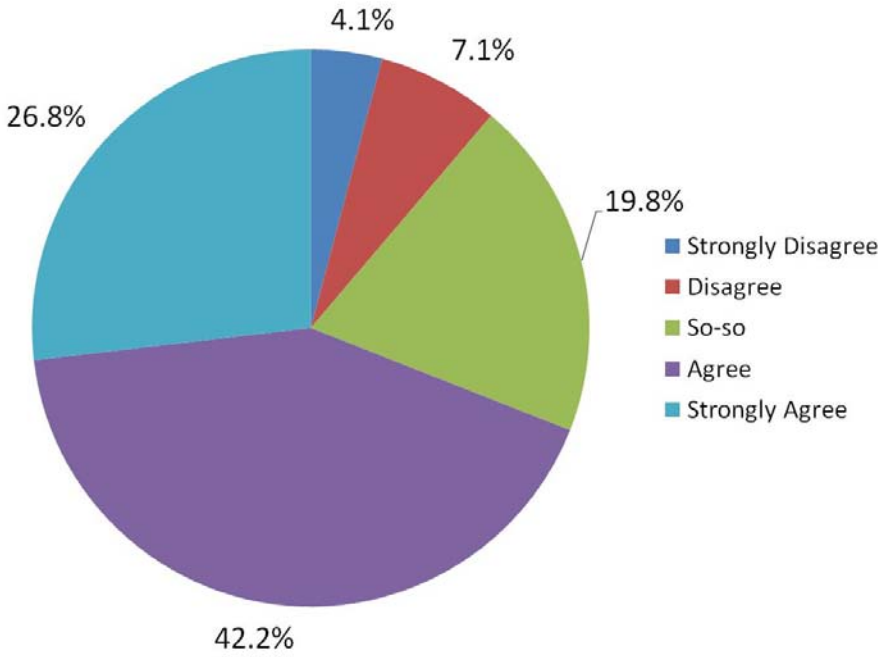
Table 12: My schedule is flexible enough to address clients with different care needs



6.4 Is your on-the-ground PSW experience valued?

Belonging to a practice-led discipline, PSWs draw on different kinds and formats of knowledge in the provision of care. Formal knowledge is mostly learned in the classroom. This knowledge is explicit, demonstrated in skills acquisition, factual information, and can be measured by instruments such as skills competencies. Another critical dimension of knowledge is experiential or tacit knowledge. As opposed to formal or explicit knowledge, the tacit aspects of knowledge are not easily shared, and can only be gained through extensive personal experience. Tacit is the "know-how" that comes from many years of first-hand experiences, as opposed to the "know-what" or the "know-why," which can be readily accessed, learned, and passed on through formal education and instruction. We asked PSWs whether they feel their experiential, on-the-ground knowledge is valued.

Table 13: My on-the-ground PSW experience is valued

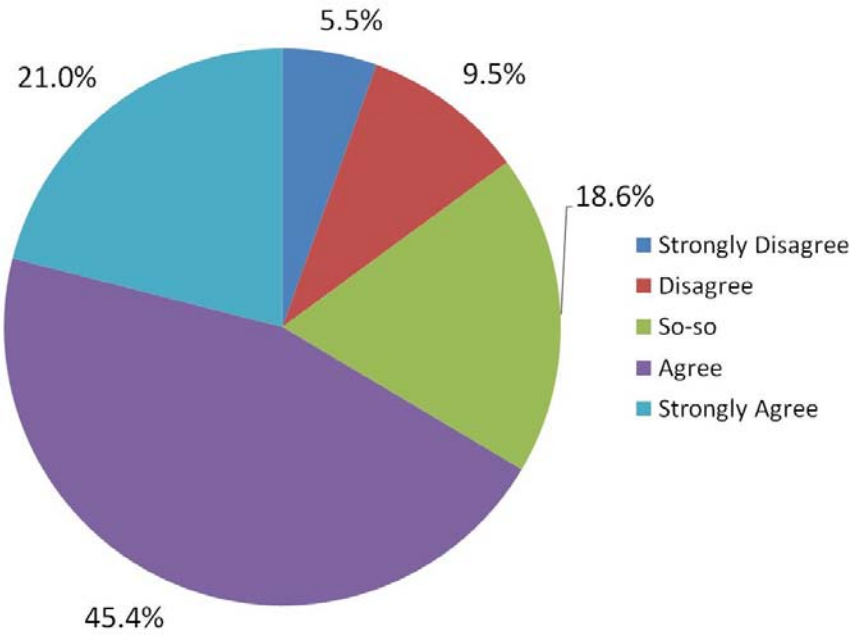


Over two-thirds (69%) of respondents feel their unique experiential knowledge is valued although almost 11% disagree, believing these experiences are not valued (Table 13).

6.5 Are PSWs valued as members of a multidisciplinary team?

As can be seen in Table 14, over two-thirds of respondents (66%) agree that they are valued as a member of a multidisciplinary team while 15% feel they are not valued.

Table 14: I am valued as a front line member of a multidisciplinary care team



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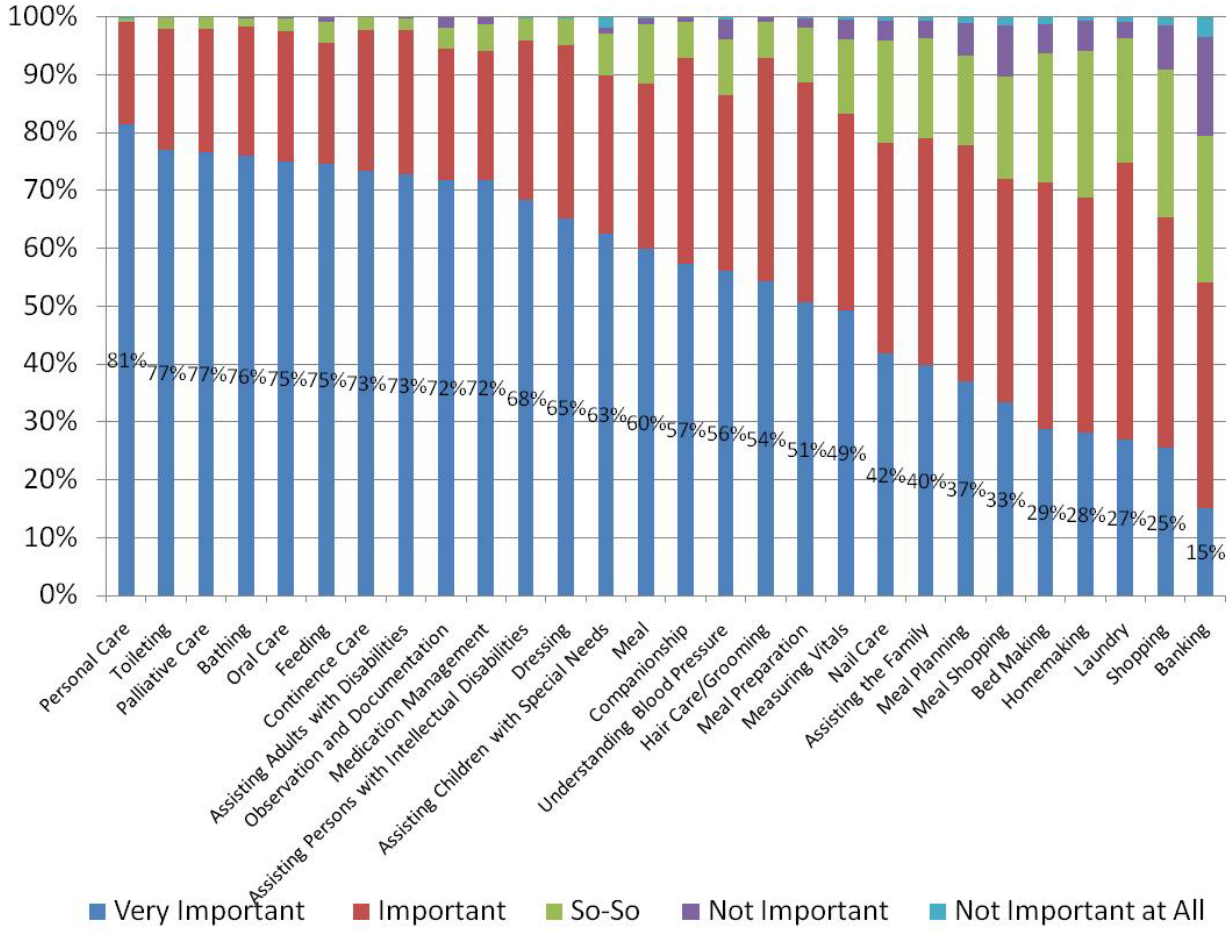
7.0 What do PSWs say about their clients?

7.1 What responsibilities do you think are most important for clients?

PSWs prioritize the following areas of care as important to a client's well being. At the top of the list is the assistance they provide in the activities of daily living (ADLs).

- Personal care (81%)
- Toileting (77%)
- Oral care (75%)
- Feeding (75%)
- Medication management (72%)
- Dressing (65%)
- Meal Prep (51%)
- Grocery shopping (33%)
- Bed making (29%)
- Homemaking (28%)
- Laundry (27%)

Table 15: What responsibilities are most important to a client's well being?



As shown in Table 15, above, PSWs rate assistance with the instrumental activities of daily living (IADLs), with the exception of medication management (72%), lower in importance to clients' well being. Helping with meal prep, shopping, homemaking and laundry rank considerably lower in importance than helping with ADLs such as personal care (81%), toileting (77%) oral care (75%), and feeding (75%).

7.2 Caring for Clients of Diverse Backgrounds

PSWs with linguistic and cultural skills are particularly crucial for the growing population of clients of varying ethnic and racial identities (Lum, Ruff & Williams, 2005, Lum et al., 2007, Lum et al., 2009). PSWs recognize that both the capacity to communicate with clients from different ethnic, cultural and religious backgrounds as well as comfort in communicating with clients from diverse backgrounds are important aspects of being able to meet care needs:

- 62% of PSWs feel it is important to be able to speak to clients in their own language (Table 16);
- 92% of PSWs believe they are comfortable communicating with clients from different ethnic, cultural and religious backgrounds (Table 17)

Table 16: It is important to speak clients in their own language

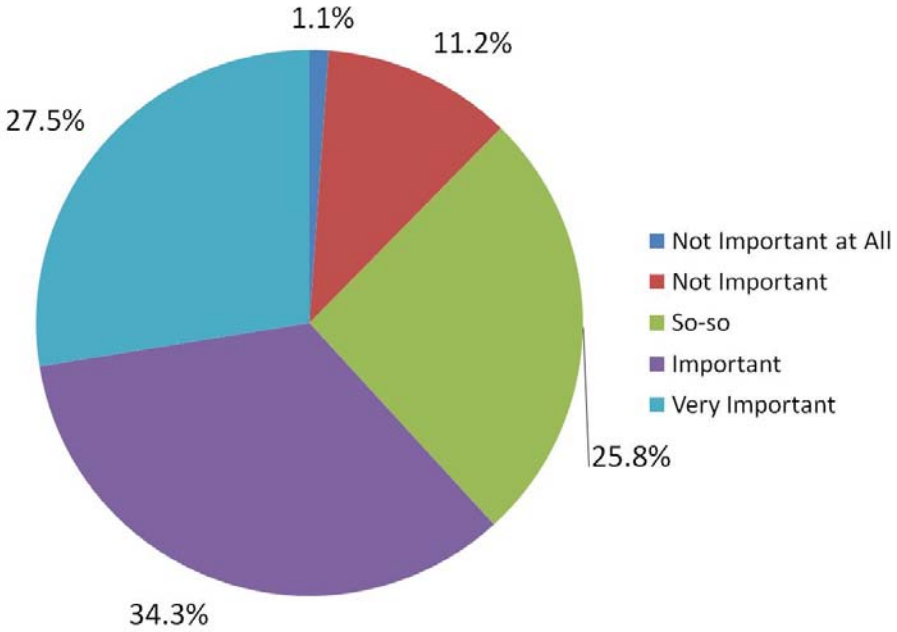
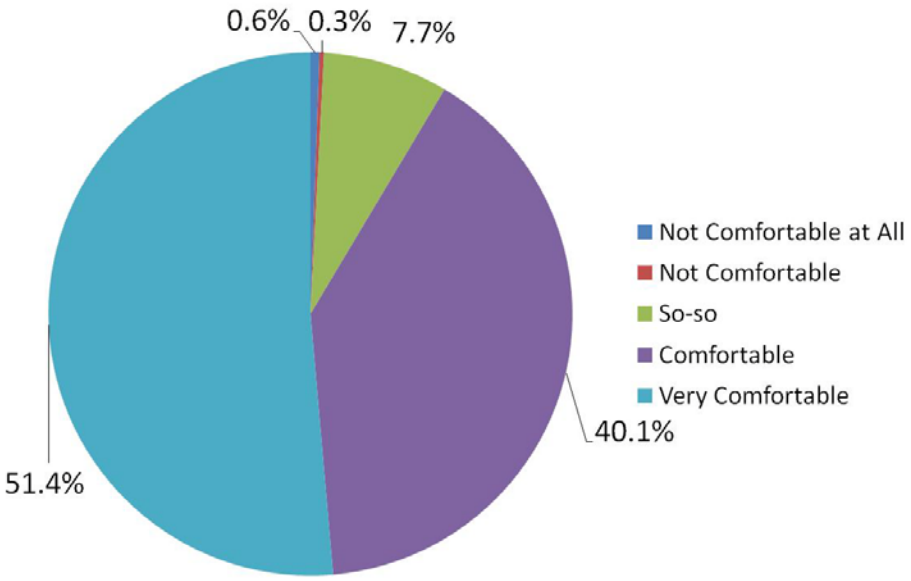


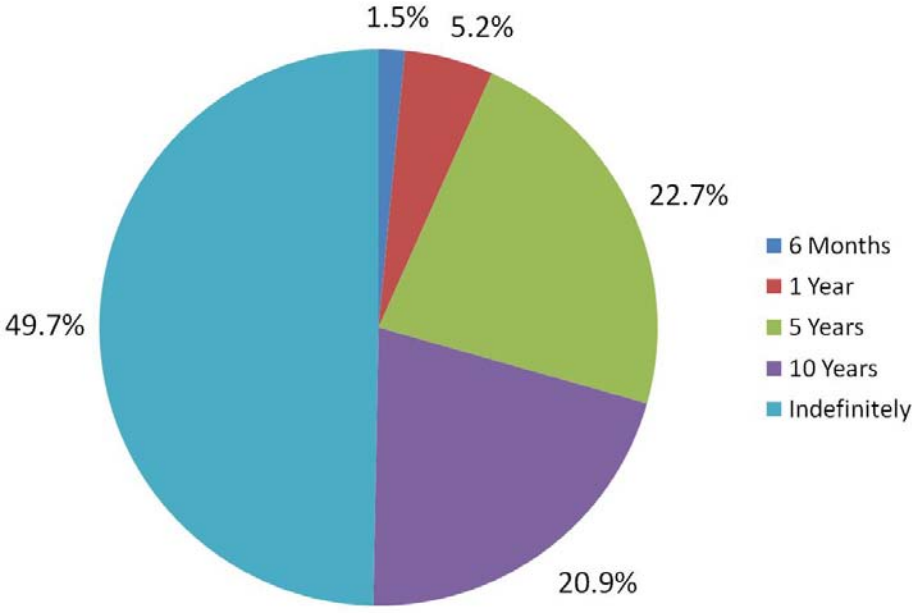
Table 17: I feel comfortable communicating with clients from different cultural, religious or ethnic backgrounds



8.0 Retention and Attrition

When asked how long they expect to continue working as PSWs, almost half (50%) of respondents indicate they expect to be working indefinitely. Few PSWs (2%) believe that their position is short term, for the next 6 months.

Table 18: How long do you expect to continue working as a PSW?



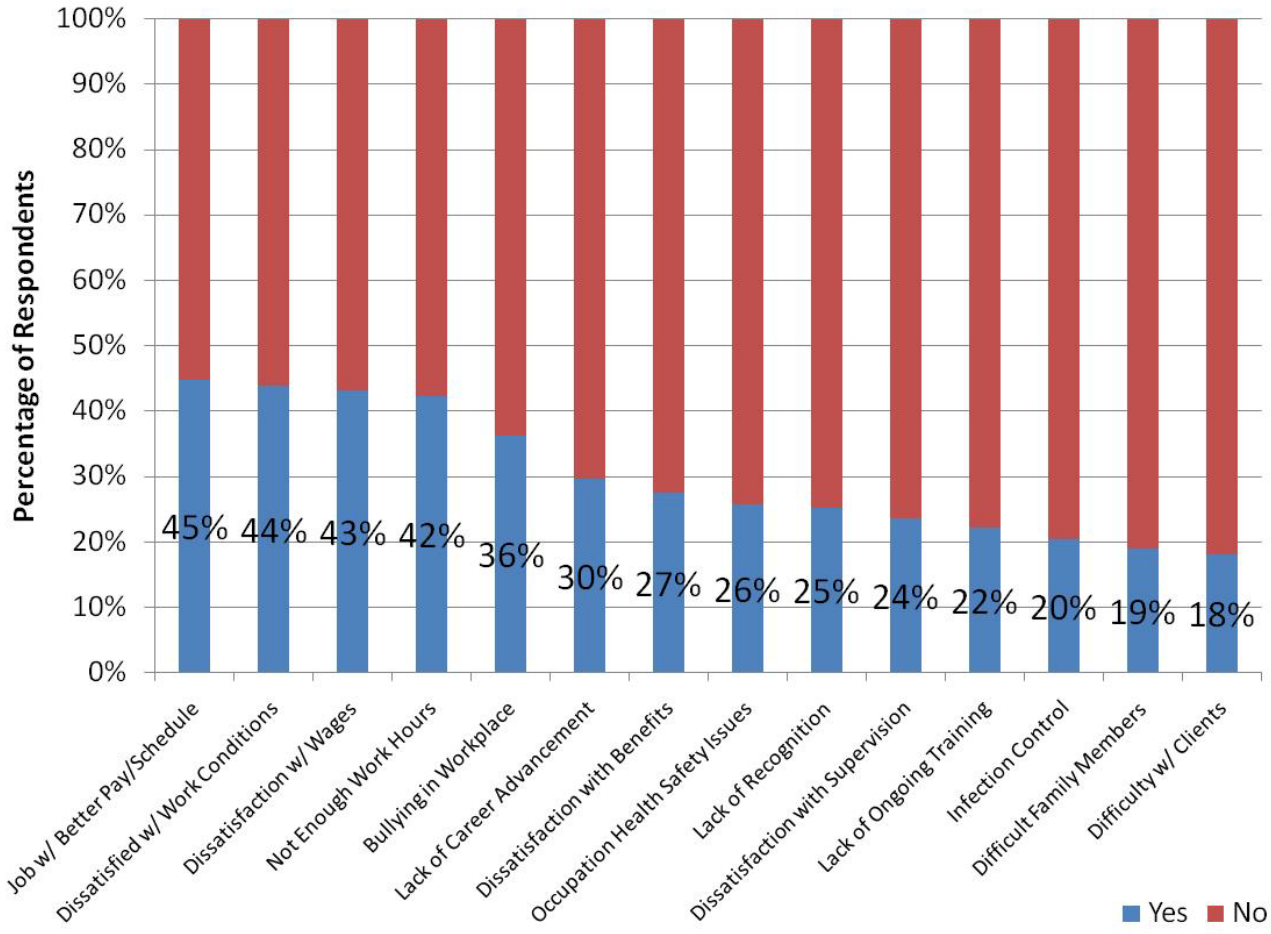
- 23% indicate they expect to be working as PSWs for the next 5 years;
- 21%, for at least the next 10 years;
- 5%, for at least the next year.

8.1 What would persuade you to stop working as a PSW?

The three highest ranked responses in this survey relate to pay, scheduling, and hours. The top reason respondents give for potentially leaving the profession is “finding a job with better pay/scheduling” (45%) revealing “dissatisfaction with wages” (43%) and “not enough work hours” (42%). However, PSWs indicate that wages, hours and scheduling present only part of the picture. The second highest response is “dissatisfaction with working conditions”, with 44% of respondents citing this as a reason to leave PSW work.

The lowest ranked reasons relate directly to client care. Only 18% of respondents indicate that difficulties with clients would cause them to leave PSW employment while 19% point to difficulties with family members as a reason to leave. Table 19 below summarizes the findings.

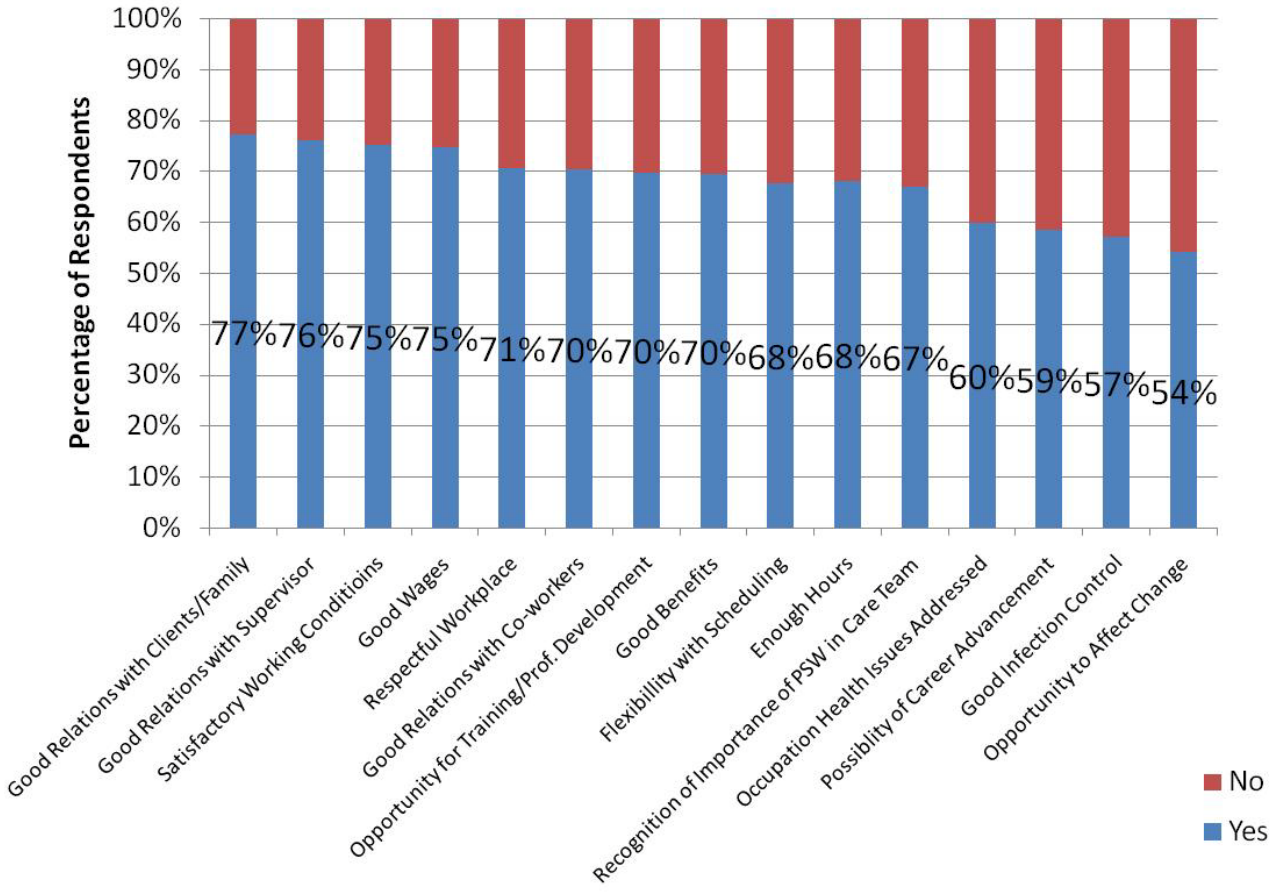
Table 19: What factors would persuade you to stop working as a PSW?



8.2 What would motivate you to keep working at your current job?

Correlatively, positive relations with clients, their families, co-workers and supervisors are strong motivators keeping PSWs on the job. As seen in Table 20, about three-quarters of PSW respondents say that factors such as “good relations with clients and family” (77%); “good relations with supervisors” (76%); and, “good relations with co-workers” (70%) motivate them to keep working at their current job. Highly ranked also are such factors as “satisfactory working conditions” (75%) and “respectful workplaces” (71%).

Table 20: What factors motivate you to keep working at your current job?



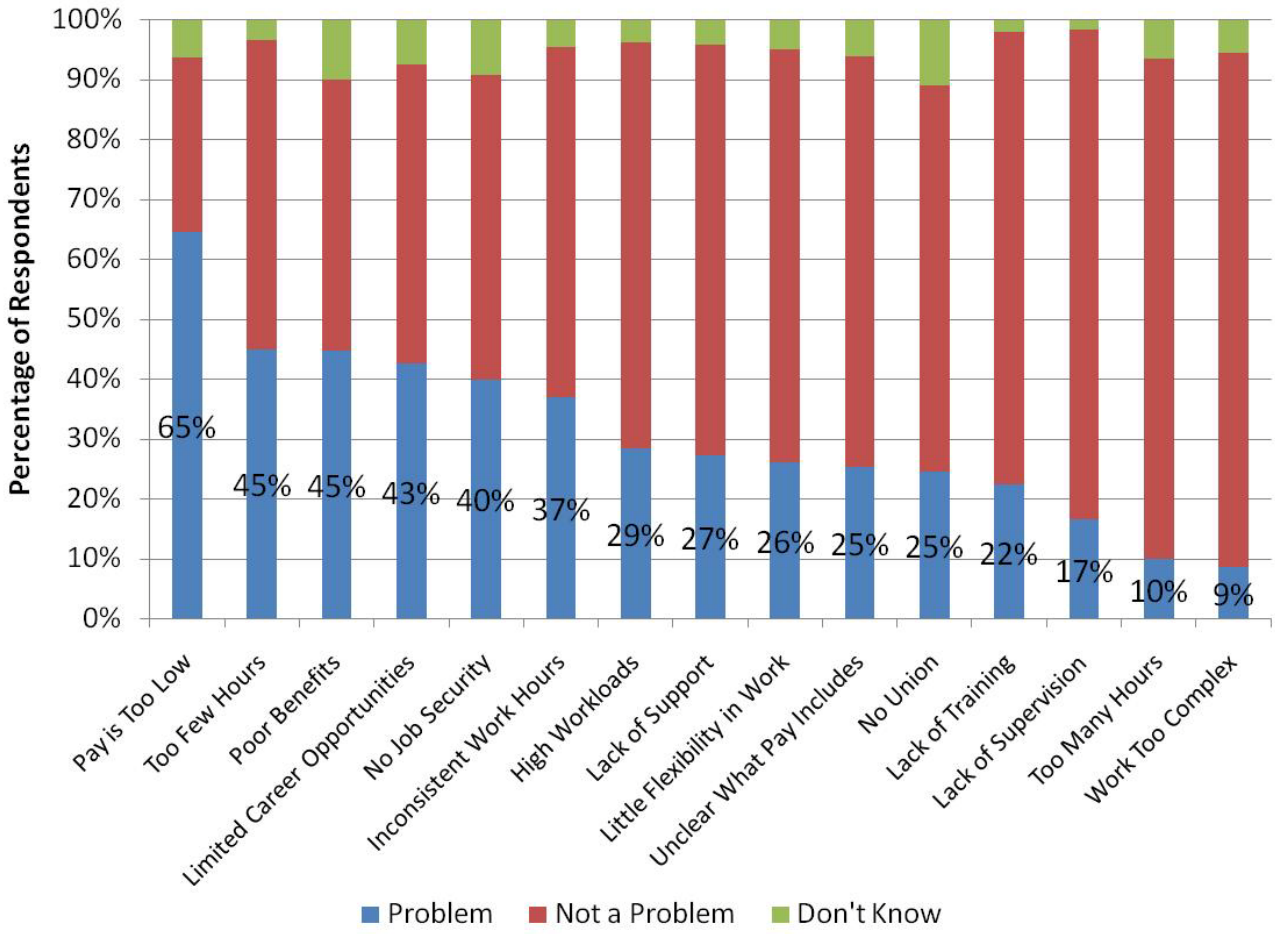
9.0 Challenges with Employers

Here we look at the problems PSWs say they face with their employers. Consistent with the reasons respondents give for considering a job change, respondents identify pay-related issues as the top work-related challenges. According to Table 21:

- Almost 2/3 of respondents (65%) indicate that their “pay is too low” and approximately one in four (26%) are “unclear about what their pay includes”;
- 45% say they have “too few hours” to work, or that “schedules are inconsistent” and unpredictable (37%);

- 45% say “benefits are poor”; and,
- 40% indicate that “job insecurity” is a problem.

Table 21: What are some challenges that you face with your employer



The least problematic challenges include:

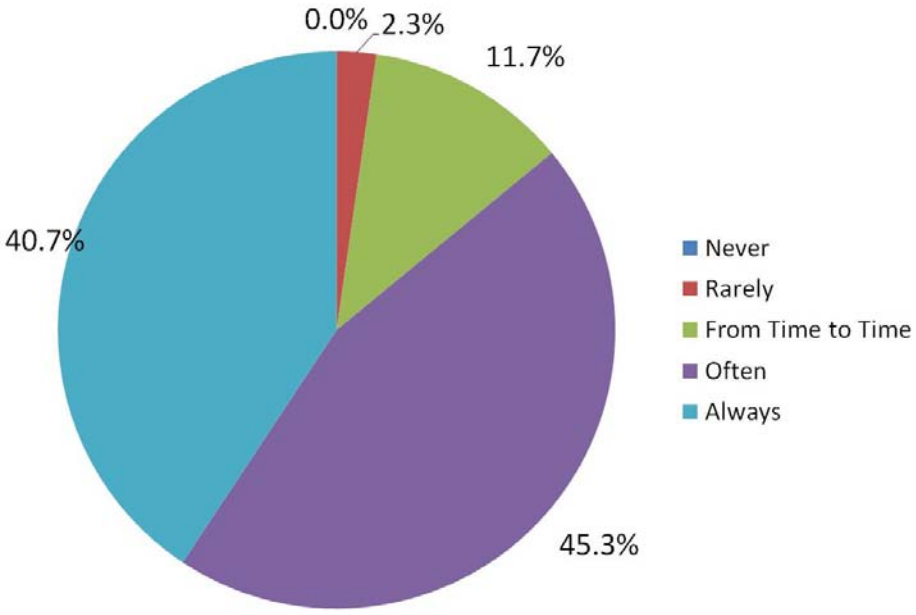
- lack of supervision (17%);
- working too many hours (10%); and,
- performing work that is too complex (9%).

9.1 Workplace Health and Safety

PSWs often balance safety risks with the need to deliver care (OCSA, 2008). Unlike providing care in singular settings such as hospitals or long-term care facilities, PSWs in the home and community care sector often work in many different homes. Each home introduces different challenges, which can potentially create elements of unpredictability and risks. As Leseluc’s (2004) analysis of The General Social Survey data indicates, higher risks of violence is associated with certain features that are present in home and community care settings. Nonetheless, when asked if their workplaces are physically safe (Table 22), the vast majority (86%) respond that their workplaces are “often” or

"always" safe. While 12% only feel safe "from time to time", even this figure should give one cause to pause.

Table 22: Is the physical environment of your workplace safe?



Workplace safety however goes beyond a physically safe workplace to include workplaces free from violence and harassment. We now turn to that broader view.

9.2 Workplace Health and Safety: Violence, Harassment and Bullying

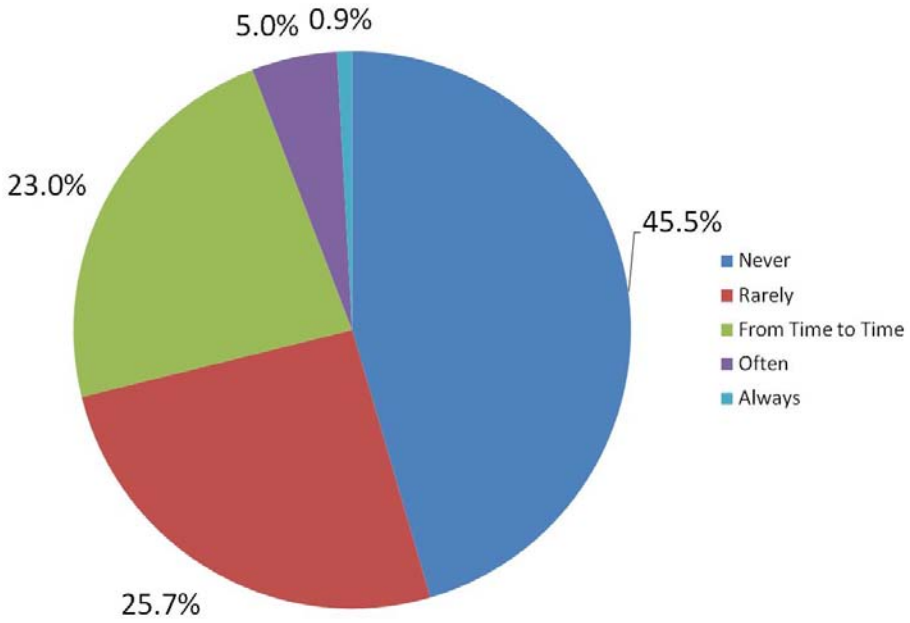
A newly amended Occupational Health and Safety Act (OHSA) came into effect June 2010. The Act now includes broader definitions of workplace safety. A safe workplace is one that is free from violence, defined as exercising, attempting or threatening to use physical force against a worker, in a workplace that causes, could cause, or suggests causing physical injury to the worker (Government of Ontario, 2010; Ontario Ministry of Labour 2009; 2010).

The Act also protects against workplace harassment, which is "engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome." Harassment may include bullying, intimidation or offensive jokes or innuendos, displaying or circulating offensive pictures or materials, or offensive or intimidating phone calls. Workers have the right to refuse work if they have a reason to believe they may be in danger from workplace violence. The Act prohibits employer reprisals.

With increased attention to these other aspects of safety, we included a series of questions probing whether, and how frequently PSWs encounter various forms of violence such as sexual, physical or verbal; bullying, or other forms of harassment based on race, gender or sexual orientation.

While it is common to think of violence or harassment as directed at the self, being a witness to these events is also a key issue in workplace safety, whether it is witness to a coworker or a client.

Table 23: Frequency of witnessing violence or harassment in the workplace



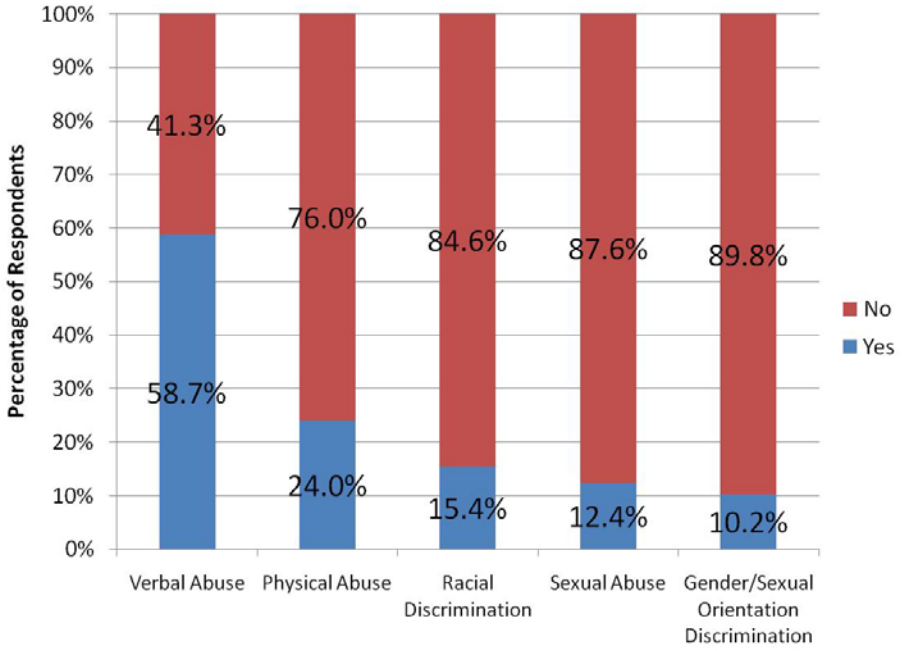
We see in Table 23 that witnessing violence or harassment in the workplace is experienced by over half of our PSW respondents (55%)

- about 6% of PSWs indicated they "often" or "always" witnessed incidents in their workplaces.
- 23% say they had witnessed incidents "from time to time";
- 26% of respondents reported rarely withnessing incidences of violence or harassment.
- 47% reported never having witnessed an incidence of violence or harassment

9.2.1 Varying Forms of Workplace Violence and harassment

Among our sample of respondents, workplace violence occurs in different forms. We asked PSWs to identify whether they had experienced or witnessed violence or harassment, and if so, in what specific forms. While most PSWs say they had neither personally experienced violence or harassment nor witnessed staff or clients experiencing violence or harassment in the worklpace, nonetheless, the 55% or more than half of PSWs who said they have witnessed incidents of violence/harassment cannot be overlooked. What is the nature of the experience of violence within this population?

Table 24: Experience with different forms of workplace violence/harassment



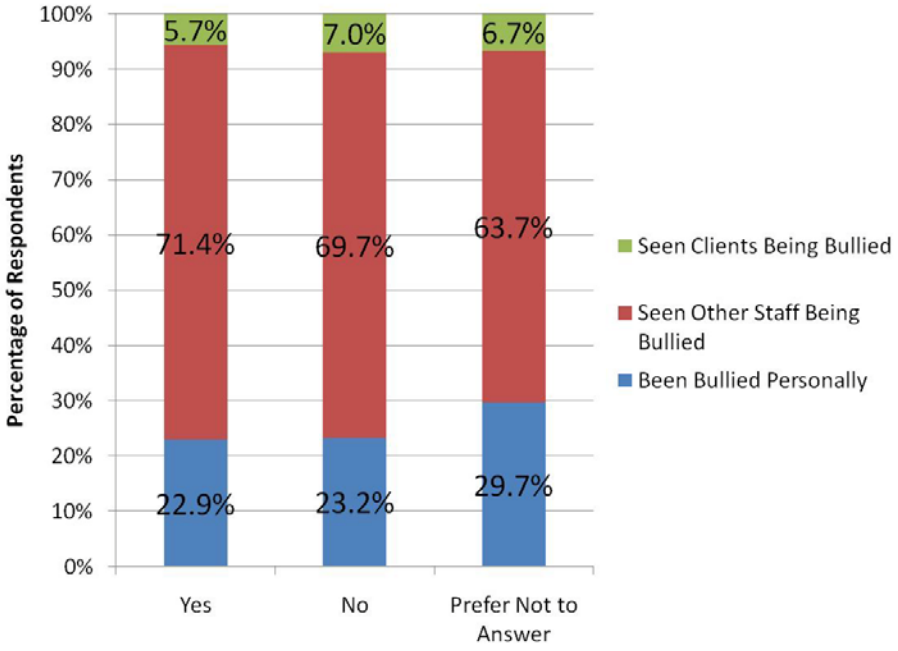
According to Table 24, survey results suggest that of those who say they have experienced violence/harassment, verbal forms appear to be the most common.

- 59% say they experienced verbal forms;
- 24%, physical forms;
- 15% say they experienced violence/harassment related to their race;
- 12%, sexual forms of violence/harassment;
- 10% say they experienced violence/harassment related to their gender or sexual orientation.

9.2.1.1 Bullying as a specific form of harrassment

As indicated in Table 25 below, most of our respondents had not witnessed or experienced, bullying in the workplace . Most PSWs say they had neither personally experienced bullying (71%), nor witnessed other staff (70%) or clients (64%) being bullied. However, a sizable minority say they have experienced bullying (23%) or have witnessed other staff (23%) or clients (30%) being bullied.

Table 25: Have you experienced or witnessed bullying?



9.3 Interpersonal Dynamics of Workplace Violence/harassment

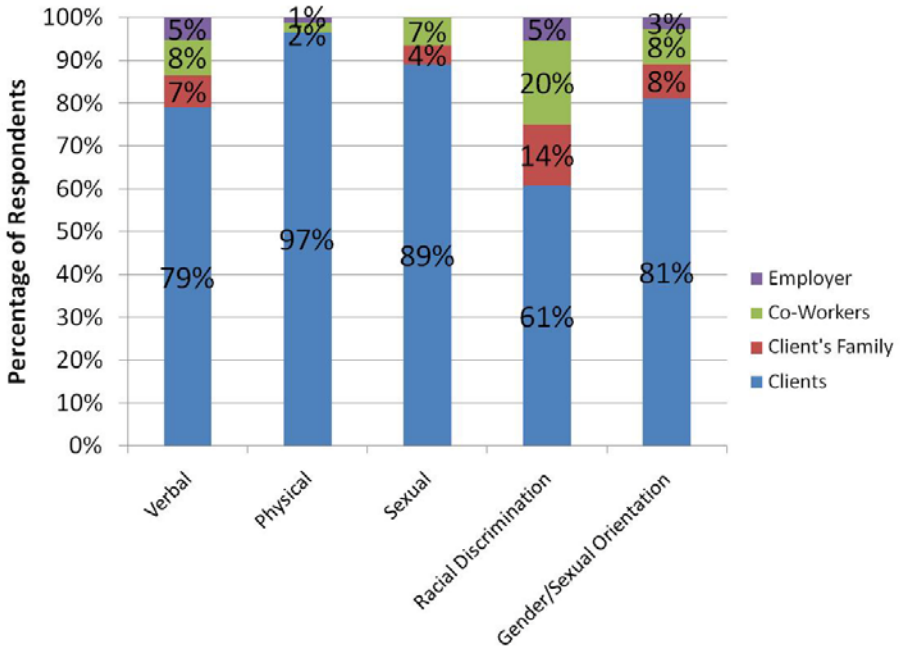
Most often, violence/harassment is understood in the context of worker-client relationships, namely, violence/harassment directed at workers by clients. However, violence/harassment is a dynamic that may be present in any one of the different relationships that exist in employment contexts beyond the worker-client relationship. Yet, violence/harassment occurring between workers and client families, workers and employers, and laterally, among co-workers receives less attention. Here we asked PSWs to identify which forms of violence/harassment they experienced, and by whom. Table 26 presents a summary of our findings.

Client-worker relationships

Respondents report that the client-worker relationship is the relationship where all categories of violence/harassment appear to occur.

- clients make up 97% of all reports of physical violence/harassment;
- 89% of sexual violence/harassment;
- 81% of gender/sexual orientation violence/harassment;
- 79%, of verbal violence/harassment; and,
- 61% racial violence/harassment.

Table 26: Forms and sources of violence/harassment in the workplace



Client's family-worker relationships
In the PSW relationships with the client family members, the incidences of violence/harassment drop dramatically, although, there are still incidences.

- 14% of all reports of physical violence/harassment;
- 8% of violence/harassment related to gender/sexual orientation;
- 7%; verbal violence/harassment; and,
- 4% maintain they have experienced sexual violence/harassment.
- There were no reports of physical violence/harassment from client's family.

Worker-worker relationships
Racial violence/harassment is most reported among co-workers.

- 20% of all reports of race-based violence/harassment;
- 8% of verbal and gender/sexual orientation violence/harassment;
- 7%, sexual violence/harassment;
- 2%, physical violence/harassment.

Employer-worker relationships
Overall, PSWs report violence/harassment within the worker-employer relationship makes up a very small proportion of all incidences.

- 5% of all claims of verbal violence/harassment;
- 5%, of race;
- 3%, of gender or sexual orientation;
- 1%, of physical violence/harassment.

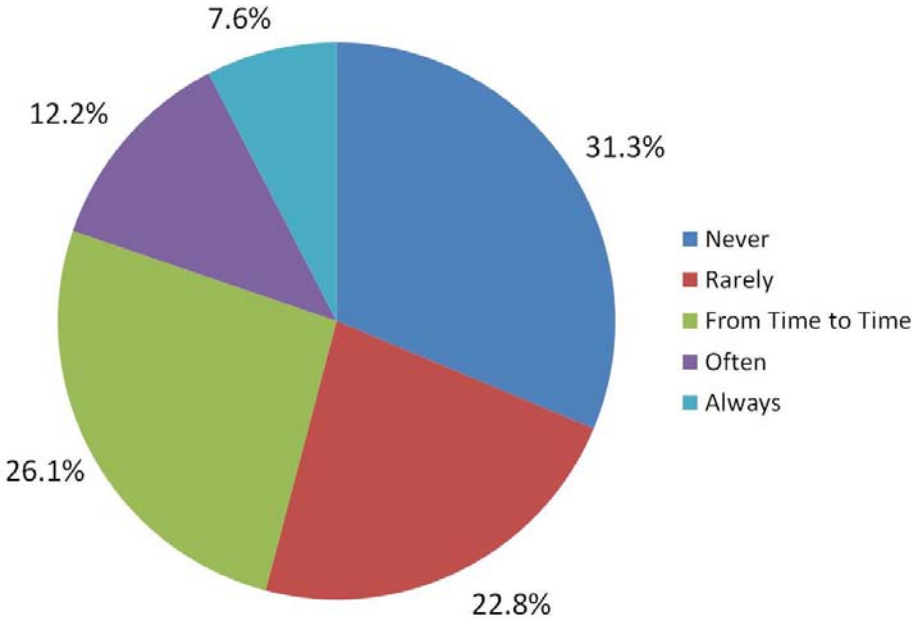
9.4 Employer Responses to Workplace Violence

In light recent amendments to Occupational Health and Safety OHSA in July 2010, which require employers to respond to incidents of workplace violence, we were interested to know how PSWs perceive their employers' responses to violence/harassment. Table 27 presents the results.

- A little over half of PSWs (54%) report that employers either "never" (31%) or "rarely" (23%) address violence/harassment issues;
- 26% of respondents indicate that employers do so "from time to time;"
- 20% of PSWs indicate that employees either "often" (12%) or "always" (8%) address violence/harassment.

It is important to note that these results reflect perceptions of how often employers address violence and harassment, rather than actual frequencies of employer responses, which PSWs may or may not know.

Table 26: How Often Has Your Employer Addressed Violence and/or Harassment?



III. Discussion: Adding It Up

Personal Supprot Workers make up a substantial proportion of the health care workforce and provide much needed assistance with daily activities in hospitals, long-term care and educational facilities, adult day programs and at home in the community. This survey results present a rather mixed picture of this very important sector, with some good news, some not so good news, and some very serious challenges.

- **Long-term job commitment.** PSWs in this survey are committed to their jobs for the long-term. Positive relationships with clients, their families, co-workers and supervisors job are strong motivators keeping them on the job. They find rewarding that others appreciate and recognize their on-the-ground experience and value them as members of multidisciplinary care teams.

- **Flexible schedules.** From our supportive housing studies, we know that the ability of PSWs to flex their schedules to meet client needs is vital to supporting older people at home. Older people's needs invariably change. The ability to give someone who is ill, or has just been discharged from the hospital extra time for care is not only critical for the well-being of older people but also cost effective for the health system. Past studies suggest that when PSWs are able to adjust care to match varying levels of care needs, the cost can effectively be averaged across a number of clients over time within a supportive housing site (Lum et al., 2010). Over half of our PSW respondents agree that by and large, if needed, their scedules are "always" or "often" sufficiently flexible to accommodate changing care needs.

- **Diversity.** Most PSWs believe that speaking to clients in their own language is important and feel comfortable communicating with clients from diverse backgrounds, in part perhaps because they too reflect the diversity of Ontario's population. This finding is consistent with the literature that points to the importance of linguistically and culturally appropriate care for clients of varying ethnic and racial identities (Lum, Ruff & Williams, 2005, Lum et al., 2007, Lum et al., 2009).

- **Certification.** Over 80% in this survey have earned a PSW "certificate" and for the most part, do not feel they face tasks at work that are beyond their experience or educational capacity. However, the unregulated nature of PSW work, coupled with the absence of a uniformly recognized formal curriculum content, and an officially recognized "certification" or "registration" process in Ontario results in much confusion and potential exploitation by unscrupulous and misleading private "career colleges".

- **Education and training: IADLS vs ADLs**. The lack of an established and recognized formal cirriculum raises additional problems from the perspective of enabling clients to age at home and the sustainability of the broader health system. Missing from the curriculum to date is an appreciation of the crucial significance of IADLs and what is involved in IADL work.

  A growing body of national and international evidence suggests that access to coordinated and integrated low cost basic services such as homemaking, bed making, assistance with laundry, grocery shopping, and meal preparation and other IADLs is essential for many seniors to remain independently in their homes (Lum, Ruff & Williams, 2005). Equally important is that PSWs combine such IADL assistance with oversight (e.g., medication reminders), frequent monitoring and social connectedness. PSWs are vital for clients' psychological and social well-being; they help to alleviate loneliness and isolation while monitoring health care changes that may require attention (OCSA, 1997). Sometimes PSWs are the primary, if not only, link between clients and their outside communities. By combining assistance with activities of daily living, monitoring and socialization, PSWs enable clients to stay at home safely (where they want to be) as opposed to more costly institutions. PSWs may contribute to reducing the unnecessary use of emergency services (911 calls) and unnecessary emergency room visits. By providing enhanced care after hospital visits, they may contribute as well to reducing ALC rates. In all these respects, PSWs' role in IADLs helps promote the sustainability of the health system.

Unfortunately, PSWs (and others across the continuum of care in the formal health system) do not readily recognize this strength. The findings disclose that PSWs place a high priority on personal care, toileting, oral care and feeding and considerably less importance on IADLs such as grocery shopping, bed making, homemaking, and laundry contrary to the evidence of what older people in fact need to stay at home. Thus, standardized additions to the formal curriculum can do much to remedy this misconception.

- **Emerging educational and training issues.** PSWs rightly recognize the need for enhanced training in areas of mental health, chronic disease management, medication management, older people with diverse sexual orientations, dementia and palliative care. Surprisingly, PSWs deem as adequate the education and training in other areas. These findings raise several issues. First, there are aspects of patient-centred care that are problematic in long-term care facilities but currently not generally addressed in the formal curriculum. Of particular note is sexuality and aging (Lum, Sladek, & Ying, 2009). Second is the changing attention to dimensions of workplace safety in conjunction with changing legislative requirements. Finally, other issues such as elder abuse is still a fairly new and emerging issue in the care of seniors.

  If PSWs are not trained to observe phenomenon, they may not notice its presence or absence. Similarly, if they are not educated about issues, they may not consider it an issue, or an issue of significance that falls within the mandate of their roles and responsibilites. Given that training occurs in many different places, varying organization cultures, practices and policies may result in varying responses to similar issues preventing a standardized response in the sector and a lack of consistency and congruence between PSW training, knowledge and practice, and agency needs and expectations. Again, what is needed is a standardized formal curriculum.

- **Recruitment, retention and turnover in the community care sector.** Respondents in this survey weigh the instrinsic benefits of PSW work against many negative features. Personal support workers are among one of the lowest paid jobs in the health care sector, while making up the largest workforce within homecare (Church et al., 2004). Furthermore, being a PSW in the community care sector in comparison to institutional care settings such as hospitals and LTC facilities tends to be more precarious, with lower rates of pay, less job security, fewer benefits and irregular hours that may or may not be guaranteed (Lum, Sladek and Ying, 2010). Because institutions can usually offer higher wages, as well as regular hours and employee benefits, PSW leave the home and community care sector for jobs in institutions if possible (CARP, 2001; Church et al., 2004; OCSA, 2000;).
  In Ontario, the MOHLTC introduced the PSW stabilization plan in response to the 2005 Caplan report on Home Care (Caplan, 2005). The strategy aimed to increase the availability of predictable, regular work for PSWs in the home care sector, increase benefits to ensure workers compensation for travel time and cost, and establish a base minimum wage of $12.50/hr for PSWs who work under contract to the CCACs (OHCA, 2008). Yet, there remain questions as to the number of full time and part time hours that actually fall under the new guarantee and how one is to measure compliance.

  In 2000, Ontario Community Support Association estimated an average turnover rate for home care workers of two to three times that of other care workers across Canada. Currently, the PSNO estimates an annual human resource deficit of approximately 2000 PSWs (PSNO, 2009). While

an aging home care labour force account for some of this deficit, PSWs also leave the profession for pay related reasons, as discussed above, and the instability of the community care sector in face of increasing complexity and pressures of the job.

Denton adds that hospital restructuring and the introduction of managed competition has exacerbated instability in the homecare environment and has motivated some PSWs to seek non-health care jobs in labour markets such as retail, manufacturing or service sectors where job conditions are better and more stable (Denton, et al, 2004). High turnover rates further confound the impact of systemic restructuring. To compensate for human resource shortages, PSWs have to manage higher caseloads, clients with higher acuities and with less time to accomplish that care. Multiple pressures lead to increased stress and decreased job satisfaction (Denton, et al, 2004).

Turnover rates among PSWs primarily affect the quality of care delivered to clients and their families. When PSWs switch agencies, move to different health care sectors, such as to LTC facilities, or leave the field altogether, clients and families experience a break in the continuity of care. Becoming acquainted with new workers involves gaining new trust and comfort levels. Additionally, when care is not provided on a regular basis by the same individual or team of individuals, important medical information about clients may not be passed along which may lead to adverse outcomes. Turnover also affects how care is coordinated and delivered, as well as the amount of time and resources agencies must devote to recruitment and retention strategies (Denton et al, 2004).

Keeping PSWs in the home and community care sector helps promote the continuity of care for clients and their families, reduces costs and allows for long-range planning (HRDC, 2003). At the core of recruiting and retaining PSWs is to promote a stable home and community care sector.

Retention:
Elliot (2004) identifies that PSW recruitment and retention is affected by many factors including, but not limited to: scope of practice, standardized training, low wages, and quality of work life issues. Because recruitment and retention are interlinked, strategies for recruiting staff have less chance of being successful if retention is an issue in the workplace. Strategies which directly address quality of work life issues appear to be the most effective direction for recruitment and retention initiatives; however strategy effectiveness is influenced by the degree to which the input of PSW's with first-hand experience is included (Elliott, 2004). While wages is an important factor, it is not the sole key issue for PSWs; quality of workplace experience tends to be overlooked and under-examined. Yet, considering quality of workplace from the perspective of PSWs priorities, invites a broader range of initiatives to be included in successful recruitment and retention strategies. From this perspective, organizational restructuring to improve the quality of workplace experience may improve job satisfaction among workers in the field that may increase career longevity; increase recognition of the continuing care sector as a viable career practice setting; and, decreased costs to the system through decreasing employers recruitment needs as a result of attrition (Elliott, 2004).

- **The experience drain.** PSNO estimates that while 7000 PSWs are trained annually, 9,000 leave the PSW workforce for various reasons (PSNO, 2009). We estimate that in our survey, 45% of our respondents (i.e., the group aged 50-59 years and the group aged 60+ years) may retire within the

next 15 years assuming retirement at around 65 years of age. Our figures suggest that there may be an imminent PSW human resource deficit, likely accompanied by a knowledge and experience drain as long-serving PSWs leave the work force over the next 15 years.

- **Workplace safety**. An overwhelming majority of respondents in our survey feel they work in physically safe surrroundings. Even within an expanded definition of workplace safety in accordance with an amended *Occupational Health and Safety Act (OHSA),* most also say they have not personally experienced other forms of violence or harassment or witnessed others, either staff or clients, suffering other forms of violence or harassment. Yet, it is not possible to disregard the substantial numbers (28%) who disagree.

  Other studies point to experiences where violence is more widespread. For example, 43% of PSWs in Banerjee et al's (2008) study reported experiencing resident-to-staff physical violence on a daily basis, while 25% reported experiencing resident–to-staff physical violence weekly. Physical violence included a broad range of incidents including: being hit, punched, pinched, and bitten, as well as being spat at and having objects thrown at them. Common verbal violence included: being sworn at and being screamed at, as well as receiving threats, or degrading and demeaning comments and racial insults. PSWs reported that these incidents occurred most often during direct care assistance/activities, such feeding, bathing, dressing, repositioning.

  While PSWs who experience persistent and frequent incidence of violence in the workplace also report that although their workplace and the conditions under which they work are intensely stressful and consistently mentally exhausting, most do not report incidents of violence, assault, or bullying. Some workers fear blame or reprimand, while others believe that violence "comes with the territory" and thus, they must tolerate and accept otherwise unacceptable behaviour. Other PSWs do not have the time to complete the extensive paperwork required to report incidents.

  Banerjee et al (2008) add that staffing levels and heavy workload demands aggravate the potential for violence. Comparing Canada and Nordic countries, she notes that personal support workers in Canada are seven times more likely to experience violence in the context of their work than those who do similar work in Denmark, Finland, Norway and Sweden. She claims that differences in workloads account in large part for this difference.

- **Employer responses to workplace safety issues**. Employers are required to prepare policies with respect to workplace violence and workplace harassment, develop and maintain programs to implement their policies, and provide information and instruction to workers on the contents of these policies and programs. Workplace violence programs must include measures and procedures for summoning immediate assistance when workplace violence occurs, or is likely to occur, and controlling risks identified in the assessment of risks. Finally, both workplace violence and workplace harassment programs must include measures and procedures for workers to report incidents of workplace violence/harassment and set out how the employer will investigate and deal with incidents or complaints (Ontario Ministry of Labour, 2010).

  Employers are required to conduct proactive assessments of risks that that may arise from the nature of the workplace, the type of work or the conditions of work. Mandatory workplace violence programs must include measures and procedures to control these risks. Employers who are aware, or ought reasonably to be aware, that domestic violence may occur in the workplace must

take every precaution reasonable in the circumstances to protect a worker at risk of physical injury. Finally, employers and supervisors must provide information to a worker about a risk of workplace violence from a person with a history of violent behaviour if the worker can expect to encounter that person in the course of work, and if the worker may be at risk of physical injury. Personal information may be disclosed, but only what is reasonably necessary to protect the worker from physical injury.

Workers have the right to refuse work if they have a reason to believe they are in danger from workplace violence. Reprisals by the employer continue to be prohibited. Certain workers continue to have only a limited right to refuse (Ontario Ministry of Labour, 2009/2010).

Valuing the contributions of personal support workers

Canadian and international jurisdictions face escalating health care costs particularly as the population ages. While Canadians aged 65 and older are healthier and more active than in previous years, older people as compared to younger people generally make greater use of the health care system. As well, older people at some point will need assistance with routine daily tasks to stay at home. In order to meet the growing care demand, health planners and researchers need to recognize the contribution of personal support workers in the health and social care continuum and measure the return on investment in personal support (Holloway-Payne, et al., 2010).

Unfortunately, PSWs' contributions to individual well-being and health system sustainability often go unrecognized largely because their work is not medical or clinical and because academics and policy analysts have not yet developed indicators to measure the return on investment of personal support. Yet, a number of studies may point in the right direction.

For example, our research on the role of community support services in the lives of older residents living in Toronto (Lum et al., 2005) suggests that personal support workers can positively affect:

- Caregiver burden;
- Clients' peace of mind;
- Perception of health and well-being as compared to peers;
- Levels of social connectedness;
- Medication management;
- ER visits.

Holloway-Payne, et al (2010) propose other areas from which indicators may be derived, including:

- Positive impact of home safety scans in preventing falls and other accidents;
- Functional status and capacity to remain independent;
- Client and family satisfaction with care.

The Veterans Independence Program (VIP), established in 1981 by Veterans Affairs Canada, uses an early intervention, preventative community care approach and makes extensive use of care

managers and home support workers to help clients remain healthy and independent in their own homes or communities (Lum, 2008). Services include:

- Health and Support Services (e.g., nurses to administer medication);
- Personal Care (e.g., assistance with bathing, dressing, respite care);
- Housekeeping (e.g., laundry, vacuuming);
- Grounds maintenance (e.g., grass cutting and snow removal);
- Access to Nutrition (e.g., Meals-on-Wheels);
- Ambulatory Health Care;
- Transportation;
- Home Adaptations.

For details on the VIP, please see: ***InFocus***: Profiling the Veterans Independence Program, 2008.

Indicators that may be derived from the VIP and other studies cited above may include the following.

At the system level:
- reducing demand for LTC beds;
- delaying entry into a long term care facilities;
- reducing ER visits because:
    - health crises are being managed effectively at home;
    - medication monitoring helps to avert adverse drug related events (Zed et al., 2008);
    - home adaptations, safety audits and grounds maintenance help prevent accidents and falls.

At the individual level:
- Satisfaction with service;
- Capacity to access a comprehensive continuum of care and home supports;
- Degree to which care is integrated as clients; move to, or through different care settings;
- decreasing caregiver burden;
- increasing peace of mind about receiving assistance when needed;
- increasing social connectedness and contact with family, friends;
- enhancing consumer choice;
- enhancing safety and independence;
- Consumer choice, family control and independence.

The value of personal support workers is that they combine assistance with their clients' activities of daily living, monitoring, and social activities. The combination of these tasks enables clients to stay at home in the community safely while helping to maintain their well-being, independence and peace of mind. At the same time, they contribute to the overall sustainability of the formal health system. Personal support workers provide the right care, at the right time, at the right place.

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