

**MAKING IT WORK:  
A STUDY OF THE DECISION-MAKING PROCESSES  
OF PERSONAL SUPPORT WORKERS  
IN LONG-TERM RESIDENTIAL CARE**

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## **ABSTRACT**

This dissertation explores the decision-making processes of personal support workers (PSWs) in long-term residential care (LTRC). These workers are lowest in the LTRC labour hierarchy, performing the majority of "hands-on" care. Research has shown that PSWs have little input in formal care planning and organizational processes, but retain some limited control over how they work on a daily/nightly basis. Given this, my study asks: where can PSWs make decisions, what factors shape their capacity to decide and, when they can make decisions, what are the factors that these decisions respond to? I use a feminist political economy framework to answer these questions, and begin by examining broader social, political, economic, and historical features of the LTRC landscape on a global, national, and provincial level. Located on this landscape is "Riverside Home", a multi-unit LTRC facility in a large urban city in Ontario. My analysis draws on data from a rapid ethnography conducted at this site, obtained through my participation as a student researcher on the project *Re-Imagining Long-Term Residential Care: An International Study of Promising Practices*. I use both observations of and interviews with personal support workers at Riverside Home, examining their daily/nightly experiences of care work including feeding residents, bathing/grooming, toileting/continence care, and clothing/laundry. My analysis demonstrates that PSWs experience a narrowed capacity to make decisions about care, and both regulations and restructuring have impacted their workload, work organization and working conditions. However, amidst this narrowed capacity to decide, PSWs make numerous important decisions throughout their daily/nightly care work, including adjusting the tempo of their work, prioritizing tasks, rearranging their workload, and coping with abuse. My findings demonstrate that PSW decision-making in LTRC is a complex social process shaped by and in response to social location (i.e. the intersecting variables of race, gender and class), work organization, regulations, LTRC (re)structuring, and models of care. By locating PSW decision-making within these multi-layered "nested" contexts, I demonstrate that the conditions of PSWs' direct care work in LTRC are neither natural nor inevitable, and thus are transformable for the benefit of both workers and the residents they care for.

## **DEDICATION**

I dedicate this dissertation  
to those whose care has made it possible:

to my beloved parents and siblings;  
to my partner in life, love, and all things;  
to my dear and inspiring friends;  
and

to my participants, the personal support workers of Riverside Home.

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## INTRODUCTION

I like what I do. I like the contact with the patients and all that. It's just the fact that you don't have enough time. That's what bothers me. And sometimes you have to cut the corners and, you know, we don't want to do this. You go home and you think and you say 'Oh, you know, I should have done this, I should have done that' but, you know, **you have to arrange your day to make it. You don't have a choice, you know.** To me, I would like to do more.

[Interview 2: 10, emphasis added]

This dissertation is about decision-making in long-term residential care (LTRC) settings. However, I will not be examining the decision-making of doctors nor of nurses, but rather of those workers whose capacity to make care decisions is most restricted and whose work has been most neglected in the literature: personal support workers (PSWs). Using the framework of feminist political economy, this dissertation explores how personal support workers' decisions are shaped by the broader social, political, economic, and historical contexts in which long-term residential care is situated. I argue that by examining these factors, we can understand how the conditions that shape direct care work in LTRC are neither natural nor inevitable, and thus are open to transformation. My goal in exploring PSW decision-making, therefore, is to transform these working conditions – and thereby, transform long-term residential care.

Long-term care (LTC) in Canada can be understood as a “care continuum” encompassing a wide range of possible services and sites for care, including home care, community-based supports, supportive/assisted living, and facility-based care (CHA, 2009). This dissertation is concerned with facility-based – i.e. residential – long-term care, or what is variously termed nursing homes, homes for the aged, personal care homes, etc. These are sites of permanent accommodation primarily (though not exclusively) for elderly clients who can no longer be cared for in their homes (either by themselves, paid or unpaid home-based carers) and whose needs exceed the services

provided by assisted living facilities. Long-term residential care facilities provide residents with daily care, encompassing health services (including 24-hour nursing services, assistance with activities of daily living, access to physician services, and other specialized health professionals and therapists), accommodation services (including meals, laundry, housekeeping) and hospitality services (including social programming and recreation).

The term “personal support worker” is not a standardized term for this job category, and these workers are also variously termed nursing assistants, nurses’ aides, care aides, and personal care aides, with these terms varying by country, region and even by facility. However, throughout this dissertation I will be using the term “personal support worker” as this is the term used in Ontario’s long-term care legislation. Regardless of the terminology used to describe this category of worker, they are an essential feature of the daily/nightly functioning of long-term residential care. In terms of sheer numbers, personal support workers make up the largest proportion of the direct care labour force in Ontario’s LTRC settings (Armstrong and Daly, 2004). Despite often being lumped together with registered nurses (RNs) and registered practical nurses (RPNs) as a part of the direct care labour force, PSWs occupy a unique position in the daily/nightly workings of LTRC facilities. Personal support workers have been identified as “the backbone” of long-term care (Noelker, 2001), as these are the workers that provide the vast majority of direct hands-on care in long-term care facilities, and as such are “on the frontlines” (Banerjee, 2010) of providing for the daily personal care needs of the residents who live there. Personal support workers’ jobs involve waking residents in the morning, readying them for bed at night, and everything in-between that residents may

need assistance with: toileting, grooming (hair care, bathing), feeding, dressing, and physically moving throughout the facility (Armstrong et al., 2009). However, despite the centrality of their work to the functioning of LTRC facilities, the importance of personal support workers is often overlooked (Konrad, 2011). Tasked primarily with the “bodywork” of care (Twigg, 2000), these workers are lowest in the hierarchical division of direct care labour in long-term care facilities. Unlike RNs and RPNs, PSWs are workers who are unregistered, and are often dismissed as being only “ancillary” to care (Armstrong et al., 2008).

Dimensions of class, gender and race are also important to consider in understanding personal support workers’ experiences in LTRC. Compared to registered nurses and registered practical nurses, PSWs are paid the lowest wages and fewest benefits, and their employers increasingly favour the cost-savings of part-time, casual and “flexible” labour to full-time status (Armstrong et al., 2008). Personal support work in LTRC is also overwhelmingly performed by women, reflecting the assumption that caring work is “naturally” a woman’s job, and thus “being both defined and paid as unskilled” (Armstrong et al., 2009: 42), and devalued despite being work that is both physically and mentally challenging. Furthermore, PSWs are also increasingly drawn from racialized, migrant populations as wealthier countries in the global North seek sources of cheap, flexible LTRC labour from the global South (Eckenwiler, 2012). While the vast majority of personal support workers in LTRC settings are women, more men are seeking work in these settings as traditional forms of male-dominated labour disappear amidst widespread changes to the labour market (Bagilhole and Cross, 2006).

Despite making up the bulk of direct care workers in LTRC settings, relatively little is known about the specific experiences of PSWs in LTRC. However, the existing literature suggests that PSWs face numerous on-the-job hazards and constraints. For instance, a survey of unionized personal support workers in LTRC facilities across three Canadian provinces (Manitoba, Ontario and Nova Scotia) found that the vast majority (60.3%) of PSWs reported having too much to do “all or most of the time” (Banerjee et al., 2008). This same survey found that 43.8% of PSWs were short-staffed on a daily basis, while 34.4% reported being short-staffed on a weekly basis. As a result of this short staffing and overwhelming workloads, PSWs reported feelings of inadequacy and exhaustion. In addition to the risks to wellbeing associated with overwork, personal support workers also face numerous risks to their health and safety on the job, including violence from residents (Armstrong and Daly, 2004; Banerjee et al. 2008, 2010; Morgan et al. 2008) and health risks associated with increasing workloads in an era of care restructuring (Armstrong and Jansen, 2006). Personal support workers also report experiences of unwanted sexual attention and racism on the job, such that the risks to workers’ wellbeing are both gendered and racialized (Banerjee et al., 2008).

The limited existing research specific to the experiences of PSWs has additionally revealed that these workers face some unique challenges in the organization of LTRC work relative to their registered direct care coworkers. PSWs have little input in the formal organization of care, and are tasked with the job of carrying out a resident care plan that, unlike registered care staff, they may have had little to no say in designing (Kontos et al., 2010a). Furthermore, with rising concerns over long-term care quality measures, personal support workers as unregulated workers report being increasingly

under managerial surveillance, while their work is reorganized to fit with the standards of accountability regulation (DeForge et al., 2011).

Amidst this environment of risks, pressures and constraints, how do personal support workers – the “women in the middle” (Foner, 1994) – actually get the care work done? As Armstrong and Daly (2004) found, sometimes the care simply *does not* get done, with some tasks skipped in order to accomplish certain other prioritized tasks. This evidence suggests that PSWs retain some measure of control over their daily work processes. However, other evidence suggests that this control is severely limited: a survey of unionized PSWs working in LTRC facilities in three Canadian provinces (Ontario, Manitoba, and Nova Scotia) found that only 23.8% of workers reported being able to affect daily planning of their own care activities “all or most of the time”; 49.7% reported being able to do so “sometimes”, 22.5% “rarely” and 4% “never” (Banerjee et al., 2008: 15). But what exactly does this “daily planning” entail? Despite being devalued as unskilled workers, in a now-classic example of participant-observation research, Timothy Diamond (1992) rendered visible the numerous and wide-ranging activities of personal support workers in the daily/nightly care of LTRC, including both the physical and emotional aspects of the labour required to accomplish care tasks. Personal support workers in long-term care prioritize tasks, devise work strategies, and make decisions about how to carry out the job of care. In other words: the daily/nightly work of personal support workers in LTRC is a continual process of trying to “make it work” while being lowest on the workplace hierarchy and facing numerous on-the-job (and beyond-the-job) hazards, risks and constraints.

With this evidence in mind, this dissertation seeks to answer the following question: how do PSWs in long-term care facilities make decisions about care work, and what are the various and multi-layered factors that shape the decision-making processes of these workers? To answer this question, I make use of a multi-level analysis, understanding PSW decision-making as situated within multiple “nested” contexts: from the social location of the worker (micro-level context) to the working conditions in which LTRC work is situated (organizational context) to the broader processes of care restructuring (macro-level context). Tracing the decision-making process means tracing the factors that impact frontline care provision, but in a way that puts workers at the centre of the analysis by highlighting their abilities to make decisions about how to carry out care tasks as well as the factors that inform this process. It also means asking the workers, and starting from their experiences. If we ask workers how they work and why they work the way they do, then we gain a better understanding of how care outcomes are the result of a *complex social process* – one that takes place within not only a specific organizational context, but also one informed by multiple social relationships, regulatory models, and broader conceptual and structural trends that inform the organization of long-term residential care.

### **Literature Review: Perspectives on Personal Support Workers’ Decision-Making**

A number of ethnographic studies have attempted to make visible the care work of PSWs as frontline workers in long-term residential care (Diamond, 1986, 1992; Foner, 1994; Lopez, 2006a, 2006b, 2007). However, in terms of the decision-making practices of these care workers, the literature is sparse. Literature on the clinical decision-making of nurses and physicians in LTRC settings is far more prolific, and reports that these

professions tend to have far greater influence in formal care decision-making processes, such as the production of residents' care plans (Dellefield, 2006). Organizational analyses of LTRC decision-making, typified by quantitatively measuring formal decision-making input, have found that personal support workers report the lowest levels of self-perceived decision-making power (Kruzich, 1995). Campbell (2002) draws on an organizational approach to model the flow of decision-making power within dyadic relationships, revealing the hierarchical arrangement of the LTRC setting and the implications that this has for personal support workers at the bottom. Interestingly, Campbell's (2002) application of Weberian bureaucracy theory expands the analysis of power differentials beyond interpersonal dynamics in order to consider the ways in which the LTC system is itself constrained by regional and provincial bureaucracies and regulatory structures. However, where this and other organizational analyses of workers' decision-making fall short is in understanding care decision-making *beyond* formal measures of input in care planning. Organizational analyses only measure care decision-making in terms of ability to influence formal organizational elements of LTRC workplaces. Organizational analyses may tell us that personal support workers have little say in deciding *what* they do in the job of care, but they tell us little about the decisions workers make as to *how* to go about doing it. In other words, they fail to understand decision-making as an ongoing process, and that workers devise strategies for providing care that are not reflected in the formal care plan or documentation of the daily activities of care.

To understand better the social processes involved in care work, some research has been done on the ways in which personal support workers implement particular kinds of knowledge (Janes et al., 2008) or draw on particular mental (Anderson et al., 2005) or

linguistic models (Berdes and Eckert, 2007) to inform their care practices. Unfortunately, such explanations for care decisions remain firmly grounded in individual-level analyses. An example of this is offered by Janes et al. (2008) in their study of how care workers make use of person-centred care models in their care practices. The authors theorized that personal support workers' care decisions are influenced by two important challenges: the unpredictability of their work, and what the authors euphemistically term "the fighting spirit", referring to the risk of resident violence which requires urgent decision-making characterized as "figuring it out in the moment." Janes et al. (2008) further argue that relational and interpersonal factors also play a role in workers' care decisions, examining the ways that PSWs interact with each other and the flow of communication through different levels of the care team. However, an important gap in this analysis is an understanding of the organization of residential work as the context within which care decisions are made. For instance, a lack of access to information technology or formal care team meetings may hinder the process of information-gathering between hierarchically-arranged team members (Kontos et al., 2010a). The theory of "figuring it out in the moment" also renders invisible the conditions that necessitate certain care decisions in order to do what is best for an individual resident (i.e. what upsets the resident the least) and also what is best for the PSW herself (i.e. to protect her safety, to retain her job, or to fulfill her understanding of quality care provision) – in other words, the context within which certain decisions are made. Ultimately, Janes et al.'s (2008) theory of "figuring it out in the moment" frames PSW decision-making as lacking critical reflective thinking, which is argued to be a problem for care because "knowing a practice option is effective without knowing *why* would make it difficult to determine when the

option might be appropriate to repeat” (Janes et al., 2008: 20, emphasis added). This analysis characterizes PSWs as blindly putting decisions into place with no understanding as to why or how they do what they do, nor reflection upon the broader conditions which shape particular decisions.

Others have examined the resistance and coping strategies of personal support workers in order to highlight the ways in which workers both work within the conditions of their workplace and shape the ways in which they perform work, attempting to retain some control of their work despite hierarchical divisions of labour in residential care. Drawing on an analytical framework used to study working-class subcultures, Lee-Treweek (1997) found that personal support workers in a private nursing home obtained some measure of control over their work through strategies of resistance, including non- and selective compliance with prescribed tasks, depersonalization strategies, and asserting their own interpretations of residents’ difficult behaviours. While these strategies of resistance are important to understand as a part of the constrained context of workers’ jobs, a focus on “coping” is not the same as a focus on “caring”. As Banerjee et al. (2008) have noted, despite a lack of autonomy and being lowest on the worker hierarchy, personal support workers also work very hard to meet residents’ care needs, and suffer from feelings of inadequacy when overwhelming workloads and short-staffing impact their ability to perform care. Furthermore, while PSWs are rarely involved in formal planning around work organization or the definition of residents’ care needs, these workers are the ones who perform the work and spend the most time with residents on a daily/nightly basis. To meet residents’ needs, personal support workers “hide diapers and secretly recycle clothes; they buy residents shampoo and attend their funerals”

(Armstrong et al., 2009: 142). Thus, despite having limited input in formal care decisions, personal support workers have developed strategies to meet residents' needs amidst gaps in the planning, organizing and support of their care.

The care work strategies developed by personal support workers in long-term care have been studied mainly as departures from official rules and instructions of the workplace. For instance, Bowers and Becker (1992) examined how personal support workers made selective decisions about rule breaking in a nursing home, contextualizing the analysis amidst workers' struggle to deal with simultaneous demands and contradictions in the workplace. In order to accomplish their "seemingly impossible job" (Bowers and Becker, 1992: 365), workers made choices about which rules to break in order to maximize both their work efficiency as well as the quality of care provided. A similar strategy is observed in Jervis' (2002) study of personal support workers in a nursing home whose departure from official rules involved prioritizing the care needs of residents over the instructions of supervisor nurses. For these frontline workers, the way that work was officially supposed to be done was understood as getting in the way of the care necessities they knew residents required. Workplace strategies of selective rule-breaking thus seem to highlight a tension between needing to accomplish certain prioritized care tasks while also meeting a particular definition of quality care.

Adding a structural framework to the understanding of workers' strategies, Lopez's (2006a, 2006b, 2007) studies of PSWs in LTRC highlight the ways in which official instructions for care tasks are impossible for PSWs to follow within the time allotted for these care tasks, forcing workers to develop their own strategies for getting care done – and often risking their own safety in the process. DeForge et al. (2011)

further explore this tension in understanding what they term care workers' "workaround" strategies for dealing with workplace structures, noting that departure from mandated practices may be positive for care in some instances, but negative in others – for instance, anticipatory sedation practices. However, the authors note that the effects of workarounds, when negative, must be contextualized by the role that workplace policy and restructuring plays. Within this context, anticipatory sedation practices can be understood as a strategy that helped workers to have residents wake up at a certain standardized time in the morning (thus requiring residents to sleep through the night). DeForge et al.'s (2011) analysis suggests that the context of work therefore necessitates strategies on the part of personal support workers to negotiate between both their understandings of the care that residents need, and the care that they are instructed to provide. In both instances, these workarounds can be understood as being "responses to structural/political conditions that render staff unable to produce adequate care to meet the needs of a resident" (DeForge et al., 2011: 424). Importantly, workaround strategies also do not really solve any of the underlying conditions or problems that necessitate their development.

These strategies of care workers are rendered invisible not only in official accounts of how the work is to be done (Lopez, 2007) but also in official instructions as to what kinds of care are to be given, as Kontos et al. (2010a) found that the care decisions of personal support workers are neglected in the formal processes of care planning. Based primarily on a standardized clinical assessment tool, the RAI-MDS (Resident Assessment Instrument - Minimum Dataset), PSWs reported that the care plan lacked the vital personal information that was necessary for workers to know in order to

carry out the tasks of their job. This lack of information required PSWs to devise their own means of obtaining and sharing this information with each other, seeking out biographical information from residents and their family members, but also relying on their own personal experiences. In this way, PSWs' work strategies involved both "imagination and empathy to properly tailor the complex and nuanced interactions implied in the tasks of bathing, dressing and feeding proscribed in the care plan" (Kontos et al., 2010a: 356-357). The tasks instructed in the care plan are indeed not even possible *without* the strategies of the PSWs; however, this work is rendered invisible in the instructions of the care plan itself. The things that PSWs must do to actually accomplish what they are told to accomplish are the very strategies that my project seeks to render visible.

As a result, personal support workers have reported that their decisions may be interpreted by management as "resistance" to the care plan or official rules of care (Kontos et al., 2010a), such that structural limitations became re-interpreted by management as worker unwillingness: a matter of personal failings rather than problematic workplace barriers. The individualizing tendency can have important implications for the kinds of recommended solutions for involving personal support workers in the formal decision-making process of care planning. For instance, while Dellefield (2006) notes that there is a need to promote "effective organizational information processing strategies" (133), she recommends that care workers "write down effective individualized or customized care processes that they have used to include in the written care plan, if time constraints do not allow them to directly participate in care plan meeting" (132). Her solutions are to work *within* the constraints of the settings, and

as such put the onus onto individuals to “work around” the organization of labour rather than actually challenging the organizational context that Kontos et al. (2010a) identify as problematic. Similarly, Lopez (2006a) has noted the ways in which a movement towards “culture change” models of long-term care has rendered invisible the structural contexts that impact upon personal support workers’ care strategies. While working in a nursing home that followed culture change approaches by valuing and listening to personal support workers and offering additional training in the “proper” techniques of care, Lopez found that these reconfigurations did not render the tasks of personal support workers any more manageable. Thus calls for additional training or workplace reorganization may be shortsighted if the structural conditions that shape workers’ care strategies are neglected.

Finding “promising practices” for quality long-term care may therefore be a matter of moving beyond individual- and organizational-level analyses and recommendations for care improvement, and this gap is precisely what my project seeks to address. The above review of literature on the care work of PSWs as frontline LTRC workers has suggested that decision-making as a framework for understanding care practices entails a particular type of analysis: one that first and foremost must be concerned with the experiences of the care worker as contextualized within particular workplace conditions. My project begins from an assertion that the conditions of work are the conditions of care (Armstrong et al., 2009), and thus the conditions of work that impact upon workers’ care decision-making processes are understood as having important implications for care experiences. This requires an understanding of not only the types of care provided (i.e. tasks assigned) but also the way in which the care is

provided (i.e. strategies for accomplishing care). By looking at decision-making, I seek to highlight the ways in which strategies for providing care are shaped by workplace organizational constraints, capturing not only individual strategies for working through these conditions, but also collective and collaborative processes of decision-making beyond an individualized analysis.

Furthermore, where my project *differs* significantly from the prior literature is in its attention to broader structural processes that shape the working conditions of long-term care. While prior literature on the role of regulation, care planning, and time constraints provides important insights into the working conditions that shape personal support workers' experiences in the LTRC setting, the broader structural processes that inform these conditions – such as health care restructuring, efficiency-based models of care funding, and global patterns of migrant care labour – are as yet an under-researched aspect of the LTRC work experience. Thus my project is not only focused on how conditions of work shape the decision-making processes of personal support workers, but also understands these work conditions as being shaped by broader macro-level social, political, economic, and historical processes.

Finally, my project seeks to *extend* prior literature on what is known about personal support workers and their working conditions in long-term residential care settings. Beginning from the assumption that workers themselves are the best sources of information for understanding their work experiences, this dissertation draws on primary interview and observational data to understand the decision-making process.

Ethnographic accounts of long-term care settings in Canada and elsewhere have been important sources for assessing LTRC planning and design, providing rich details on

their physical design and history, as well as the experience of daily life in these facilities (Baum, 1997; Davies, 2003; Gubrium, 1975; Mathiasen and Noakes, 1959; Townsend, 1962). A few studies have used ethnographic techniques to explore the LTRC experience from the perspective of personal support workers, examining how their work is organized, the tensions and difficulties that arise in their jobs, and the factors that inform these conditions (DeForge et al., 2011; Diamond, 1992; Foner, 1994; Gass, 2004; Lee-Treweek, 1997; Lopez, 2006a, 2006b, 2007). It is this latter body of work that my analysis contributes to, using the question of decision-making as lens for understanding how the conditions of LTRC work are the conditions for care.

### **Chapter Descriptions**

This dissertation is composed of six chapters, with a separate conclusion section at the end. The first two chapters lay the groundwork for understanding my research. In Chapter 1, I establish the theoretical framework by which I address my research question: how can we understand personal support worker decision-making in LTRC settings using a feminist political economy analysis? I provide my understanding of feminist political economy, and use this perspective to further elaborate upon my research question. I conclude that a feminist political economy approach to LTRC decision-making requires an examination of the “nested contexts” in which LTRC work is situated, including intersecting inequalities of race, gender, and class, LTRC (re)structuring, regulation, work organization, and models of care that inform and shape LTRC work.

Chapter 2 provides an understanding of the research design and methodology used in my dissertation. In line with a feminist political economy framework, my dissertation makes use of primary data in order to understand PSWs’ experiences in their

own words. These data were collected via my involvement in a larger study, called *Re-Imagining Long-Term Residential Care: An International Study of Promising Practices*. In Chapter 2, I describe how this project was designed as a *rapid ethnography*, which is a form of ethnographic research that encompasses many of the traditional elements of ethnographic research (i.e. field observations, interviewing, and document analysis). However there are some unique features to this method: first, it is a form of team ethnography and thus involves a number of researchers in the field simultaneously. Second, as the name would suggest, rapid ethnography takes place over a much shorter timeframe than traditional ethnography, and thus requires focused observation and extensive background research on the site of analysis prior to entering the field. In Chapter 2, I explain the merits of this method, the practicalities of data gathering in my role as a student researcher on this project, and the process by which I came to my own analysis in the present dissertation.

Chapters 3, 4, 5, and 6 comprise the analytic components of my research. In Chapter 3, I explore at the broadest level the “nested contexts” in which LTRC work is situated. Beginning with global processes in the movement of care labour across borders, I then discuss the ways in which care in Canada is becoming increasingly privatized – and suggest that both these global and national processes have led to care inequalities. At the provincial level, I examine how LTRC is funded and regulated in Ontario, and the implications these contexts have for the working conditions that personal support workers have reported in LTRC facilities across the province.

In Chapter 4, I focus in on the particular site of “Riverside Home” – the urban Ontario-based LTRC facility that provides the setting for my study of PSW decision-

making. With the details of the previous chapters' broader contexts in mind, I examine the specific funding and organizational structures of Riverside Home, the resident case mix, and work organization of its staff. I also address how this particular facility envisions the role of its personal support workers and the concept of "good care", linking these representations to broader notions of care and care work and suggesting the ways in which these conceptual linkages are an important context for understanding personal support workers' decision-making.

Chapter 5 presents my analysis of personal support workers' experiences with decision-making at Riverside Home, divided into four activities that were reported as being central to their daily/nightly care work: feeding, bathing/grooming, toileting/continence care, and laundry/clothing. Using both interview and observational data, I find that PSW decision-making is shaped by broader processes in care work (re)structuring, regulation, work organization, and approaches to care – as well as the implications of gender and race for decision-making. This chapter concludes that personal support worker decision-making is shaped by these factors both in terms of the *capacity* to make care decisions and in terms of the *form* of decisions that these workers make. In this sense, decision-making is both a product of and response to a specific set of working conditions – conditions which themselves are understandable as a product of nested organizational, provincial, national, and global contexts.

Following this analysis, Chapter 6 further explores the experiences of PSWs at Riverside Home to analyze how PSW decision-making can be situated within broader trends in approaches to long-term residential care. Three themes are explored in this chapter: first, the ways in which LTRC is increasingly organized under clinical and

market logic approaches to care provision, and implications these trends have for too-narrowly defining what is needed for resident care. Second, I examine the disjuncture between “person-centred” approaches to care and the supports and resources that workers actually have to implement these approaches. Third, I examine the ways in which enhanced emphasis on accountability has served to further entrench the division of labour in LTRC work, and what this has meant for personal support workers at the bottom of the care work hierarchy.

I conclude that personal support worker decision-making is a complex social process, and that workers’ decisions are both shaped by and made in response to broader, nested and multi-layered contexts. LTRC (re)structuring, regulation, and work organization are all structural factors that contextualize both the capacity of PSWs to make care decisions, as well as what kinds of decisions workers do make in their daily/nightly experiences with care. I also conclude that personal support workers’ decision-making is shaped by intersecting inequalities on the basis of race, gender and class. Finally, the decision-making process is contextualized by broader trends in LTRC approaches to care, with workers often caught between conflicting and contradictory models of care. Ultimately I suggest that personal support worker decision-making provides a useful lens for understanding how LTRC working conditions are the conditions for resident care. I end this dissertation with an understanding of how my findings contribute more broadly to the literature on feminist political economy, care work, LTRC research methods, and LTRC reform. I also suggest some important directions for future research and action in the LTRC field.

## **CHAPTER 1**

### **Theoretical Grounding: A Feminist Political Economy Framework<sup>1</sup>**

My analysis of personal support workers' decision-making in LTRC, and the larger project from which its data are drawn, is informed by a feminist political economy perspective. This perspective has much to offer in terms of understanding decision-making beyond an individual-level analysis. As noted in the preceding literature review, there are numerous problems that arise in focusing on decision-making as the actions of individual workers or as the product of an individual facility's organizational culture. A feminist political economy framework instead allows me to analyze workers' decision-making as a social process, contextualized by and inseparable from the interrelated layers of institutional, historical, and ideological forces that shape this process. It is a framework that understands LTRC work as being shaped by and situated within social, political, and economic contexts that both structure the kinds of decisions available to workers, as well as the development of particular decision-making strategies on the part of workers navigating these contexts. I begin this chapter by briefly articulating the underlying orientations and assumptions of feminist political economy. Using these assumptions as a starting-point, I then develop a feminist political economy framework for the present study, drawing on conceptual resources from an array of literature on care work, health care restructuring, and models of care. Finally, this framework is discussed as a starting point for thinking about how my study of LTRC personal support workers' decision-

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<sup>1</sup> Portions of this chapter were used in the publication of a book chapter preceding the final submission of this dissertation; see Day (2013).

making may contribute more broadly to the transformative goals of feminist political economy.

### **Articulating Feminist Political Economy**

As feminist political economy is a mode of inquiry that grew from feminist critique of what were seen as problematic shortcomings in the political economy tradition (Vosko, 2003), it is worth examining briefly the underlying orientations of the political economy perspective itself, particularly as it has been developed in Canadian scholarship. In an introduction to Canadian political economy, Clement and Williams (1989: 10) explain this perspective as one that is “holistic” in understanding social relations as being shaped by dynamic interconnections between politics, economics and ideology. The political, economic, and cultural aspects of social life are viewed as inseparable, interconnected parts of a whole – parts which cannot be understood in isolation. Political economy is also a materialist perspective, viewing social relations as shaped by the mode of production, the organization of which is historical, political and social in its development, and characterized by major inequalities in power (Clement, 1997). The goal of a political economy analysis, therefore, is to produce a critical account of how social relations are shaped by the historically-contingent and socially-constructed mode of production and reproduction of daily life. From a political economy perspective, the current capitalist mode of production and its exploitative organization under a profit-driven logic is neither natural nor inevitable, but rather is a socially-constructed set of relations that arose within a specific historical context (Armstrong et al., 2001). In being socially-constructed and historically-contingent, these relations are thus open to change

and transformation, in a process marked by tensions, struggles, resistance, and potentially competing or contradictory interests (Armstrong et al., 2008).

This possibility for change and transformation also forms the basis of political economy's critical lens: to examine how the socially-constructed and historically-contingent relationships of the political economy as a whole are relationships of inequality (Armstrong et al., 2001). In focusing on inequality, political economy raises the question of who benefits from the organization of social relations, with the intention of transforming those relations in more equitable ways. However, the tendency in early political economy analyses was to focus on inequality from the perspective of class and economic relations within the formal (i.e. paid) economy – and it is this tendency which has garnered extensive feminist critique (Luxton, 2006). In focusing on the inequitable economic relations of paid work, political economy was charged with being blind to matters of gender, and thus unable to study society as a whole (Maroney and Luxton, 1987; Smith, 1989). Initially this critique took the form of highlighting the ways in which the organization of market relations and the “formal” economy in Capitalism both sustains and intrinsically relies upon the division of unpaid labour in the home – a division rooted in inequitable gender relations (Armstrong and Armstrong, 1983; Connelly and MacDonald, 1983). These inequalities are neither natural nor inevitable, but rather are just as historically-contingent and socially-structured as class-based inequalities of the political economy. Consequentially, women's domestic labour is not only rendered invisible when gender is neglected in political economy, but also women's participation in the paid labour market is decontextualized from the gendered inequalities that mark this participation – including the wage gap, job segregation, and precarious

labour. Focusing on the link between paid and unpaid labour led feminist political economists to articulate the concept of social reproduction: an integrated understanding of the relationship between paid and unpaid work, as shaped by state, market, and ideological forces that are profoundly gendered (Luxton, 2006). The intersections between race/ethnicity, class and gender further expanded a feminist political economy understanding of inequality to include racism and processes of racialization in analyses of inequitable divisions of labour, grounded in specific historical and regional contexts (Armstrong and Connelly, 1989; Vosko, 2003). Articulating these intersections offers a particularly important perspective for understanding women's migratory labour as situated within the context of global capitalism (Arat-Koc, 2006).

Feminist political economy has thus sought an expanded understanding of political economy in order to recognize "that all social structures, processes, and relations are profoundly gendered, as well as classed and racialized" (Armstrong, 2007: 529). Reconfiguring political economy through a feminist lens, the interconnections between the political, economic, and ideological structures that shape social relations are understood as being not only divided by class tensions, but also by gender and race – as well as other intersecting social locations such as age and sexuality (Armstrong et al., 2008). Through this reconfiguration, feminist political economy is concerned with multiple dimensions of inequality reflected in and sustained by the interconnected "whole", as well as the inequitable power relations, struggles, and contradictions therein.

In identifying these divisions and struggles, feminist political economy seeks to transform social relations in ways that are more equitable. This transformative goal follows from the above-noted central assumption of political economy: that change is

indeed possible, as “people collectively and individually make their own history, although not under conditions of their own choosing or simply as a result of ideas that spring independently to their minds” (Armstrong et al., 2001: viii). The decisions of social, economic and political actors are informed and structured – but *not predetermined* – by historically-contingent “social and material boundaries” (Clement and Williams, 1989: 11). Social actors are imbued with agency and the ability to exercise choice; however, choice must be understood as being made from within the limits of a material and ideologically-mediated range – a range developing within particular historical and territorial contexts. Thus political economy analyzes social relations “within a larger context and through time, and it has as much to do with the choices people are presented with as with the choices they make from those available” (Coburn, 2001: 45).

Understanding what range of choices are made available, the interests and relations that shaped this range, and the interconnected social, political and economic relations that influence both the processes of decision-making and the conditions under which decisions are made is of primary concern for a political economy perspective. Feminist political economy offers an expanded view of the ways in which multiple and intersecting inequalities on the basis of gender, race and class further constitute the structural conditions that are not of one’s own choosing, but which, in being neither natural nor inevitable, are open to transformation (Armstrong, 2001).

### **Developing an Analytic Framework for a Case Study of LTRC Decision-Making**

The underlying assumptions of feminist political economy have three interrelated implications for developing an analytic framework of LTRC workers’ decision-making processes. First, developing a feminist political economy analysis first requires attention

to the ways that inequalities, hierarchies, and power differences shape the experience of this work, with particular emphasis on the ways in which this experience is gendered. Understanding this work requires also an articulation of the specificities of health care, a context in which tensions arise in the various conceptualizations of care as love, care as labour, the marketization of care and care work, and the medical model of health care – all with particular consequences for the organization of long-term care. This analysis must also be multi-scalar, approaching long-term residential care work as situated within historically-shifting and ideologically-shaped social, political, and economic contexts (Armstrong and Armstrong, 2001). The decision-making of LTRC workers is a social process that emerges from and is situated within multiple “nested” contexts, requiring a view that is at once local (the practices of workers in a particular workplace), institutional (the organization of the workplace), regional (ownership, funding, and regulatory frameworks that inform the provision of LTRC), national (restructuring practices and jurisdictional divisions between public and private responsibilities), and even global (migratory labour patterns, international trade regulations). Workers’ decision-making in LTRC is thus understood not solely as the product of individual workers’ actions or inactions, but rather as a product of conditions, contexts and contradictions far beyond the individual workers’ choosing, shaped by larger social, political and economic forces. Finally, the analysis must attend to the ideas and values that simultaneously shape and are reflected in the interconnected structural conditions of LTRC work. This requires attention to conceptual influences on the organization and structuring of LTRC work, such as the models of care that inform LTRC restructuring, the value accorded to care and care work, and how particular notions about gender and race both inform and are

embedded within assumptions about care and care work. To develop this analytical framework further, I draw upon a range of literature on how care work, care restructuring, and models of care combine to shape the specificities of the health care context in which LTRC work is embedded. I now turn to a discussion of the concepts, tensions and contradictions that this context raises for a feminist political economy of LTRC workers' decision-making.

### **Intersecting Inequalities: Gender, Race and Class in Global Divisions of Care Work**

A feminist political economy framework calls for attention to how care work has been rendered invisible, poorly remunerated and undervalued (Armstrong et al., 2008). From this perspective it is crucial to understand how intersecting inequalities on the basis of gender, race and class have contributed to the denigration of care work. Feminist care scholars have long pointed to the processes by which care work is accorded low value and status, naturalized as “women’s work” (Finch and Groves, 1983; Leira and Saraceno, 2002; Fine, 2006) and thus accorded low status in being associated with the inherent “nature” of women. The devaluing of care as a natural task of women is enshrined in social policy that envisions the family as the starting point of care – and a source of free care labour as governments seek to download public care costs. For instance, under the guise of “community care”, policy is developed around the provision of care services in the home. This shifting of care to the private sphere has been further sustained by “notions of the family as haven, as repository of warm, caring, human relationships based on mutual responsibility and affection, and thus a private protection against a cold, hostile, outside world” (Dalley, 1996: 31-32). The family model of social policy idealizes care in the home as the best possible care, associated with feelings of love and security –

a haven in a heartless world. However, given the association of care with the natural capacities of women, critical care literature has long critiqued the preference in social policy for home-based care as policy that implicitly relies upon the unpaid labour of women to take up care tasks (Neysmith, 1991; Baines, et al., 1992; Dalley, 1996; Daly and Lewis, 2000). In the context of LTRC, personal support workers are overwhelmingly women, reflecting an extension of the assumption that caring work is "naturally" a woman's job, and is accordingly "defined and paid as unskilled" (Armstrong et al., 2009: 42).

Furthermore, unable to have their training and credentials recognized, non-white immigrant women increasingly provide a source of cheap, exploitable and readily-available labour in LTRC (Armstrong et al., 2009; Braedley and Luxton, 2010), exemplifying how the gendered division of care labour is additionally divided along lines of class and race (Duffy, 2005). This division can be situated within an understanding of how the global forces of capitalism shape the provision of care. Here the work of Lisa Eckenwiler (2012) on migrant care workers is worth examining at length in order to understand how race, gender and class intersect in global patterns of care labour migration amidst "eroding conditions and capacities for care" (Eckenwiler, 2012: 49). As nation states in the global South cut back on their own public services in order to cut costs in a context of heavy national debt, structural adjustment policies, and transnational economic trade agreements, the care work of women is doubly impacted: both in terms of losing public service jobs in the paid care sector, and in being expected to take up the slack of unpaid caring in the home as the public provision of care erodes. In these contexts, women are increasingly expected to be "flexible" in filling-in care gaps created

by neo-liberal economic restructuring in the context of global capitalism (Eckenwiler, 2012: 52). The result is a global flow of women's care labour from the global South to the global North, as women seek employment abroad in the growing LTC markets of wealthier countries for the sake of their own survival and/or that of their families.

Eckenwiler (2012: 50) further notes this process of care labour migration is sustained by racial and ethnic stereotypes that constitute women from the Philippines, the Caribbean, and India as being "naturally caring" and having the innate capacity to provide care. As Browne and Braun (2008: 21) note, this dual process of the feminization and "colorization" of care labour on the basis of gendered and racialized expectations of migrant care workers further legitimizes their low pay and precarious status in LTC settings, leaving women of colour particularly vulnerable to exploitation. As such, the decision-making of LTRC workers must be understood as situated within a context that is marked and sustained by global divisions in gender, race and class.

In recognizing these intersecting divisions, it is furthermore important from a feminist political economy framework to understand how such inequalities can have implications far beyond the symbolic value of care work in terms of workers' compensation or the status accorded to paid care labour. For instance, as Karen Messing (1998) has noted, a consequence of gender-blind analyses of the workplace has been the tendency to view women's work as "less dangerous", such that the hazards of women's work are often rendered invisible and denied compensation. In being seen as an extension of women's "nature" and subsequently gender-segregated, the paid care labour of LTRC facilities presents a context in which workers may face particular difficulty in having the conditions of their job problematized as a site of risks, hazards and stress. These

conditions refer not only to the organization of the work and the tasks involved, but also the physical spaces in which the work takes place, as well as the equipment and other material resources available to do so.

Additionally, feminist care scholars have noted that women's increasing participation in the paid labour market has not been simultaneously met with additional support for care needs and responsibilities outside of the workplace. Women continue to be responsible for the care of children and vulnerable adults in the home (Armstrong and Kits, 2004), due to the gendered division of labour in the home, the aforementioned association of caring with women's "nature", and the ways that paid labour has been structured around a male bread-winner model (Neysmith, 1991; Knijn and Kremmer, 1997). The remittances that migrant care workers send back to their source countries also demonstrates that women's responsibility for family care continues across borders (Browne and Braun, 2008; Eckenwiler, 2012). Given the assumption that paid work cannot be understood separately from unpaid work, a feminist political economy perspective requires attention to not only how the conditions of work produce inequalities along gendered, racial and class lines, but also to the ways that responsibilities and pressures outside of paid care are a further important context to consider in understanding the experiences of LTRC workers.

### **Neoliberal Context: Restructuring, Downloading and Privatization Across the Care**

#### **Continuum**

Long-term residential care is a specific type of care provision that can be situated more broadly across a continuum of interrelated care services. In Canada, long-term care has not been explicitly included in the *Canada Health Act*, and thus is a system of care

that falls outside of the country's universal health insurance (Alexander, 2002). Long-term care in Canada has differing histories specific to each province (Banerjee, 2009), requiring particular attention to provincial patterns in funding and service integration. Long-term care has not been fully integrated into either the health or social service systems of the provinces, yet nevertheless is affected by changes and restructuring in both of these sectors. When we examine this restructuring as an ongoing project, some key trends have been identified as having important implications for LTRC work.

As numerous authors have noted (Armstrong and Armstrong, 2010; Fuller, 1998; Leduc Browne, 2000; Williams et al., 2001), service delivery and funding structures across the care continuum are being transformed through processes of neoliberal restructuring, primarily in the form of cost-cutting strategies and increasing privatization. First, cutbacks in federal transfers to the provincial acute health care (i.e. hospital) systems have fostered a push towards deinstitutionalization or transfer to what is understood as cheaper care as a means of keeping care costs down – a process that simultaneously cuts costs and fosters reliance on market forces in the provision of care (Williams et al., 2001). This neoliberal restructuring has had consequences for long-term care, pushing it from hospital (and public) provision into “the community” in the form of either home care or non-hospital institutional settings (i.e. long-term residential care facilities). At the same time, the “retreat of the state” (Aronson and Neysmith, 1997) from community-based care has failed to establish an adequate system to support the neoliberal deinstitutionalization project. Long-term residential care facilities have been increasingly relied upon for care previously provided in hospitals which, in falling outside of the public health care insurance system, are sources of care that “are not only

cheaper to operate but also cost governments less because patients pay more” (Armstrong and Armstrong, 2010: 88). The contracting out of services in long-term residential care facilities has been another means of keeping costs down, as has the expansion of private for-profit facilities (Armstrong et al., 2008). In the non-profit LTRC sector, the adoption of for-profit business-oriented managerial techniques has been encouraged as a means of cutting costs and eliminating “inefficiencies” in the provision of care, cutting services under the pressure of fewer resources to provide care (Daly, 2007). Thus, in pushing long-term care out of hospitals and into homes or long-term care facilities, neoliberal reforms can be understood as having “effectively privatized the organization and delivery of services, the work involved in LTC, and the costs of and responsibility for LTC” (Seeley, 2012: 110).

Historical shifts in processes of funding and ownership inform how long-term care is organized and delivered. Within a neoliberal context of cost-cutting, increasing privatization, and the adoption of for-profit managerial methods, restructuring processes also have numerous troubling implications for long-term residential care workers. For instance, pressures to cut costs have resulted in reduced staffing, while at the same time the neoliberal mandate to shift care out of hospital settings and into long-term facilities has resulted in LTRC residents with increasingly complex care needs (Armstrong and Armstrong, 2006; Armstrong et al., 2009). The rise in acuity and decline in resources has translated into workloads that expose workers to numerous health and safety risks on the job (Armstrong and Jansen, 2006; Baines, 2006; Banerjee et al., 2008; Morgan et al., 2008). If workers are being asked to do more, and to do so under conditions that are increasingly dangerous, a feminist political economy analysis of decision-making needs

to attend to how decisions are made (and what decisions are possible) under not only constraints on workers' time, but also in the face of threats to health and safety.

Furthermore, neoliberal managerial techniques have developed alongside restructuring in the continuum of care to eliminate “inefficiencies” in a cost-cutting era. As a result, personal support workers' jobs in LTRC have been reorganized to fit with new standards of accountability regulation (DeForge et al., 2011). The development of new rules, regulations, and systems of oversight form a context in which workers are increasingly under the scrutiny of managerial surveillance, creating tensions between the mandate to follow organizational process and the necessities of care labour. Analysis of how workers navigate these tensions thus represents an important point of inquiry for understanding decision-making.

### **The Medical Model: Skills, Knowledge and Hierarchy**

Among the possible permutations of care models, two are of particular importance to consider for a feminist political economy of care work within the LTRC setting: the medical model and market models of care. Both of these models of care have important implications for the organization and working conditions of LTRC personal support workers. Analyses of the medical model raise important issues around the hierarchical division of care labour, the denigration of personal support work and invisibility of care workers' skills. Analyses of the market model of care further contribute to an understanding of the contradictory positions from which care workers struggle to conform to both ideals of caring and the constraints of market-oriented workplaces. Together this literature provides the framework through which I will understand personal

support workers' decision-making processes as situated within workplace conditions that are informed by broader social, political and economic processes.

As a part of the care continuum, long-term care facilities have been analyzed as sites that rely upon and reproduce the notion of a medical model of care (Armstrong and Banerjee, 2009). As Armstrong and Armstrong (2010) note, health care is increasingly organized around an understanding of health as strictly biological in form, with “the fixing of body parts” (42) as the solution to health problems. The medical model’s drive towards the elimination of individual pathology and variation gives rise to standardization of care practice that emphasizes the value of “tasks rather than health”, or a focus on care outcomes (Armstrong and Armstrong, 2010: 84). The result is a concept of care that is focused on the processing of bodies and the particular care practices applied to them at the expense of the determinants of health, such as environmental contexts in which these bodies exist and the social relationships in which care is provided (Raphael, 2000; 2004). The medical model addresses an individualized, decontextualized body, such that care practices take on the meaning of bodily management, monitoring and treatment (Cancian, 2000, Reiser, 1995). This model is manifested in the provision of long-term care based on medical diagnosis and the definition of care tasks as medically necessary (Armstrong and Banerjee, 2009).

Re-conceptualizations of care that focus on the “whole” person have been an important critique of the body-focused medical model of care (Cancian, 2000). For instance, Gordon (2006) notes that in an attempt to highlight the distinctive skills of their profession, a significant shift in the professionalization of nursing has been to downplay the medical aspects of the job and emphasize instead the social, “feeling” aspects of

nursing. This emphasis on “feeling” work as being definitive of the job of nursing is explained by Gordon as indicating a desire to retreat from the bodily, hands-on tasks “that are accorded low status within the medical system” (2006: 116). However, as Twigg (2000; 2002) has pointed out, a problematic outcome of refocusing care models on the “feeling” work of care has been the denigration of the bodywork involved in caring, such that hands-on care of the body becomes increasingly pushed onto personal support workers who are accorded neither the same professionalized status nor the same remuneration, nor seen as equally skilled workers compared to other health care professionals (i.e. physicians and registered nurses). Hallgrimsdottir et al. (2008) further note that when care work is “downloaded” along the skill hierarchy, this process occurs along gendered pathways. We can understand this downloading as occurring at two levels of labour division: first, the broader level of care restructuring, as noted in the above discussion, has pushed long-term care from hospital settings into LTRC facilities – places in which a larger proportion of managers are female compared to other health care settings, reflecting the low value accorded to LTRC. Second, within LTRC facilities, the majority of “hands-on” care work (i.e. feeding, bathing, clothing, and the other activities of daily life) is performed by the unregistered, lowest-on-the-hierarchy personal support worker – a job category overwhelmingly occupied by women. With “skilled” care work defined through professional models based upon technical medical knowledge, expertise, education, and professional registration, personal support workers fall outside of the professionalized discourse of what kinds of work count as skilled.

This gendered process of hierarchical organization leaves personal support workers susceptible to being understood as “ancillary” rather than central to care

(Armstrong et al., 2009), not only rendering their work invisible, but also reinforcing its precariousness and poor remuneration. On this point, Braverman's (1974) analysis of deskilling and degradation of work under scientific models of management in capitalist societies is useful for understanding the consequences of a hierarchical division of labour – a division which persists despite the fact that, as numerous authors (Diamond, 1986, 1992; Kontos et al., 2010a; Foner, 1994; Weinberg, 2006) have noted, the hands-on bodywork involved in long-term care facilities actually requires a great deal of skilled interpersonal labour to accomplish important care outcomes. As a result, this work and the knowledge it requires – such as knowing how best to make a care recipient comfortable, how to interpret the behaviours of an LTRC resident, and innumerable other assessments that have a direct material impact on care recipients – is rendered invisible in a narrow definition of not only what counts as a skill, but also what counts as a necessary aspect of care. What gets counted as a necessary aspect of care leads to further consideration of the assumptions that shape the management, organization and funding of the long-term care sector, in a second model important for a political economy analysis of LTRC work: the market model of care.

### **The Market Model: Tensions in Paying for Care**

The governance of long-term care and the assumptions built into care planning in the organization of the LTRC workplace can be further explored in relation to markets and financing in order to understand the ways that “market model” of care may impact upon the working conditions and decision-making processes of personal support workers. The market model of care is characterized by efficiency-based care delivery (Armstrong and Armstrong, 2010), or what Daly and Lewis (2000) have observed as the application

of market principles to the organization of care. Under the market model, care needs are redefined as activities that can be quantified and measured, such that “the tasks that can be counted are given priority – the number of meals delivered, baths given, and sheets changed” (Baines et al., 1992: 41). Under this model, the value of care becomes a matter of whether services deemed “appropriate” have been delivered or not, and the financial aspects of care take centre stage in managerial organization and oversight. As Daly and Lewis (2000) note, the application of market principles to care affects who delivers care to whom and under what conditions, leading to a greater targeting of service provision under specific assessment techniques and measurements of need and risk. Care work thus becomes reorganized under the market-based logic of risk management, resulting in an emphasis on evidence-based practices, service contracts, and outcomes rather than inputs (i.e. “getting results”) (Fine, 2005: 259). The conceptual territory carved by the provision of care based on definitions of medical necessity is such that care needs that fall outside of the “medical model” continue to be neglected, and here we can understand how there is convergence between both the medical and market models: a medical model that narrowly defines care on the basis of bodily necessities all too easily fits with market-based logic of counting, measuring and formularizing the provision of care services. Evans (1997: 449) notes that the consequence of this re-shaping of care under the market model is “a slimmed-down” provision of care, with fewer services available and at the lowest possible cost.

A strategy in the care literature for analyzing the market model has been to focus on the question of what happens to the quality of care in market-based organizational contexts, and with what consequences for care workers’ decision-making. Given the

organizational constraints that characterize market-based care contexts, Nicky James (1992) argues that the possibility for supporting emotional aspects of care are both quashed and rendered invisible by organizational limitations on care. That is, there is a conflict between the possibility for individualized and emotional care and the ways that the workplace is hierarchically organized. To organize care in ways that attend to the individual, James notes that care workers are active in “learning enough about each patient and their family to be able to judge when routines should be interrupted” – but that for this to happen, the workplace needs to be “flexible enough to be responsive to such individually made decisions to break routines” (495). Thus care workers face a tension “between organisational priorities and organising individual patient care” (James, 1992: 495). What is missing from James’ analysis is the broader contextual background of how the care workplace is structured. As the above-discussed neoliberal context of restructuring has highlighted, the way that care is organized and restricted in any given workplace is only one piece of a larger puzzle to understanding the market model’s problematic consequences for paid care labour. Furthermore, the reinforced association of individualized, personalized care with better quality care is an assumption that the private for-profit care market has been all-too eager to harness in the promotion of market-based care as enhancing personal choice and expanding care options (Knijn, 2000).

James’ (1992) analysis exemplifies the ways in which challenges to the market model of care may end up reproducing problematic assumptions that hinder an analysis of care work. For instance, in analyzing the market model, Stone (2000) laments that “family-like relationships are forbidden in a culture that replaces real family with paid workers”, such that “organization, management, professionalization, and

commercialization undermine good care” (111). For Stone, “family” comes to be synonymous with “good care”, such that the idealized relationship is what ensures the provision of quality care. However, as noted in the above discussion of gendered care work, care in the family has been reinforced as primarily the private responsibility of women, serving to reproduce the notion that care work is a natural extension of women’s roles, and neglecting the fact that care in the family context is not always the best nor most desirable place for care (Guberman, 2004).

A tension lies in the assumed conceptual link between family (i.e. unpaid) care and positive care outcomes, while at the same time sustaining suspicions of market-based care relationships. As Tronto (2010) has warned, when care moves out of the home there is a greater tendency to view its form as suspicious and in need of scrutiny – as somehow more prone to problems than care in the home, which is then reinforced as the “natural” environment for care. Thus Stone’s (2000) analysis of the market model reveals an interesting dichotomy: an assumed distinction between care performed by unpaid care workers in the home, and care performed by paid care workers, in what might be understood as a “love/money” dichotomy. What marks this distinction is an assumption about motivations to care, and whether care work is motivated by “genuine care or altruism” (England, 2005: 389): that is, is caring for (activities of care) motivated by caring about (feelings)? In challenging the market model, there is a risk of conceptualizing “good care” or better care as that which is performed with “true” feeling and emotion. In driving out the emotional aspects of care, market relations are problematized for demeaning the “noble calling” of care work (England and Folbre, 1999: 48), such that the contractual or pay-based nature of the care comes to be the focus

of analysis. Thus the tendency of market model critiques to dichotomize between love and money in the care relationship appeal to an idealized version of care based on altruism and self-sacrifice.

In doing so, critiques of the market model are concerned with how to fit the characteristics of “family-like” care within market-based relationships, rather than challenging the market-based structures in which care concepts develop. This is where a feminist political economy perspective becomes particularly useful in emphasizing the broader contexts in which care work is situated. To neglect the broader context in which care work is organized under the market model is to run the risk of taking for granted a continued association of care with love and unpaid labour. This is a problem that hinders both King’s (2007) and Nakano Glenn’s (2000) otherwise useful critiques of how the market model exploits the unpaid labour of care workers. King’s (2007) solution to this model does not extend beyond a question of how to support relational caring within market-based organizations of care, and as a result the assumptions embedded in the concept of care are unaddressed. She argues that the market model can be challenged by making space for the support of workplace emotions in organizational care contexts, and thereby “enable organizations to deliver responsive, appropriate and relational care” (King, 2007: 209). However, it is not clear how the official incorporation of workplace feelings and emotions would address the above-discussed neoliberal structural context in which the problematic marketization of care arises. Nakano Glenn’s (2000: 92) critique is similarly limited to suggesting a “reward system” and organizational support for care workers who “go out of their way” to provide relational or emotional care beyond the limits of standardized, task-focused care – in effect, rewarding care workers who are able

to provide aspects of care that fall outside of their job requirements. This suggestion requires workers to provide care in self-sacrificing ways, to the point of disregarding their own care needs.

Both Nakano Glenn and King fail to incorporate an understanding of hierarchical workplace relationships and the bureaucratic organization of care work. This context is essential to understanding how the form of care in the market model is not only shaped by micro-level interactions of social actors within market-based contexts, but also by broader market ideologies and interests that subject care to the demands of profit-maximization and cut-backs, as well as the attempt to control care labour through the standardization, measurement, and documentation of care tasks (Leduc Browne, 2010). Furthermore, their strategies for challenging the market model of care are founded upon the assumption that all emotion associated with caring is positive and helpful, indeed a solution to the problem of “slimmed-down”, narrowly-defined care. This does not offer us a way to conceptualize negative emotions or inequality in care relationships, and limits our understanding of care work as an exclusively rewarding experience – which plays all too easily into the very same conceptualization of care that sustains the exploitation of and poor remuneration for care workers.

Thus critiques of the market model that rely upon idealized forms of care or that neglect the structural context in which the market model of care arises risk generating a fear of care work in LTRC settings as commodified care, as an “anonymous, objectified, self-interested exchange” (Nelson, 1999: 44). An alternative approach is offered by Baines’ (2004) analysis of care labour under the market model, in which both the structural and conceptual contexts are considered. She notes that the market model of

care is situated within a context that is increasingly characterized by a flexible workforce, with a reliance on irregular shiftwork and precarious jobs with few benefits and little security. This context leads Baines to consider the “compulsion-coercion continuum” in which care workers struggle: on the one hand, workers are coerced to perform unpaid care work so as to not lose their jobs, revealing that the market model of care is too narrowly defined to capture necessary care activities. At the same time, care workers also feel compelled to perform this work due to a sense of self-identity as a “good person”, seeing the provision of care outside of their official contractual obligations as a way of fulfilling the altruistic care ideal (Baines, 2004). Rather than reproducing the love/money dichotomy, Baines’ problematization of care workers’ experiences provides a way for us to understand both the structural contexts and hidden assumptions upon which the market model of care relies. The task-based, results-focused organization of care in the market model precludes the possibility for a concept of care beyond tasks which can be quantified or measured, while at the same time this model is sustained by the association of care with ideals of altruism, love and self-sacrifice. This tension provides a basis for analyzing how care needs are defined and how care work is organized in LTRC settings, as well as the explicit and implicit assumptions upon which this organization relies.

The market model of care thus points to a problematic and disconnected logic, one which serves to highlight how the above-discussed intersecting inequalities in care labour, the neoliberal context of care restructuring, and the medical model of care are all interconnected from a feminist political economy perspective. The market model of care narrowly conceptualizes care as quantifiable, physiological tasks that can be counted, measured, and performed within a market-based contract. Under market logic, care takes

on market-based value as a package of services provided to the cared-for as “consumers” or clients of care (Knijn, 2000). However, the conditions of that market contract rely upon both the paid *and unpaid* labour of poorly remunerated and low-status care workers. These workers, as discussed above, are marked by divisions of gender, race and class (England and Folbre, 1999; Duffy 2005), and their work is increasingly being reorganized according to the logic of neoliberal cutbacks, downloading and privatization – a “slimming-down” of care services, which the medical model and its narrow focus on physiological outcomes all-too easily serves to aid.

### **The Specificities of Care Work: Tensions in Articulating the Care Relationship**

The previous sections have sought to explicate the ways in which a feminist political economy analysis of LTRC work requires attention to the devaluation of care labour, the restructuring of care labour, and the models that inform the organization of care work. Together, these aspects of LTRC serve to highlight the setting as one that is rife with tensions and contradictions for the care workers who work there. In this section I wish to highlight a few of these tensions in order to demonstrate the specificities of care work as a particular kind of work: one which, unlike other forms of industry, involves a *relationship*.

Articulating this relationship requires analysis of care work as a social process, and the first step towards understanding care as a social process is to understand how the care relationship develops. If care is a social process, then the care relationship emerges through social rather than “natural” origins. One strategy for emphasizing the social origins of care relationships has been to reframe care as the product of emotional labour, such that the care relationship is produced through the work and efforts of the carer

(Hochschild, 1995). This analysis provides an important challenge to the aforementioned problematic rendering of care as unskilled and naturally occurring—which justifies poor remuneration for paid care labour and a reliance on (and idealization of) women’s unpaid informal care (Leira and Saraceno, 2002). However, we are left with an additional dilemma: care is positioned as the effect or outcome of only one social actor, the carer, while the cared-for are relegated to the role of passive objects of (emotional) caring labour. Focusing on the care work of one “side” of this relationship neglects the ways that carers are simultaneously in need of care themselves – a concern in particular for LTRC workers who struggle to have the health hazards of their workplace acknowledged (Daly and Szebehely, 2012). The carer/cared-for dichotomy thus has serious implications in terms of whose care needs will be recognized, what will be recognized as a care need, and how will these care needs be supported.

One way to take up the dilemma of dichotomous, unidirectional care relationships is to problematize the care relationship as a social process involving “some degree of bi-directionality and mutuality” (Dannefer et al., 2008: 105). There are, however, numerous problems that arise from the concept of care as a mutual exchange. While the concept presents an opportunity to dismantle the carer/cared-for dichotomy, mutuality may be a normative ideal that erases difference in the care relationship. For instance, Engster (2005) conceptualizes care as a mutual relationship involving responsiveness or “dialogue” with the cared-for to determine their needs. But “dialogue” assumes that the cared-for can express their care needs, such that differences in capacity are erased. Furthermore, mutuality leaves no space for problematizing knowledge and the privileging thereof. Conflict in interpreting care needs can arise between care recipients (or

“consumers” in the market model) and care facilities (Tronto, 2010), as well as in defining and interpreting illness and health, and the planning of care needs on the privileged basis of expert knowledge (Fox, 1995; Kontos et al., 2010a; Moss and Teghtsoonian, 2008). Given the analyses above, it is clear that policy, health care and organizational contexts all contain varying and problematic interpretations of what *counts* as care.

A conceptualization of mutual care relationships on the basis of dialogue thus requires a critical analysis of power. The ideal of dialogue is, on the surface, a positive one that has been particularly important for political purposes – for instance, in the disability movement for critiquing object-oriented discussions of care and the characterization of care relationships as inherently rooted in dependency (Fine, 2006; Barnes and Mercer, 2003). However, the concept of care as a dialogical relationship assumes that, first, the cared-for are homogeneously and intrinsically located in a position of subordination compared to powerful carers. This assumption leaves us no means by which to understand the exploitation of care workers, the violence they experience, or the precariousness of their labour (Banerjee, 2010). Second, the concept of care as a dialogue assumes that an equal playing field can be achieved between the cared-for and carer through a shifting of power in the relationship. The problems of this assumption are made clear by Ungerson (2000), who notes that attempts to level the playing field do not erase the potential for abuse of this empowerment on the part of the cared-for, putting care workers themselves at risk. Ungerson’s (2000: 84) analysis reveals the ways in which “both participants in this commodified relationship are vulnerable, although in rather different ways”. Conceptualizing care as a dialogical or mutual relationship assumes

power imbalances can be solved in ways that render invisible the multiple vulnerabilities of both carers and the cared-for.

A concept of care relationships as *interdependent* has been proposed as a way to address these issues identified with mutuality. However, as Fine and Glendinning (2005) have noted, this strategy introduces some new problems with regard to inequality. First, interdependency erases inequality between persons in terms of accessible support resources and the capacity/ability to provide support for others. Second, it absolves the state of both the responsibility to provide care supports and to account for how the care relationship is affected by the actions (and inactions) of the state. Finally, the concept of care relationships as interdependency neglects the fact that not everyone has a network of help available to draw on while simultaneously caring for another – an oversight that has significant implications from a feminist political economy perspective, given the divisions of gender, race and class in care labour (Armstrong and Connelly, 1989). Thus, while there are problems with conceptualizing care as a dependency-based relationship, the concept of interdependence may be just as problematic in neglecting the context of inequality.

The critique of interdependency suggests that if we are to think of care as a relationship, we might consider the possibilities offered by conceptualizing care as a *multi-directional* relationship. This is the perspective taken up in Lanoix's (2010) analysis of relationships between different types of carers. Expanding beyond the carer/cared-for dualism, she looks at how unpaid carers (that is, family members) may continue to perform direct care duties as well as form a link between paid care workers and the cared-for. Unpaid carers also often take up the slack of emotional labour that

workers struggle to perform under the slimmed-down provision of care under market-based restructuring. We can also consider how paid carers are required to perform tasks beyond the formal definitions and measurements involved in the tasks of their jobs – work that is uncounted and invisible, but nonetheless required to get the job done (Baines, 2004). The concept of care as a multidirectional relationship is thus another opportunity to challenge the supposed division between *formal* paid care and *informal* unpaid care work.

We might also consider how the care relationship is informed by “a normative framework of obligation and responsibility” (Daly and Lewis, 2000: 285), and what this normative framework may mean for LTRC workers struggling to produce care under particular expectations of what “counts” as quality. Leduc Browne (2010) calls this normative framework the “care effect”, which requires that the efforts of care be concealed, rendered as a selfless “gift” in order to be understood as caring. This normative framework of altruism, sacrifice, and care as a gift highlights an important tension in understanding care work in the LTRC context. First, care workers are paid to provide care – and yet the conditions of this paid labour implicitly rely upon unpaid and uncounted relational tasks, and the knowledge of care workers that is rendered invisible (Kontos et al., 2010a). Second, what counts as care is defined narrowly under market logic of standardized, formulaic, measurable, and countable tasks – and yet “good” care is understood as care that is individualized, personal, and tailored to individual needs (Nakano Glenn, 2000). The normative production of the care effect is thus central to understanding the care relationship as one that does not exist in isolation from normative expectations of care that underlie the structure of LTRC work, broadening the scope of

care work analysis to contextualize care relationships within the inseparable conceptual and material conditions of lived experiences. This dissertation aims to understand the decision-making processes of LTRC personal support workers as contextualized by these interconnected structural, organizational, and conceptual layers of analysis.

### **Feminist Political Economy: Transformative Potential**

In sum, from a feminist political economy framework, my investigation of care workers' decision-making processes makes use of a multi-level analysis, questioning the barriers and facilitators of decision-making as situated within multiple "nested" contexts: from the social location of the worker (micro-level context) to the working conditions in which she is situated (organizational context) to the broader processes of care (re)structuring (macro-level context). Working within a feminist political economy framework that assumes social actors shape their histories, albeit not under conditions of their own choosing (Armstrong, 2001), this dissertation approaches the decision-making of PSWs as a *complex social process*, both a product of and response to the multi-layered nested contexts in which LTRC work takes place. Thus this project is focused more specifically on understanding workers' strategies for doing care work amidst the following five contextual layers:

- 1) The worker's immediate social location, as informed by the intersecting variables of gender, race, class, immigration status, etc. – e.g. financial needs, family life/responsibilities.
- 2) Work organization and working conditions – e.g. time constraints, workload, assigned tasks.
- 3) Regulatory requirements – e.g. workplace rules, managerial surveillance.
- 4) LTRC (re)structuring and global chains of care – e.g. funding cuts, policy changes, marketization of care, global importation of care labour.

- 5) Multiple (and potentially conflicting) models of care and definitions of care needs, as manifested in LTC (re)structuring, worker training manuals, resident care planning, and workers' understandings of what is needed for "good care".

Tracing the decision-making process means to trace the factors that impact frontline care provision, but in a way that puts workers' experiences and knowledge at the centre of the analysis. In this way, a feminist political economy framework informs not only the analysis of my project, but also its chosen methods – as will be detailed in the following chapter. Drawing on a feminist political economy framework, Dorothy Smith (1989, 1990, 1992) has argued that "relations of ruling" are embedded in the textual artifacts of institutions, bureaucracies, and disciplines, forming "institutionalized practices of knowing" that order the world from a particular standpoint. Thus texts such as statistics about LTRC workers, descriptions of their work in job manuals, and records of their daily/nightly tasks are understood not as objective facts, but as products of particular power relations and interests. Starting from the standpoint of workers' own experiences and knowledge by asking workers how they work and why they work the way they do offers a better understanding of how care work involves a *complex social process* – one that takes place within not only a specific organizational context, but at the intersection of multiple social relationships, structural trends, and conceptual models that inform the organization of long-term residential care.

The primary goal of using a feminist political economy framework is to contribute to the critical argument that the working conditions of LTRC settings have important implications for care. By rendering the decision-making processes of workers visible, this dissertation begins from the assumption that care is the end result of how care workers must strategize as a condition of their work – devising strategies to perform care, to avoid

injury, to manage their multiple responsibilities within and outside of the workplace, and so on. This leads to a second goal: attending to care work from a political economy perspective renders visible the oft-neglected skills and labour of PSWs that make possible the everyday/everynight life in long-term residential care facilities. This project thus is an attempt to combat the ways in which personal support workers are marginalized by formal processes of care planning, workplace organization, and broader structural and ideological processes informing long-term care. In the spirit of feminist political economy, the focus on decision-making is intended to challenge the notion, shaped by ideologies about gender, race, and care, that personal support workers are “unskilled” and expendable. The intention is thus to contribute to broader political efforts to have this labour valued and supported.

Thirdly, a feminist political economy framework understands decision-making processes beyond linear models of individuals’ clinical evaluations and knowledge utilization, investigating decision-making as contextualized by structural constraints, conceptual models, and complex care/work relationships. Investigating *barriers* to care decision-making, a feminist political economy of decision-making requires attention to contradictions and disjuncture between policy and practice – for instance, disconnections between the formal care planning process and the experiences of struggling to provide care “on the frontlines” (Banerjee, 2010). This will allow me to suggest some ways to resolve this disjuncture through structural improvements, rather than relying on individual-level solutions of worker “empowerment” or additional training. Furthermore, in also investigating *facilitators* to care decision-making, a feminist political economy framework can offer insight as to how care workers in LTRC settings might be better

supported, suggesting some “promising practices” that emerge from workers’ own experiences.

## **CHAPTER 2**

### **Project Design and Methodology**

My dissertation could be considered a project within a project within a project, as it makes use of data collected during a project entitled *Healthy Ageing in Residential Places* (HARP), which *itself* is a part of an even larger project entitled *Re-Imagining Long-Term Residential Care: An International Study of Promising Practices* (hereafter shortened to *Re-imagining LTRC*). To understand where my own dissertation comes from, it is necessary to first understand these broader projects, and my involvement as a student researcher on both. I begin this chapter by detailing these larger projects in terms of their goals, research design, and data collection methods, with reference to my own involvement as a student researcher and in relation to wider relevant methodological literature. I then articulate the methodological specifics of my own dissertation's study in terms of its analysis and underlying epistemological assumptions.

#### **Re-imagining Long-Term Residential Care**

*Re-imagining LTRC* is a seven-year Major Collaborative Research Initiative (MCRI) funded by the Social Sciences and Humanities Research Council of Canada (SSHRC) involving an international, interdisciplinary team of researchers seeking to investigate promising practices in LTRC. The project is designed as a cross-comparative study involving six countries that correspond with Epsing-Andersen's (1990) typology of welfare regimes in a capitalist economic system: Canada, the US and the UK, representing a liberal welfare regime (typified by increasing marketization, privatization, and inequity in care provision and access); Norway and Sweden, representing a social democratic welfare regime (typified by a universalist approach to care); and Germany,

representing a conservative welfare regime (typified by a mix of social insurance care models). Across these jurisdictions, promising practices are sought in terms of the approaches to care, work organization, accountability, and financing and ownership of LTRC that can support the dignity of and respect for both care providers and residents, and that make (or can make) LTRC a positive, equitable and desirable place for both care and work.

As explored in the Chapter 1, the guiding conceptual framework for the *Re-imagining LTRC* project includes a feminist political economy approach, reflected in the project's aim to produce an analysis that is multi-scalar, gender-focused, and attends to issues of inequity and accessibility. *Reimagining LTRC* consists of multiple layers of analysis throughout the seven years of its duration, beginning with mapping what is known about long-term care, conducting site visits of LTRC facilities using site switching and rapid ethnographic techniques (to be discussed at length below), analysis of data from and methods used in these site visits, and knowledge dissemination. At the time of this writing, *Re-imagining LTRC* is presently in its sixth year of collaboration, and is in the midst of completing site visits to LTRC facilities across the jurisdictions involved in the project.

*Re-imagining LTRC* involves not only the interdisciplinary team of academic co-investigators, but also employee union partners, employer association partners, post-doctoral fellows, and graduate students. My own involvement as a graduate student researcher on the *Re-imagining LTRC* project began in the fall of 2009. My PhD supervisor and principal investigator on *Re-imagining LTRC*, Dr. Pat Armstrong, offered me a research assistant position that fit with my own research interests: investigating

varying models of care. I produced a review for Dr. Monique Lanoix, a co-investigator on *Re-imagining LTRC*, on key literature in care theory, care in social policy, care labour, and the ethic of care. In conducting this research, I came to understand there are consequences for the organization and provision of LTRC depending on how “care” in terms of its nature, its tasks, and its actors are conceptualized (Day, 2013). I presented my analysis at one of *Re-imagining LTRC*’s monthly team seminars, a venue in which collaborators shared their preliminary research findings and brainstormed areas for future investigation and potential research questions that the project would need to attend to in conducting its own empirical work. Exploring this literature led to further opportunities to work with one of the project’s post-doctoral fellows, Dr. Albert Banerjee, in producing a report (for use internal to the project) on the concept of “quality care” as conceptualized in LTRC workers’ education and training. This report drew on both textual education resources (e.g. textbooks and best practice guidelines, continuing education materials) as well as interviews with key informants in the LTRC sector, including nurses’ union representatives, medical directors, and educators in nursing and personal support worker programs. This work led me to question the potential disjuncture between the idealization of care in the “official” descriptions of and instructions for care provision, and the realities of producing care in the everyday/everynight work of LTRC – a disjuncture that Diamond (1992) clearly highlighted in his experiences of moving from frontline care work training to the actualities of working as a nursing assistant in an LTRC facility.

Given the questions that were accumulating for me throughout my research assistant work, my supervisor offered the opportunity to participate as a student researcher on the first empirical fieldwork of *Re-imagining LTRC*: a site visit at a LTRC

facility in Ontario. As a member of the research team, my role was to produce field observation notes and conduct interviews with workers during the site visit, and in return I would receive access to the project's data for analysis in my own dissertation research. This access would allow me to ask the research questions that had been developing for me throughout the course of my research assistant work – questions that came to form the basis of this dissertation, as described in Chapter 1. With this arrangement made, I produced a dissertation proposal for my research committee's approval, and obtained ethics approval with York University's Office of Research Ethics (Certificate # STU2012 – 116; see Appendix A). In my ethics application package I outlined how my project would be conducted in my role as a student researcher on the fieldwork involved in the larger *Reimagining LTRC* study, which itself had already obtained ethics approval (Certificate #2011 – 254). I now turn to a detailed description of the site visit in which I participated (including the study's development, site selection, methodology and data collection techniques), and situate an understanding of this project within the broader methodological literature.

### **The First Site Visit of Re-Imagining LTRC: “Riverside Home”**

The international cross-comparative work on the *Re-imagining LTRC* project began with a site visit to a single LTRC facility in Ontario, and it was on this site visit that I was to participate as a student researcher. Here I should note that this site visit was technically a part of a sub-project for *Re-imagining LTRC*, called *Healthy Aging in Residential Places* (HARP). This sub-project has two main research objectives in conducting site studies of LTRC facilities:

- 1) to develop new definitions of healthy, active aging that include those who reside and work in LTRC; and
- 2) to identify promising conditions and practices that promote and allow active healthy aging for both staff and residents in LTRC.

As the Ontario site visit was to be the first “in the field” undertaking for the broader *Reimagining LTRC* project, it was considered a pilot study in that it would provide a template for refining methodological techniques and building researchers’ capacities for replicating future site visits in the other provincial and international jurisdictions involved in the wider project.

#### *The Site Selection Process*

In order to find an appropriate LTRC facility for the first site visit, a great deal of initial preparatory work was undertaken by the principal and local (i.e. Ontario-based) co-investigators on the *Re-imagining LTRC* team. Throughout the spring of 2012, interviews were conducted by the lead and co-investigators with union representatives, senior managers in LTRC, and a representative from the Ontario Ministry of Health and Long-Term Care to identify potential Ontario-based sites that would be conducive to the goals of investigating promising practices in approaches to care, work organization, funding and governance that foster active, healthy aging for both residents and workers. Interviewees were asked to explain why they recommended the particular sites they did, and were informed that we were not necessarily looking for “award winning” facilities. Awards indicate a pre-determined measure of facility quality, and we were most interested not in finding a site that matched already-determined measures of “promising practices”, but rather one which could help contribute to new understandings of and

insights into promising practices. In other words, finding a site that already fit with predetermined measures of award-winning criteria would not tell us much about how these criteria were selected as measures of quality, who decided what these indicators would be, how the indicators of quality were measured to determine the facility's award-winning status, nor what indicators are potentially missing.

A number of possible Ontario LTRC facilities were recommended throughout this consultative process. In discussion with the wider project research team, a LTRC facility was eventually identified from the various options and approached as our first choice for participation: a facility that I will refer to with the pseudonym "Riverside Home".

Riverside Home was particularly appealing to the research team for a number of reasons. Located in the heart of a large urban Ontario city, the facility is quite a large site (more than 60 beds), with care units separated roughly by the types of care that residents need – one unit is for residents with greater cognitive impairment, while the other is for residents with less cognitive impairment but greater physical impairment (i.e. requiring wheelchairs, assistance with transfer, etc.) The facility provides 24 hours of nursing care to its residents, making it an ideal site for studying care practices "around the clock". After a lengthy internal ethics review process with Riverside's own ethics board and a great deal of liaison work with facility management, access was eventually granted for a week-long site visit to Riverside Home for December 2012.

### Site Visit Research Methodology

The methodology used in the site visit to Riverside Home (and in the subsequent site visits conducted elsewhere during the ongoing *Re-imagining LTRC* fieldwork) was *rapid ethnography*. The specific methods of this approach were collectively developed

over time by drawing on the research efforts, expertise and experiences of the broader *Re-imagining LTRC* team, as well as the literature on how this method has been applied to other types of studies in prior social science research. This collective effort took place over the months between having selected Riverside Home as the setting for the first site visit and our entry into the facility, and required frequent coordinating meetings to share ideas and new information about both the site and the methodological literature. As a rapid ethnography, the Riverside Home site visit drew on techniques of ethnographic fieldwork, rapid ethnography as a specific form of ethnographic study, and team ethnography.

Rapid ethnography shares many of the same techniques and approaches that have made traditional ethnographic methods so appealing to LTRC researchers. Like traditional ethnography, rapid ethnography involves multi-method collection of data both in and out of “the field” (i.e. the site of study). Rapid ethnography is also similarly a method that requires archival research, surveys, participant observation in the site of study, interviewing techniques with key informants, and reflexive analysis in order to “collect sufficiently *complex* descriptions” of a particular case (Baines and Cunningham, 2011: 74). These techniques of traditional ethnographic fieldwork have been extensively used in other examples of LTRC research, producing rich accounts of the everyday life of the wide range of social actors involved in LTRC (Gubrium, 1975; Savishinsky, 1991) and portraits of LTRC as distinctive cultural spaces (Henderson and Vesperi, 1995; Stafford, 2003). Ethnographic research has also been used for the purpose of investigating specific questions about LTRC life and work, including resident perspectives on home, comfort and privacy (Bland, 2005, 2007; McColgan, 2005), food

and mealtimes (Harbers et al., 2002), and the working conditions and dilemmas experienced by LTRC workers (DeForge et al., 2011; Diamond, 1986, 1992; Foner, 1994; Lopez, 2006a, 2006b, 2007).

Collectively this work has demonstrated the promises of using an ethnographic approach in LTRC research, as the level of detail produced in an ethnographic study can help to “generate new theoretical concepts, identify the steps in a particular social process, reveal the organizational principles of social groupings, identify explanatory mechanisms in social dynamics, and link these issues to broader theoretical frames of understanding” (Puddephatt et al., 2009: 1-2). By participating in, or “getting close to” (Emerson et al., 2011: 2), the everyday/night routines of LTRC facilities, researchers have used ethnographic techniques to produce complex understandings of LTRC as places and spaces of care, care work, and social processes that extend far beyond the walls of the facility itself. Others have also noted that ethnographic approaches to LTRC settings offer a particularly instructive experience in classic dilemmas of conducting ethnographic fieldwork, including negotiating boundaries between the researcher and participant roles, and to what extent one can “participate” in a setting that is at once a site of medical *and* social care (Tinney, 2008), as well as the challenges posed by shifting power differences between one’s self as a researcher, the staff caring for residents, and the residents themselves (Baumbusch, 2011).

Where rapid ethnography differs from the more traditional ethnographic methods used in prior studies of LTRC is in terms of its focused scope, shorter timeframe, and multi-researcher design. It is a highly focused form of ethnographic research, requiring a purposive approach to both interviewing and observations in the field (Wolcott, 2008).

Defining the purpose of the research thus itself requires considerable preliminary thought as to what the variables of interest are in relation to the research question under study, as well as in relation to the theory guiding that research question (Handwerker, 2001). As the term “rapid” ethnography suggests, the actual immersive fieldwork of this method also takes place over a very short period of time compared to lengthy traditional ethnographic design, and thus requires extensive preliminary background information on the case under study *before* entering the field. Background data are collected in the form of interviews with key informants and textual/electronic artifacts from the site in order to both gain as much information as possible prior to the site visit as well as to more clearly focus attention on the “important activities” that are relevant to the research question (Millen, 2000: 281). Finally, rapid ethnography is designed to involve two or more researchers in the process of data collection, and an effort is made to involve a mix of researchers who are both more and less familiar with the case site in order to bring new perspectives to both observation in the field and analysis of data (Baines and Cunningham, 2011).

There are numerous benefits to a rapid ethnographic research design, which made this method particularly appealing as the basis for the site visits involved in *Re-imagining LTRC*. The first and most obvious advantage is that it is much faster to produce compared to traditional ethnography, requiring a shorter and more condensed period of time in the field compared to more lengthy immersive projects. Time is a limited resource for the seven-year *Re-imagining LTRC* project, as the numerous site visits comprising its empirical studies are but one phase in this multi-year collaboration. Of further appeal is rapid ethnography’s focused approach to observing and understanding everyday practice,

which makes this method particularly useful for asking questions about “the intersection of policy and practice”, connecting micro-level experiences with macro-level patterns for the extension of theory (Baines and Cunningham, 2011: 77). Guided by the underlying assumptions of feminist political economy, it was important for the broader *Re-imagining LTRC* project that the chosen fieldwork method incorporate observational techniques in understanding the complex social processes of LTRC life, acknowledging that text-based artifacts of an institution are embedded with the “relations of ruling” (Smith, 1989; 1990) that can obscure the experiences, marginalized points of view and knowledge of workers and residents.

Finally, as this research design involves more than one investigator in the field, rapid ethnography also has numerous benefits in being a form of *team ethnography*. Erickson and Stull (1997) note that team ethnography has been and continues to be an important innovation in ethnographic research design, posing a challenge to the “Lone Ranger” archetype that appears to dominate ethnographic literature – the image of a sole researcher roughing it alone in the field, producing accounts of social life through one’s own individualized struggles and accomplishments (Erickson and Stull, 1997). Gathering ethnographic data as a team has numerous unique benefits, including the ability to verify one’s observations of the same situation against those of others, and to benefit from new perspectives and interpretations offered by researchers’ diverse social locations (including differences in gender, race, culture, and discipline) (Erickson and Stull, 1997). When more than one researcher is involved in the fieldwork, reflexivity also becomes a collaborative exercise (May and Pattillo-McCoy, 2000).

To maximize these benefits, a team for the site visit to Riverside Home was sought that included researchers from not only the local context (i.e. Ontario), but also from among the *Re-imagining LTRC*'s international collaborators: being outsiders to the Canadian LTRC system meant that they could provide “fresh eyes” in the field, offering their own expertise and a point of comparison from the perspective of how LTRC works within their own countries. Furthermore, in the spirit of knowledge transfer, our international collaborators could make use of what they had learned in the Canadian context when returning to their own locales – hence there is a *site switching* component to the rapid ethnographic approach used by *Re-imagining LTRC*. Among our international collaborators, three were able to participate in the research team at Riverside Home: a senior academic in social gerontology from the UK, a senior academic in social work from Sweden, and a highly experienced social worker from Sweden with a background in LTRC work. Diversity was also sought in terms of participation from a wide array of disciplines and positions. In the end, the Riverside Home site visit team was composed of twelve researchers in total (plus one hired project coordinator and the principal investigator) who would enter the field at Riverside Home, representing a wide array of expertise in LTRC and LTRC-related fields, including academics in social work, nursing, gerontology, sociology, and history. The team included seven senior academics, a post-doctoral fellow, a social worker, and three PhD students – one of whom was me.

Herein the site visit method used by *Re-imagining LTRC* does depart somewhat from one of the benefits that have been noted of the rapid ethnographic approach. Typically, one of the benefits of rapid ethnography is considered to be its inexpensiveness relative to lengthier forms of ethnographic fieldwork (Baines and

Cunningham, 2011). However, sending twelve researchers into the field was an expensive undertaking, particularly as three members of the team were international researchers travelling to Canada for the sole purpose of participating in the fieldwork. Of the total research team, only two members were local enough to Riverside's location to feasibly travel back and forth to the site throughout the study; all other members required nearby accommodations. However, an additional benefit to involving numerous researchers on a single ethnographic study is the ability to apply more widely for funding sources, which helped to defray the costs of both the initial site visit and subsequent returns to Riverside for additional follow-up interviews, as well as for professional transcription services.

Two additional benefits of a team approach were of particular importance to the site visit of Riverside Home (and to the broader *Re-imagining LTRC* collaboration in general). First, as Woods et al. (2000) note, ethnographic teamwork enhances the ability to work through ethical issues from multiple points of view. This was an important benefit to conducting the Riverside Home site visit, as the ethical challenges in conducting LTRC research are numerous, with concerns raised about residents' capacity to provide informed consent, conflicts of interest in terms of researcher goals vs. resident/worker benefits, and the question of how to ensure that participation is free from coercion (Cassel, 1988). In being a part of a large research team, we were able to work through our questions on "what to do if..." as a group, drawing on each others' diverse fieldwork and LTRC experiences to produce a protocol as a collective that considered the multiple ways that both residents and workers may be rendered vulnerable through our research project.

Second, ethnographic teamwork enhances the opportunities for distribution of workload and responsibilities (Woods et al., 2000). Given that the *Re-imagining LTRC* project has only seven years to complete its goals, collaboration at all stages of the project is essential. Prior to entering the field, the Riverside Home site visit team worked collaboratively to develop the materials that would be required during our visit to the facility. Pamphlets and flyers were developed to help us inform staff about our project and presence during the fieldwork. Interviewing guides were circulated to all site visit team members and were developed in ways that would incorporate areas of key concern for the various theme groups involved in the project, with team members providing feedback on the phrasing and ordering of questions. While this, unsurprisingly, led to some debate among our team members as to what should be included and what was a feasible questionnaire length, it was in the end a discussion that improved the interviewing guide as a product of our collective input and experience. As I was most interested in interviewing personal support workers, I provided an initial interviewing guide for this type of worker. Team members who had more experience with interviewing frontline staff subsequently helped to shape this guide into a briefer, broader series of key questions (see Appendix B: Interview Guide) that could be more easily administered given the time constraints these workers often experience – a particular concern as we hoped to capture many of our interviews “spontaneously” (i.e. convenience sampling) as we built rapport with participants throughout our site visit.

#### *Detailed Project Design of the Riverside Home Site Visit*

Once a site had been selected, the initial task was to collect as much information about Riverside Home as possible in advance of the site visit. This work was undertaken

by me and a fellow PhD student research assistant hired by the *Re-imagining LTRC* project. Gathering what information was available from Riverside's public website, we realized that there were large gaps in our knowledge about the facility, particularly pertaining to its workers and internal rules and regulations. In collaboration with the principal and co-investigators of *Re-imagining LTRC*, we compiled a list of background documents to be requested of Riverside Home:

- a. The resident care policy
- b. The resident bill of rights and/or facility Mission Statement
- c. Materials on the facility's care philosophy
- d. Orientation guides for new staff hires and volunteers
- e. Orientation materials for new residents and/or family members of residents
- f. Floor plans of the residence as a whole, including room layouts and outdoor spaces
- g. Policy and procedure manuals for all types of staff
- h. Collective agreements for all unionized staff types
- i. Training and educational materials for all types of staff and volunteers
- j. Job descriptions for all staff types (i.e. tasks and responsibilities)
- k. A chart of the facility's organization and management
- l. Workplace health and safety promotion materials (manuals and training documents)
- m. Health and Safety Committee documents
- n. Detailed information on residents: their acuity, case mix, demographic characteristics.
- o. Detailed information on staff: training and accreditation, number of staff by type, demographics of staff, turnover rates, absence/injury rates.
- p. Resident and Family Council policies
- q. Other: any documents/ materials relating to the facility's organizational practices, decision-making philosophies, care philosophies, and care work organization (for example, some sources for this information may include pamphlets/brochures, manuals produced for staff or visitors, documents produced by residents/family members' councils, etc.)

In response, key informants at Riverside not only sent us numerous textual artifacts but also granted us access to the password-protected internal website used by its employees, which contained information on policies, training manuals, union activities, job postings, internal statistics, and other details of the facility's inner workings. With access to this

information, I compiled a background document for the team of researchers who would be participating in the site visit to Riverside, adding information on the basis of feedback obtained from team members in the weeks leading up to the visit. Following the principles of rapid ethnography, this document was intended to give a detailed portrait of the facility, its staff, its residents, and relevant aspects of its daily policies and practices that would help to familiarize team members with the site prior to our visit. This document was also intended to help researchers focus in on aspects of the facility that needed further explanation “in practice”, forming initial points of inquiry to be taken up with informants during the site visit itself.

Prior to entering the field, a series of pre-interviews were conducted by senior researchers on the team with key informants at Riverside Home, in order to identify some preliminary themes and issues among the various types of workers as well as to build familiarity and rapport with participants. The interviews were conducted with participants identified through snowball and purposive sampling techniques, and included senior administrators and management, RNs, RPNs, and PSWs. These interviews were also used to further refine our interview guides for use during the site visit.

The on-site portion of the site visit to Riverside Home took place from Monday December 3<sup>rd</sup>, 2012 to Saturday December 8<sup>th</sup>, 2012. Appendix C describes the breakdown of this week, outlining the team’s weekly activities and daily observation shifts, which were conducted by two researchers at a time per unit, per shift. This schedule was designed with numerous concerns in mind, first of which was the timing of our shift changes. My initial background research into staff collective agreements at the residence

revealed that work shifts for daily care staff (PSWs, RPNs, and RNs) followed the following shift schedule:

07h30 - 15h30 for the day shift  
15h30 - 23h30 for the evening shift  
23h30 - 07h30 for the night shift

We designed our observation shifts to begin just before the staff hand-off processes between shifts, starting with the night-to-morning staff change and carrying through to the last shift change from evening-to-night staff, ensuring that each of our three observation shifts would have an opportunity to see a staff shift change. Our schedule also allowed us to have a similar hand-off process of our own: with the exception of the first shift of the day, oncoming researchers were able to be debriefed by those leaving the floor, providing better continuity across our observation teams. Unlike the staff shifts, our observation shifts did not cover a full 24 hours at Riverside, as we did not schedule observation teams past midnight. However, it would be incorrect to assume that nighttime in residential care is uneventful in terms of care workers' activities and routines (Diamond, 1992; Martin and Ancoli-Israel, 2008; Schnelle et al., 2003), and as such we made a particular effort to introduce ourselves to the night shift workers as they came on the floor, and asked questions about what nights are like in terms of their work and resident behaviours. Team members assigned to the last observation shift of the day also often stayed well beyond the scheduled midnight end time in order to obtain interviews with workers or to observe work routines on the invitation of staff, allowing us to gain a sense of what nighttimes at Riverside Home were like.

The schedule of the site visit was also designed to follow the principles of rapid ethnography in terms of the benefits of having a mix of insiders and outsiders in the

research setting (Baines and Cunningham, 2011). By pairing Canadian researchers with non-Canadians, students with senior academics, and researchers with different disciplinary interests, the schedule allowed for researchers to be in pairs that would enrich their understandings of the setting and to learn from each other's perspectives. To assist with building rapport among our participants, researchers stayed on the same floor for the duration of the site visit (while varying the timing of the shifts). The middle of the week was devoted to team meetings for reflection on initial findings and any challenges that had been encountered in the field, as well as for scheduling interviews with key informants identified during observations on the previous days.

#### *Data Gathering and Research Techniques of the Site Visit*

Three data gathering techniques were used during the site visit to Riverside Home: participant observation, interviewing, and “photovoice”. Participant observation is the core technique of ethnographic research, and involves the dual tasks of witnessing the activities of others in the setting and participating as a part of that setting – which may range from merely being present in the site to actively contributing to the goings-on (Schensul et al., 1999). At Riverside Home the “participant” aspect of participant observation was limited to a “job-shadowing” role<sup>2</sup>, modeled on the ergonomic observation techniques developed by researchers at CINBIOSE (Messing and Caroly, 2011). This involved observation of how care work is carried out in the physical spaces of the facility by all workers, as well as the social dynamics that unfold within these spaces between workers and residents. An effort was made to assign researchers to a

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<sup>2</sup> This applies primarily to instances of observing staff as they worked at various hands-on care activities – for instance, activities such as feeding residents (PSWs) or administering medication (RNs, RPNs). In these instances, we could not join in on as full participants in the setting. However, in other instances, our team members participated more fully – for instance, having conversations with residents while lounging in the sitting rooms, joining in on activities like sing-alongs and tea parties, and so on.

variety of observational shifts in order to gain a better sense of the daily routine as a whole.

Observational data were recorded through field notes, with team members receiving training on ethnographic techniques and note-taking prior to entering the field. The fact that we were visiting Riverside Home as researchers was openly communicated to all persons in the research setting through the use of special nametags for our team members, as well as through attempts to connect with workers prior to our site visit. Since our researcher identities were not being hidden from participants, we were able to jot down a great deal of field notes "in the moment" during our observations rather than having to do so in secretive ways or after leaving the site at the end of an observational shift (although further elaboration on field notes post-shift was always necessary to capture additional details for later analysis, particularly when field notes could not be made "in the moment" or when it would have been inappropriate or uncomfortable to do so). These field notes not only describe the processes and practices we observed, but also contained the research team's reflections on these observations as a part of the "interpretive process" involved in shaping observational accounts (Emerson et al., 2011: 20). A guide was prepared to serve as a framework for focusing researchers' observations through the *Re-Imagining LTRC* project's broader research questions (Burgess, 1982) (see Appendix D: Observation Guide), which helped to focus the research team's observations upon the processes and interactions going on at Riverside Home, rather than on individual activities.

To supplement our observational data, interviews were conducted with a wide array of workers and volunteers during the mid-week days of our site visit during which

no observation shifts were scheduled. Interviews also took place “on the floor” whenever the opportunity arose with a willing participant. Having more than one researcher scheduled per observation shift meant that researchers could leave the floor to conduct interviews without worrying about missing important observational moments; additionally, team members who were not scheduled on that observation shift could sit in on the interviews and participate in the discussion, making our interviews at times as much of a team effort as our observations were. In consultation with the whole research team prior to entering Riverside, an interview guide of open-ended questions was developed for each type of participant we would encounter in our site visit, to be used in a semi-structured interviewing style (i.e. researchers could ask questions outside of the guide, following up on points of interest as they occurred). The guides were designed to reflect the key themes of interest in the *Re-imagining LTRC* project, broadly tapping into work experiences in relation to approaches to care, work organization, accountability, and financing. All interviews were digitally recorded and professionally transcribed verbatim, and informed consent was also obtained from all participants prior to interviewing and recording (see Appendix E: consent forms).

A wide range of workers were interviewed during the Riverside Home site visit, including PSWs, RNs, RPNs, senior managers, activity staff, meal helpers, volunteers, and cleaners. Family members of residents were also interviewed. Participants were identified using purposive sampling for some staff (e.g. key senior managers) as well as convenience and snowball sampling techniques for others (e.g. frontline care staff and family members). In agreement with Riverside Home management, separate interviewing rooms were provided for research team members to retreat to for privacy during

interviews. Many interviews were conducted with two or more researchers present, as well as two or more participants, forming a group interviewing experience – a technique that can foster animated discussion as participants compare experiences (Fontana and Frey, 1994). Interviews were also sought with residents, using a strategy known as “photovoice” to solicit participation from those with cognitive limitations by combining resident-directed photography with follow-up interviews (Dyches et al., 2004).

*My Own Project in Relation to the Site Visit of Riverside Home and Re-Imagining LTRC*

While the above discussion has tried to articulate the methodological considerations involved in producing the data used in this dissertation, there are a few additional considerations specific to my own analysis that is to follow. As noted above, my involvement on the researcher team of the Riverside Home site visit was intended to be one of mutual benefit. In exchange for my contributions as a team member on the site visit, I was granted access to the collective data produced by the site visit team (including team members’ observation field notes and all interview transcripts, in addition to the archival materials already acquired from Riverside) for the purposes of conducting my own dissertation analysis. It is important to note that, while I am drawing on data from a site visit to a single LTRC facility, my unit of analysis in this dissertation is more specific than that of the site itself: I am drawing on data from this site visit to produce a study of PSW decision-making processes. While my project is thus modeled on a case-study design (Stake, 1994), the “case” in question is not Riverside Home as a site, but rather is more specifically the PSWs of Riverside Home. However, guided by a feminist political economy approach to linking the data from this single site to the broader structural and historical contexts, my project might be best considered an example of taking up the

extended case method, as articulated by Burawoy (1998), connecting micro-level practices with macro-level context.

Following a multi-method research approach (Morse, 2003), I make use of text-based, observational and interview data to investigate the research questions I articulated in the preceding theory chapter. First, to understand personal support workers' decision-making processes as situated from within particular structural and regulatory contexts, I investigate how the roles of PSWs in Ontario are understood in the "official" texts of professional work organizations. As I am interested in the models of care that may shape the role expectations of care workers, I also investigate the education standards and training materials available to care workers at Riverside, in order to identify themes and tensions for further analysis in the interview and field note data – as well as to investigate any "official silences" (Lopez, 2007: 239) that may obscure the decision-making process of workers.

Additionally, the observational data from the Riverside Home site visit offer "thick description" (Geertz, 1973) from which care decision-making in practice throughout the work day/night can be analyzed, allowing me to develop a "richer canvas from which workplace insights may be drawn" in comparison to interviewing data alone (Tope et al., 2005: 489). As context is central to a feminist political economy orientation, the ethnographic methods used in the Riverside Home site visit provided an opportunity for contextual immersion in workers' decision-making processes by observing not only workers' practices in the setting, but also details that Emerson et al. (2011) argue constitute key elements of our observed and experienced realities: sensory details (sights, smells, sounds), detailed descriptions of social interactions, emotional exchanges, and

reflections and impressions experienced in the course of conducting fieldwork. Field notes are then examined for an understanding of how workers put their care strategies into practice in the specific physical and social space of the facility – spaces that I experienced for myself during my time at the Riverside Home site visit. As such, I approach the field note data with the underlying assumption that the activities I and my fellow team members observed in the field were the product of a series of care decisions put into practice.

Finally, I also use all of the interviews conducted with PSWs at Riverside Home to analyze care decision-making processes as well as the factors that constrain or facilitate care decision-making, and contextualize these processes within broader understandings of care workers' experiences. Observational techniques alone can tell me what care decisions PSWs make and how workers accomplish care tasks in particular ways, but they will not necessarily capture workers' explanations for why they do the work the way they do. Thus to understand workers' experiences as explained in their own words, I use the interview data from the Riverside Home site visit in combination with observational data, in order to capture worker's narratives of care decision-making (Gubrium and Holstein, 1998). The combination of textual analysis, observational and interviewing data thus allows me to examine and interpret both the "how" of workers' care decision-making (i.e. how do workers do their care work in-practice?) and the "why" of care decision-making (i.e. what explanation is there for why they work in particular ways?), as situated within broader historical, social, political, and economic contexts.

For coding and analysis of all text-based, observational and interview data, I used the constant comparative method (Boeije, 2002) to develop exhaustive coding categories

and analyze the linkages between them. In this method, open coding is first conducted by sorting episodes of data into an initial set of identifying codes (first stage codes), which are then sorted further into more detailed thematic codes (second stage codes – see Appendix F for a detailed list). This sorting of data into visual thematic “piles” allowed me not only to ask the questions I was interested in, but also to investigate under what conditions a particular experience takes place, and with what implications: for instance, when is “Time” important for workers’ decision-making, in what form/relationship, and why? The answers the data provide to such questions are what form the basis for my analysis. However, it should be noted that as the purpose of my study is not to produce “grounded theory”, I follow the methodological example set by Baines (2006) in linking emergent themes through my analytical framework of feminist political economy, thereby situating participants’ experiences of decision-making within the broader structural context.

In addition to using feminist political economy as my theoretical lens, a feminist epistemological approach underlies both my own project and that of the broader *Re-imagining LTRC* project from which my data are drawn. Feminist epistemology is grounded in an understanding that research participants are subjects rather than objects of our research (Shope, 2006), whose experiential accounts form the basis of knowledge production. As feminist philosopher Lorraine Code (1995: 18) has noted, experiential accounts have been “too readily equated with anecdotal evidence” (Code, 1995: 18), and thus devalued, by object-oriented positivist epistemology. However, experiential accounts have been an important source of knowledge for feminist efforts to critique long-standing sociological “facts” and theories about social life that did not correspond to

the lived realities of persons relegated to marginalized positions in the social order (Collins, 1990). It is these marginalized “lived realities” that I seek to attend to in my focus on understanding personal support workers’ decision-making processes through observational and interviewing techniques. As others (Kontos et al., 2010a) have noted, PSWs struggle to have their knowledge and experiences recognized and incorporated into the official care plans of residents or the organization of their workplaces. The work of Dorothy Smith (1989, 1990, 1992) helps to understand how this struggle of knowledge marginalization can be considered a product of the “relations of ruling” that are embedded in the textual artifacts of institutions, bureaucracies, and disciplines, forming “institutionalized practices of knowing” that order the world from a particular standpoint. Texts such as statistics about LTRC workers, descriptions of their work in job manuals, and records of their daily/nightly tasks are understood not as objective facts, but as products of particular power relations and interests. From a feminist epistemological orientation, starting from the standpoint of workers’ own experiences and knowledge by asking workers how they work and why they work the way they do offers a better understanding of how care work involves a complex social process. Thus this dissertation follows the example set by Armstrong et al. (2009), who in beginning their inquiry from the point of workers’ own experiences also begin from the assumption that “those who work in facilities and are in contact with residents on a daily basis provide an excellent source of information on the conditions of work and care” (13), specifically a source and perspective that often goes “unrecorded in official data” (13).

Feminist epistemology also problematizes the notion of value-free knowledge production, arguing that positivist ideals of objective knowledge production are not only

impossible as the knowing subject cannot be removed from the social world in which her knowledge is experientially formed and contextualized (Harding and Norberg, 2005; Hawksworth, 2006; Smith 1987). This epistemological position has two implications for knowledge production: first, in acknowledging that “there is no way in which we can escape the social world in order to study it” (Hammersley and Atkinson, 1995: 17), the researcher is understood as bringing her own pre-conceived conceptual categories with her to the field and to the analysis of her data, such that all knowledge produced through social research is necessarily shaped by one’s own particular social location and experiences. In other words, the researcher is never a neutral observer: an assumption that elsewhere I have argued encourages a reflexive approach in the form of understanding the role that her own preconceived conceptual categories in the process of knowledge production (Day, 2012). Furthermore, these epistemological assumptions about situated knowledge production hold true for our research participants as well, understanding their knowledge as shaped by their particular intersecting social locations in terms of gender, race, class, etc. (Haraway, 1988). Given these assumptions, the voices of LTRC workers must be placed at the centre of the analysis in order to infer the processes of decision-making from their experiences, but also contextualized within the broader social relationships that shape these experiences.

### **CHAPTER 3**

#### **The Broader Contextual Layers: Long-Term Residential Care in the Global, Canadian and Ontario Contexts**

This chapter investigates the broader context in which the specific case of Riverside Home is situated. Recalling the questions developed in Chapter 1 (Theoretical Framework), the goal of this dissertation is to explore personal support workers' decision-making processes amidst five contextual layers:

- 1) The worker's immediate social location, as informed by the intersecting variables of gender, race, class, immigration status, etc. – e.g. financial needs, family life/responsibilities.
- 2) Work organization and working conditions – e.g. time constraints, workload, assigned tasks.
- 3) Regulatory requirements – e.g. workplace rules, managerial surveillance.
- 4) LTRC (re)structuring and global/national/provincial trends in long-term care – e.g. funding cuts, policy changes, marketization of care, global importation of care labour.
- 5) Multiple (and potentially conflicting) models of care and definitions of care needs, as manifested in LTC restructuring, worker training manuals, resident care planning, and workers' understandings of what is needed for "good care".

These contextual layers have been presented as being ordered from the very specific (workers' immediate social location) to the facility-based level (organization of the workplace) to the broader provincial/national/international level (restructuring and policy) and finally the level of abstract concepts (models of care). Although I have presented them here as separate layers with a particular order, from a feminist political economy perspective I envision these layers not as separate contexts, but rather as being "nested" within each other: for instance, models of care inform both the broader context

of LTRC (re)structuring as well as workplace organization. For the sake of organization, however, I will be discussing these contexts separately and one “layer” at a time.

In this chapter, a wider lens is applied to understanding four of the contextual layers: LTRC (re)structuring, work organization and work conditions, regulatory requirements, and models of care that impact the direct care work of PSWs. I will explore LTRC re(structuring) through global, national and provincial trends in funding, ownership and financial policy. I then examine the absence, removal, and re-development of key pieces of LTRC policy that further impact PSWs’ working conditions. Models of care that impact personal support work in LTRC are then examined through the role definitions of these workers as imagined in training resources and provincial professional associations. The chapter culminates in an overview of research on the working conditions experienced by personal support workers across the provincial context.

By beginning with a wider lens at the global/national/provincial level, the present chapter develops a framework for understanding and seeing the links between the nested, multi-layer contexts that shape workers’ experience in LTRC settings. What are the global relationships and forces that shape international patterns of LTRC care and work? Amidst this context, how has Canada developed systems to address its LTRC needs? What are the consequences of funding LTRC in particular ways? What are the consequences of removing, developing or neglecting to develop LTRC regulation? What are the consequences of imagining the roles of workers in particular ways? And finally, as a product of these broader structural developments, what have been the experiences of personal support workers in Ontario’s LTRC settings? In moving from the global to the local, themes emerge in addressing each of these questions that have particular relevance

for understanding the decision-making of LTRC workers as situated within broader social, political and economic processes that extend well beyond the walls of my Riverside case study.

### **The Global Context: Divisions and Inequalities in Long-Term Care**

Perhaps the best place to start in thinking about a global context for a case study in long-term care would be to consider first an issue that has been taken up as a world-wide phenomenon: the growth of humanity's aged population, deemed a "demographic milestone" by the World Health Organization (WHO, 2011: 2). Demographic aging is occurring (and is projected to increase) in both so-called "developed" (i.e. the industrialized, wealthier states comprising the Global North) and "developing" (i.e. the less industrialized, poorer states comprising the Global South) nations (WHO, 2011). However, this aging of the world's population is not occurring evenly: leading into the year 2050, the percentage growth of older populations in developing nations is projected to be larger than the growth anticipated for developed nations (WHO, 2011), meaning that less wealthy countries will have to develop supports for their growing elderly population with fewer financial resources and more quickly compared to wealthier nations. Despite nation-based variation in the rates at which this growth will occur, humanity's aging has been attributed to two broad shifts: increases in life expectancy coupled with declining fertility rates (WHO, 2011). People are generally living longer and fewer people are being born, with the result that the proportion of elderly persons in the global population is projected to grow.

These observed demographic shifts have become a concern at the level of global health, economics, and policy-making. Recent reports from large multinational

organizations including the World Health Organization (WHO, 2011), the United Nations (UN, 2002), the Organization for Economic Co-operation and Development (OECD, 2005), and the Global Agenda Council on Ageing Society (Beard et al., 2011) have investigated the implications that population aging will have for international trends in demographics, labour markets, and care systems. One of the most pressing concerns to emerge from examining the trend in global aging is to what extent these trends will translate into increasing need for long-term care of the elderly (Colombo et al., 2011; Saltman et al., 2006). However, it would be far too simplistic a view to understand this concern as being a product of “more old people = more need for care”; rather, a number of other global socio-demographic and economic trends must be additionally considered.

One crucial factor to consider alongside the increasing need for long-term care is where the bulk the world’s supply of long-term care is provided, and by whom. Applying first a gendered lens to this question, it is clear that there is a global division of care labour in both the “private” spheres of the home and the “public” spheres of formal, paid care services. As Columbo et al. (2011) note, societies develop their formal long-term care systems based on varying notions of responsibility for care, political and financial pressures, and changing demands and expectations for care by various groups – all of which in turn influence how long-term care is organized, financed and regulated in any given national context. Despite these variations, one aspect of long-term care that is a global commonality is that any society’s formal provision of long-term care services for the elderly is only a very small portion of the actual supply of long-term care: the vast majority of this care is provided by friends and family, primarily by women, and primarily in the home (Columbo et al., 2011). Furthermore, the bulk of care labour in

formal, paid contexts is provided by women for poor remuneration and in positions accorded far less value relative to their contributions to economic development and societal wellbeing (Folbre, 1999), rendering this work both hidden and devalued. The ways in which paid and unpaid labour are linked also have important implications for sustaining global divisions of care labour, as Naussbaum (2002) points out that the structuring of paid work in ways that are incompatible with the gendered division of care labour in the home further entrenches gendered inequalities in education, employment and earnings. Thus the gendered division of care work suggests that global population aging is not only anticipated to impact the need for future long-term care, but more specifically has implications for the women workers who perform this work in both paid and unpaid contexts.

A second factor to consider amidst the increasing need for long-term care is the rise of globalization. Understood as a multifaceted trend, the term globalization describes the “complex economic, political, cultural, and geographic process in which the mobility of capital, organizations, ideas, discourses, and peoples has taken on an increasingly global or transnational form” (Moghadam, 1999: 367). In particular, economic globalization – characterized by the transnational flow of both capital and labour – has been identified as a context of central importance to understanding global trends in long-term care. Examining the impact of economic globalization, Eckenweiler (2011; 2012) outlines how the neoliberal economic policies that characterize this trend serve to foster the flow of migrant care labour as well as global inequalities and care deficits. Structural adjustment policies of the World Bank and International Monetary Fund have encouraged the indebted, less wealthy countries to which they are applied to cut public spending on

health care in order to balance their national budgets and become competitive players in the expanding global marketplace – to participate, in other words, in the processes of global capitalism (Coburn, 2001). Amidst austerity measures that prioritize economic growth, care increasingly becomes a private responsibility. As a result, not only are family members (mostly women) of these nations increasingly called upon to fill in the gaps in care in the absence of sufficient public supports and services, but also paid care workers (again, mostly women) are cut from public payrolls as budgets are slashed across care sectors (Eckenweiler, 2011; 2012) – women being the first to be laid off due to gender biases, and their tendency to occupy lower positions in the hierarchical organization of work (Moghadam, 1999). The dual downloading of responsibility for care into the home combined with a lack of local employment opportunities forms the context in which women from less wealthy nations increasingly seek employment across borders in order to sustain themselves and/or their families.

Furthermore, while women make up the bulk of labour in long-term care, there is some evidence to suggest that men are increasingly entering the long-term care workforce as the demand for long-term care grows. Men represent a “non-traditional” source of labour for states seeking to address gaps in the long-term care workforce, and men are more likely than women to be recruited into long-term care work from jobs outside of social or health care (Hussein et al., 2014). Long-term care presents a promising employment opportunity for men as the range of locally-available options in traditionally male-dominated occupations either disappear or are outsourced in a globalized economy (Bagilhole and Cross, 2006; Lupton, 2006). Migrant men in particular may be attracted to long-term care as wealthier countries develop recruitment strategies to meet their

growing need for personal support workers in LTC (Hussein et al., 2014). Thus, while very little research has been done on male workers in LTRC settings, the existing evidence suggests that a growing demand for LTC amidst the context of globalization and labour market shifts may contribute to men's involvement in what has traditionally been (and what largely remains) the "women's work" of long-term care.

A third factor to consider in the growing need for long-term care is the way in which migration of care labour is further fostered by policies enacted by and for the benefit of wealthier destination countries. Migrant workers provide a source of labour that can help to sustain destination countries' own neoliberal restructuring processes, characterized by "adherence to the virtues of a market economy and, by extension, a market-oriented society" (Coburn, 2001: 53). Amidst processes of cost-cutting, care downloading, and increasing privatization of care, destination countries additionally benefit from the labour of migrant care workers. By refusing to recognize the education credentials of migrant care workers, the economies of destination countries benefit from an influx of skilled care labour at a lower pay grade, all without having to extend the benefits of citizenship or its associated political rights or pay better wages for either migrants or those in the destination countries (Eckenweiler, 2011). Migrant care workers also allow wealthier receiving nations to further pursue their own austerity measures, increasingly privatizing care costs by pushing care into private homes and developing cash-for-care schemes – all of which increase demand for cheaper, more "flexible" labour (Anderson, 2012). Finally, intersecting gendered and racialized notions of the innate, "natural" care capacities of migrant care workers from source countries such as the Philippines, India, and the Caribbean are reinforced by both selective immigration

policies on the part of destination countries and recruitment strategies on the part of source countries (Eckenweiler, 2012). In these ways, migrant care work, in its “feminized and colorized” form (Browne and Braun, 2008), sustains wealthier source nations’ processes of neoliberal restructuring – conditions that are justified amidst the above-noted growing national concerns over the future elderly population’s need for long-term care, who will pay for this care, and who will provide it.

Gendered and racialized global divisions of care, globalization and neoliberal economic policies are all facets of a global context that can thus be broadly characterized as being one of divisions and inequalities in care. The acknowledged growing need for long-term care as the population ages is situated within a global context in which care work and responsibility is simultaneously inequitably distributed, symbolically and materially devalued, exported at the expense of local care needs, and imported without sufficient recompense. Each nation has its own historical, social, political and economic particularities in developing its approach to long-term care; however, by examining global inequalities in care, it becomes clear that there are interconnections that have specific implications for care workers. From this global perspective, Kittay et al. (2005) argue that there is thus not a singular global crisis in long-term care (i.e. the growing number of people who will be in need of care), but rather *crises* of care, as manifested in the exploitation of unpaid carers, the importation of migrant care workers, and the growing care inequalities between nations that are fundamentally interdependent. I now turn to examine the specificities of one national context – Canada – in order to understand how one long-care system within this interconnected global context has

developed, and the implications these developments have had for care work in this context.

### **The National Context: Long-term Care (Re)structuring in Canada**

In forming portraits of long-term care in Canada, numerous authors (Alexander, 2002; Armstrong and Banerjee, 2009; Bannerjee, 2009; Berta et al., 2006; Hirdes, 2001; Jansen, 2011) and reports (CHA, 2009; CUPE, 2009) begin by emphasizing the exclusion of explicit policy on long-term care from the *Canada Health Act* – federal legislation which specifies the guidelines to which Canada’s provincial and territorial health care insurance systems must adhere in order to receive federal funding. The exclusion of long-term care from the *Canada Health Act* is significant as it means that there is no federal mandate to protect or provide long-term care as a publically administered, comprehensive, universal, portable, and accessible service. Care that falls outside of the protection of the *Canada Health Act* is accorded less value and lower policy priority, and is left further vulnerable to access barriers, service exclusion, and user fees – all of which enhance conditions of inequality (Armstrong and Banerjee, 2009). Thus in terms of its “system design, funding allocation, policy development and regulatory compliance” (Banerjee, 2009: 38), long-term care is a provincial/territorial responsibility, as is all health care in Canada (with the exception of care for First Nations/Inuit and veterans, which are overseen federally). However, unlike insured health care services that fall under the *Canada Health Act*, long-term care is a provincial/territorial responsibility in the absence of any federal principles.

The result of this decentralization has been enormous pan-Canadian diversity in long-term care development, with wide variation in terms of how provincial and

territorial ministries of health administer, fund and regulate their provinces' long-term care services (Berta et al., 2006). Despite this provincial variation, it is still possible to outline a general sense of structure – and re-structuring – of Canadian long-term care at the “big picture” level. Efforts to understand a sense of the Canadian long-term care context are now all the more important given the recent discontinuation of Statistics Canada's annual survey and publication of Residential Care Facilities in Canada<sup>3</sup>, which provided facility data at both the national and provincial levels for the long-term care sector that this dissertation is concerned with: long-term residential care (LTRC).

First, a few key national statistics specifically on LTRC facilities: according to the final and most recent Statistics Canada data available, in 2009/2010 there were 2,136 “homes for the aged”<sup>4</sup> in Canada, with a total of 215,313 approved beds and 204,008 residents (Statistics Canada, 2011). Generally, these facilities are quite large: the vast majority (152,772, approximately 71%) of all approved beds were reported in facilities with 100 or more beds each (Statistics Canada, 2011). The ownership of long-term residential (LTRC) facilities in Canada can be characterized broadly by their profit status: non-profit facilities are owned by a particular level of government (federal, provincial or municipal) or by private voluntary lay or religious organizations, while for-profit facilities are owned by corporations, organizations or individuals (CUPE, 2009). The proportion of and trends in ownership status are important additional aspects to consider

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<sup>3</sup> This survey was discontinued in 2012, making the 2011 release of data for the year 2009/2010 the most recent compilation of pan-Canadian LTRC statistics available.

<sup>4</sup> These numbers are used to give an impression of the size of Canada's LTRC system with two important caveats to keep in mind: first, while the survey from which these data were gathered was mandatory, it was a self-reporting form in all provinces except for Quebec (which used administrative data). Second, among the facilities included in the survey on “homes for the aged” are “homes for the aged, nursing homes, lodges for senior citizens and rest homes” (Statistics Canada, 2011: 9), meaning that some retirement homes and other types of supportive housing may be included in the data: sites that provide much lower levels of care and are not comparable with LTRC facilities that provide 24 hours of nursing care and support with activities of daily living.

in contextualizing the structure and organization of Canadian LTRC. There is wide provincial variation in terms of the proportion of for- vs. non-profit ownership, but in general evidence has shown a growing trend towards privatization of ownership of LTRC: in Canada, about 54% of facilities are owned by for-profit entities, providing 44% of all approved beds (Statistics Canada, 2011). The proportion of for-profit ownership has increased across many provinces – especially Ontario (as will be discussed in greater detail below), in which nearly two-thirds of new LTRC beds created since 1998 have been in for-profit owned facilities (CUPE, 2009).

Pan-Canadian research has demonstrated that despite provincial differences in ownership mix, on a national level differences exist between ownership types in terms of facility size, staffing levels, and resident characteristics. On average, government and religious non-profits are larger than lay non-profits and for-profits, non-profit facilities have significantly higher staffing intensity levels<sup>5</sup> than for-profit facilities, and government facilities tend to have much higher proportions of residents with more complex care needs (Berta et al., 2006). These differences suggest that in the Canadian experience, facility ownership has implications for working conditions in terms of the number of residents to be cared for, the degree of resident care needs, and the amount of labour available to take on this care. Numerous Canadian studies have further demonstrated that ownership affects quality of care, with for-profit ownership being associated with an array of poorer quality care outcomes (Bravo et al., 1999; Doupe et al., 2006; McGregor and Ronald, 2011; McGregor et al., 2006; Shapiro and Tate, 1995). These poorer-quality outcomes have been linked to the way in which for-profits have

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<sup>5</sup> With staffing intensity for an LTRC facility calculated as the total number of hours of care by all care staff in a year divided by the number of residents in the facility, and the result divided again by 365 days (Berta et al., 2006). This provides a measure of the facility's number of care hours per resident per day.

lower staffing levels and care hours compared to non-profits, with studies in British Columbia (McGregor et al., 2005) and Ontario (Berta et al., 2005) concluding that for-profit facilities purchase fewer direct-care hours for residents. As Berta et al. (2006) notes, ownership influences the ways that “facilities secure capital and pursue growth, as well as their capacity to address residents’ needs and health issues” (189-190) – in other words, ownership influences a facility’s investment in staffing and hours of care, which has a direct impact on care outcomes. It is thus clear from national portraits of Canadian LTRC that trends in facility ownership are important to consider as a context underlying the conditions of LTRC work, as these are also the conditions of care.

Of further importance is the system by which LTRC is funded in Canada, particularly given the lack of coverage under the *Canada Health Act*. As Penning (2002) notes, the distribution of public funding for Canadian health care strongly reflects the prioritization of those services covered by the *Canada Health Act*: acute hospital and physician costs make up the bulk of public expenditure. Funding for long-term residential care at the federal level primarily takes place in the form of per-capita tax transfers to the provinces. This funding system has undergone numerous changes over the past 40 years, resulting in widespread jurisdictional variation in long-term care development. From 1977-1996, the *Established Programs Financing Act* saw federal transfers provided to the provinces in the form of targeted, per-capita funding to the provinces specifically for the development of long-term care, a provision which was responsible for stimulating facility growth in the post-1977 era of the *Canada Health Act* (Alexander, 2002). The targeted transfers, though small in sum, resulted in wide provincial diversity as each jurisdiction was free to develop its own approach to long-term care provision, with provincial

differences in terms of how services are accessed and administered and the funding formulas that are applied (CHA, 2009). Targeted federal funding was lost in 1996 with the development of the *Canada Health and Social Transfer*, which collapsed funding for health, welfare and post-secondary education all into one lump transfer to the provinces. In 2004, targeted funding was once again reintroduced in the form of the *Canada Health Transfer*; however, decisions as to how to divide up the transferred lump health care funding continue to be left to the provinces, with no mandatory requirements aside from hospital and physician services in accordance with the *Canada Health Act*. With provincial health ministries developing their own funding approaches and priorities, the result is a Canadian LTRC system that could be characterized as a diverse “policy mosaic” (Hirdes, 2001) in terms of budgets and, subsequently, available resources for sustaining LTRC (and other types of long-term care across the care continuum, such as home- and community-based care). Thus, while some services that are provided in LTRC facility settings do fall under the public insurance provided under the *Canada Health Act* in being counted as “medically necessary” (i.e. nursing and physician costs), it is up to the provinces to determine what remaining services will be publically funded, and to what degree, and under what payment system – resulting in wide geographic variation and inequality in terms of the resources available to fund LTRC and, subsequently, the private costs of accessing LTRC (Fernandes and Spencer, 2010; Hirdes, 2001).

Finally, in terms of national policy trends in Canadian LTRC, it is useful to once again return to the point made above regarding LTRC’s exclusion from the *Canada Health Act*. As MacLean and Klein (2002) argue, the result of this exclusion has been that policy tends to prioritize acute and hospital-based care, posing barriers for both

politicians and the public to recognizing LTRC as an essential aspect of the care continuum. At the same time, it is important to note that services which *are* covered under the *Canada Health Act* are being steadily eroded through the delisting of services, the redefinition of hospital settings, the closure of chronic care, rehabilitative and psychiatric hospitals, the cutting of chronic care beds, the encroachment of for-profit privatization, and the adoption of for-profit managerial techniques - all in the name of cost-cutting (Fuller, 1998). This erosion is a part of the ongoing restructuring of the Canadian health care system at large, with the unraveling of Canada's post-WWII welfare state giving way to a new paradigm of reduction in public expenditure (and perceived inefficiencies of the public sector) through the promises of the private market (Armstrong and Armstrong, 2001; 2010). Since the 1980s, restructuring of Canada's care system has been justified by a "crisis" rhetoric, characterizing public care costs and spending on health as spiraling out of control and in need of immediate reigning-in – particularly in the context of rising provincial and national debt (Sky, 1995). Williams et al. (2001) argue that this undermining of public health exemplifies a neoliberal shift in Canadian public policy, which can be partially understood as a product of Canada's participation in processes of economic globalization. Increasingly Canada has developed domestic policies and signed international agreements that prioritize Canadian participation in the global economy, characterized by a "perceived need to free capital from the constraints of public policy in order to ensure competitiveness in global markets" (Williams et al., 2001: 16). The effect of this shift is twofold: first, in the process of scaling back government's role to provide health services, the health field is opened to private enterprise as an opportunity for profitable investment "like any other

commercial field” (Williams et al., 2001: 17). Second, as a cost-cutting measure, care is increasingly downloaded from public to private settings, moving care from publically-funded hospitals into community-based facilities or, far more often, the home.

Accompanying this shift is the justification that a focus on home- and community-based care represents a quality-improvement strategy, as care that is provided “closer to home” is assumed to be preferable (for the cared for and their families) and of better quality than care in institutional settings (Dalley, 1996; Shapiro, 1992). However, an unspoken assumption of this shift is that families are available to sustain care in the home in the absence of public support. As Chapell (2011) notes, Canada is far from unique in having care policies that assume the availability of family labour in the home to take up the majority of care responsibilities – nor in the fact that the vast majority of this unpaid labour is performed by women (Armstrong and Armstrong, 2001). Yet the specific Canadian context in which public support has developed for home-based carers has some important implications for trends in facility-based care settings themselves. While long-term care policies are under provincial oversight, the trend in Canadian home-care policy is “to act as a safety valve when care is not available or insufficient” (Chappell, 2011: 13). When care of the elderly is required, the first stop is the home; all other settings, including long-term residential care, are considered fall-back options. As Armstrong and Banerjee (2009) note, there are many hidden assumptions that underlie the neglect of LTRC in policy development, all of which contribute to a notion of facility-based care “as a symbol of failure on the part of medicine, families, women, and/or individuals” (20) – the failure of medicine to “cure” the bodies of the elderly, examined in Chapter 1 through the medical model of care, but also the failure of individuals to remain

independent in their own homes and care for themselves, as well as the failure of families (i.e. informal carers, mainly women) to fill in the care gaps created by a lack of comprehensive public policy.

This “retreat” of the Canadian state from care (Aronson and Neysmith, 1997) has had important implications for the resident composition of LTRC facilities and, subsequently, the conditions of LTRC work. Utilization rates of LTRC across Canada have been declining, possibly attributable to improved health among the older population compared to the past, but also due to the trend of shifting the elderly with low-care needs to home-based care (CHA, 2009). Given that low-level care alternatives such as supportive or retirement housing are restricted to the very few elderly Canadians who can afford to pay for the largely out-of-pocket expenses of such settings (CHA, 2009), the vast majority of frail elderly Canadians are cared for in their homes - despite the fact that this “alternative” to facility-based care is so poorly supported by Canadian public policy (Chapell, 2011). The result of this shifting of care has been that residents of LTRC facilities increasingly have far more complex care needs than they have in the past (CHA, 2004, 2009; CUPE, 2009; Menec et al., 2002; OHC, 2008): a setting for care that is only accessible when care can no longer be sustained in the home, or when there is no one in the home to provide this care, or when formal home supports are not available. Thus amidst the declining utilization rates, the populations who do reside in Canadian LTRC facilities tend to be older<sup>6</sup> and frailer, with higher intensity care needs and more complex diagnoses, than they have been in the past – a trend which has implications for the

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<sup>6</sup> While the majority of LTRC residents are 75+ years old, there has also been recent growth in the number of younger adults with disabilities in LTRC settings as the same restructuring processes described above have resulted in a lack of investment in other facility-based care options for this population (CUPE, 2009). This younger population faces unique challenges in LTRC settings, with unmet psychosocial care needs being far more prevalent for this group than physical care needs (Hay and Chaudrey, 2013).

intensity of LTRC work, as well as the resources and skills necessary to care. Finally, the vast majority of LTRC residents are women (CUPE, 2009), as women are less likely to have a spouse to care for them informally in the home in their old age, as well as less likely to have the financial ability to pay for private care options (Armstrong and Banerjee, 2009).

Together, the lack of coverage under the *Canada Health Act*, the trend towards for-profit ownership, the lack of targeted federal funding, and policy trends in the broader health care system coalesce into the broader, national landscape of Canadian LTRC. As this landscape is characterized by significant provincial differences in policy, funding, and even terminology, it is now necessary to zoom-in on the specificities of the Ontario LTRC system in which the case study of Riverside Home is embedded.

### **The Provincial Context: Encroaching Privatization in Ontario LTRC**

The Ontario LTRC system falls under the jurisdiction of the Ontario Ministry of Health and Long-Term Care (MOHLTC), the government ministry which is responsible for planning, designing, and monitoring/regulating health care in the province. In Ontario there are three types of facilities considered to be “residential care” by the MOHLTC, which can be distinguished by the level of care each provides as well as by ownership and profit status (MOHLTC, 2008a):

- Supportive housing: low to moderate care needs, non-profit status.
- Retirement homes: low to moderate care needs, for-profit status.
- Long-term care homes (also known as nursing homes, municipal homes for the aged or charitable homes): higher care needs requiring 24 hours of nursing care, and a mix of private for-profit, private non-profit and municipal non-profit status.

It is the third category, long-term care homes, which the following discussion of Ontario LTRC is concerned with. As of August 19, 2014, the MOHLTC lists 649 long-term care homes in the province (MOHLTC, 2014). Ontario's LTRC system is the most highly-privatized in the entire country (OHC, 2002): in 2004, more than half of all the province's beds were in for-profit homes (Smith, 2004). The dominance and rapid expansion of private for-profit ownership in the province has been analyzed as an ongoing trend: while 20,000 new beds were added to Ontario's LTRC sector between the years 2000 and 2007, the majority of this expansion took place in for-profit facilities (Neysmith, 2009). This context has raised numerous concerns in terms of access to care, quality of care and, ultimately, quality of working conditions (Armstrong and Armstrong, 2006; Jansen, 2011; OHC, 2002). However, to understand the critiques of Ontario's expanding for-profit LTRC sector, it is necessary to first examine how LTRC in this province is structured in such a way that both makes profit possible for these for-profit facilities and encourages cost-cutting in both for- and non-profit facilities.

The MOHLTC provides formula-based per-diem subsidies for four separate "envelopes" to all facilities regardless of ownership/profit status: nursing and personal care, program and support services, raw food, and accommodation costs. While subsidies for food, accommodation and programming/support are fixed, the subsidies for nursing and personal care are determined by comparing a facility's Case Mix Measure (i.e. a measurement of the intensity of the facility's residents' care requirements across a variety of indicators) to an indexed provincial average of all facilities' Case Mix Measures (Banerjee, 2009). This means that funding for LTRC facilities is distributed not on the basis of individual needs, but rather on the basis of a facility's average need relative to

that of a provincial measure. As of 2010, resident acuity measures to determine funding for nursing and personal care are developed using the Resident Assessment Instrument Minimum Dataset, RAI-MDS 2.0: an assessment tool for determining case mix measures on the basis of a range of Resource Utilization Group (RUG) categories, primarily rooted in medical diagnoses and physical conditions of the resident. The accommodation envelope funds the costs of the facility, administration, housekeeping, building/operational maintenance, dietary, and laundry; however, these funds are provided by fees charged to residents on the basis of set rates determined by the MOHLTC. As of July 1, 2012, the daily rates for facility accommodation are \$55.04 for a basic (shared) room, (\$1,674.14 monthly), and premiums for semi- and private rooms charged according to how old the facility is and when the resident was admitted: \$64.04 for a semi-private room in a newer long-term care home (\$1,947.89 monthly), \$63.04 for a semi-private room in an older long-term care home (\$1,917.47 monthly), \$74.79 for a private room in a newer long-term care home (\$2,274.86 monthly), and \$73.04 for a private room in an older long-term care home (\$2,221.64 monthly). On July 1<sup>st</sup>, 2013 these rates were raised to \$56.14 for a basic room (\$1,707.59 monthly), with a maximum additional \$10 premium for a semi-private room and \$21.50 premium for a private room in “newer” facilities (in older facilities, the premiums remain at an additional \$9 and \$19.75 for semi-private and private rooms, respectively, on top of the increased basic rate)

It is only through accommodation fees and the provision of “extra” services that profit can be made, as the surplus from all other funding envelopes must be returned to the province (Armstrong and Armstrong, 2006). Higher fees can be charged for

“preferred accommodation” (i.e. private rooms), and extra fees charged for “optional services” that are *not* covered by accommodation or by other health insurance. Charging residents fees for hairdressing and the provision of non-prescription drugs and specialized health services and therapies is thus one way that profit can be made by facilities. Furthermore, the opportunities for collecting resident fees have increased: under the *Long-Term Care Homes Act*, Ontario’s present LTC legislation, the maximum number of beds in a facility available to be charged as “preferred accommodation” is set at 60%. This percentage has climbed from that specified under the 1972 *Nursing Homes Care Act*, which capped the maximum number of preferred beds at 40% - an increase resulting in a declining number of affordable beds and subsequently lengthening wait-lists for the ones that remain (OHC, 2002).

Provincial policy reforms to the organization of LTRC services have further fostered an environment in which for-profit services have not only expanded, but have done so to the detriment of the non-profit sector. As Williams et al. (1999; 2001) note, Ontario experienced an enormous shift in LTRC policy in the mid-1990s, corresponding with the above-noted Canada-wide pressures experienced by the provinces in post-1980s cuts to federal health care funding spearheaded by the election of a Conservative federal government. In 1996, the MOHLTC established Community Care Access Centres (CCACs) in order to consolidate the means of accessing LTRC services into a single, province-wide entry procedure. CCACs are non-profit organizations run by voluntary boards, now distributed throughout 14 Local Health Integration Networks (LHINs) across Ontario. While CCACs are responsible for assessing and placing LTRC applicants, they are also responsible for determining their local jurisdiction’s need for LTRC services and,

using budgets allocated through the MOHLTC, purchasing these services from providers. This purchasing takes place under a “managed competition” model (Williams et al., 1999; 2001): for-profit and non-profit providers compete with each other to provide services for purchase by the province for homecare, while in LTRC competitive bidding for contracts occurs when funding is allocated (on the recommendation of the LHINs) for new beds by the province. As CCACs’ budgets for purchasing services are fixed, the result is a system in which providers, both for- and non-profit, are encouraged to deliver services at the lowest possible cost in order to remain competitive in home care, while for-profit LTRC facilities cut costs in order to leave some for profit.

In this context, both for- and non-profit LTRC facilities make use of cost-saving strategies. While cost-cutting in for-profits is clearly for the purpose of boosting the private company’s bottom line (and thus profits), cost-cutting in non-profits can be understood as a product of both the “managed competition” purchasing model, as well as by the fact that government funding of LTRC has been insufficient to address the changing financial and care landscape. While there have been budget increases in the subsidies LTRC facilities receive, these increases have not kept pace with either the growing acuity of residents in LTRC settings, nor with inflation levels (OHC, 2002). Furthermore, regulatory changes such as mandatory upgrades incur additional costs that are not subsequently accompanied by additional government funding, leaving facilities to find the money themselves (OANHSS, 2011). While the accommodation envelope is the only aspect of LTRC facility funding by which for-profit homes can extract profit<sup>7</sup>, it is

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<sup>7</sup> In this respect, policy changes have further fostered the accumulation of profit: in 2000 Ontario LTRC operators successfully lobbied for the removal of what had previously been a 50/50 split with the government of all remaining surplus from the charges paid by residents receiving “preferred” (i.e. private and semi-private) accommodation. Now, operators are allowed to keep 100% of this surplus, with no

also the only envelope through which non-profit homes can obtain surplus funds for the purpose of re-investment in the facility. Regardless of ownership type, the funding model of LTRC in Ontario is thus one that fosters cost-cutting across the sector.

However, delivery of care by the cheapest means possible has dire implications for both work and care. Services funded through the accommodation envelope can be contracted out to the cheapest possible provider. Dietary, laundry, and housekeeping services are thus increasingly provided by privatized, contractual labour rather than by LTRC facilities themselves – and the means by which these vendors provide cheaper services is primarily through lower wages, fewer benefits, and part-time precarious positions (Armstrong et al., 2008). Contracting out labour, often to large, multinational corporations (NUPGE, 2007), also fragments who is understood to be a part of the “care team”: in dividing up workers, contracting out services creates a barrier to understanding laundry, dietary, and housekeeping services as central to residents’ health and wellbeing (Armstrong et al., 2008), and further hinders the development of inter-disciplinary approaches to care and has an impact in decision-making (CHA, 2009). Within the LTRC facility, tasks can be reorganized in a number of ways to reduce costs: downloading tasks from higher-paid, regulated workers to lower-paid, unregulated workers so as to reduce the number of higher-paid staff (CNA, 2005); using diapers, restraints and medications to reduce direct care staffing levels; and hiring staff through part-time or casual positions are all ways that facilities can cut costs (Armstrong et al., 2009). Thus while insufficient

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requirements as to how to use the funds. While this reform granted further opportunities for non-profit facilities to re-invest in care and services, it simultaneously meant that additional surplus for for-profit operators can simply become additional profit, at the loss of government revenue with which to reinvest in LTRC funding budgets (OHC, 2002).

funding is noted to be a cause for concern in terms of care quality (CHA, 2009), this context also has significant implications for workers and the working environment.

Given the way in which the province's funding model has developed, the encroaching privatization trend that broadly characterizes the Ontario LTRC system is relevant to understanding care and care work not only in for-profit facilities alone. Rather, Ontario's LTRC funding model is one that broadly encourages cost-cutting, and the provision of care with as few resources as possible, in both for- and non-profit settings. The effect of this context is that opportunities for the pursuit of profit flourish, while at the same time public resources are rationed in ways that make non-profit care increasingly difficult. The development of Ontario's LTRC system can thus be understood as being driven by a market model of care, with care "slimmed-down" under the application of market-based principles (i.e. fewest services provided at the lowest possible cost for the provider) to the financing and delivery of care (Evans, 1997: 449). However, Ontario's system of LTRC finance and delivery are not the only aspects suggestive of a market model approach to care: further evidence can be found in the development of Ontario's LTRC regulations, and the implications this context has for personal support workers.

### **Regulation of Ontario LTRC: Contradictions and Tensions for the LTRC Worker**

Regulation of LTRC, as with funding, is overseen at the provincial level. The piece of legislation presently governing LTRC operations in Ontario is the *Long-Term Care Homes Act*, which was read in 2007 and received final assent in 2010. The act consolidates what were previously separate pieces of legislation that fragmented oversight of the province's LTRC system, having had different legislation for municipal

homes, charitable homes and homes for the aged (Banerjee, 2009). Throughout the 1990s and early 2000s, numerous highly publicized scandals in Ontario LTRC facilities emerged, revealing inadequate care standards, poor financial accountability, and poor compliance with existing care regulation and inspection processes (OHC, 2002; 2008). A review produced for the Ministry of Health and Long-Term Care likewise called for enhanced public accountability, enforceable standards, and stronger compliance legislation (Smith, 2004). In response to these concerns, the *Long-Term Care Homes Act* of 2007 was developed under a theme of enhanced accountability and tougher enforcement of care standards, with provisions for yearly facility inspections and public reports of inspection results, whistle-blowing protections for reporting resident abuse, and limited restraints policy to improve care quality (Banerjee, 2009).

This form by which “enhanced accountability” has come to be defined, however, requires a significant increase in reporting mechanisms, in turn requiring increased paperwork and documentation to demonstrate to both the MOHLTC and the public that these standards are being met. The shift towards enhanced accountability has thus had significant consequences for the staff upon whom the work of documentation falls. A recent independent review of Ontario’s staffing and care standards found that accountability for care outcomes in the province is primarily focused on compliance with MOHLTC standards and guidelines and financial accountability, which “results in situations where staff end up focusing on compliance related administrative and process activities instead of providing care” (Sharkey, 2008: 27). Others (Armstrong et al., 2009) have found evidence that Ontario LTRC workers are increasingly required to spend time performing “meaningless paperwork” while already being severely understaffed. The

“meaninglessness” of this documentation is further enhanced by the fact that only those care activities that can be quantified and that match the specified measurements of care outlined in the resident care plan are captured – a care plan that focuses on the physical ailments and medical needs of the resident, as determined by the content of the RAI-MDS. The consequence is that the documenting of care takes on the meaning of documenting a narrow range of medically-defined conditions and physical tasks, thereby neglecting the knowledge, skills and efforts of the workers who perform those tasks, as well as the unquantifiable social and emotional labour involved in making the physical care possible (Kontos et al., 2010a). Documentation that fails to capture this information is “meaningless” in that it captures only a partial picture of what is required for care, revealing the supposed enhanced accountability of this paperwork is itself too narrowly defined to capture care in a meaningful way.

Despite the recent interest from the MOHLTC to enhance particular regulatory requirements for the sake of accountability, systematic deregulation has also been a marked trend in Ontario’s LTRC system. When deregulation has occurred, it has done so in ways that serve the financial interests of the LTRC sector by eroding staffing level standards and, subsequently, reducing staffing costs (OHC, 2002; 2008). In 1996, the Ontario Conservative government abolished the previously mandated minimum 2.25 hours of care per resident per day, while the same government also removed the requirement for providers to adhere to planned or budgeted staffing levels. Removal of these standards has had enormous impact on LTRC personal support workers and their working conditions. One survey post-removal of the minimum care standard found that 94% of workers reported quality of care had declined as a result (Armstrong, 1997).

Another large, province-wide study conducted in the wake of the removal of minimum standards revealed large differences in staffing ratios, insufficient staffing hours, and an insufficient number of specialized care staff to meet resident needs (PricewaterhouseCoopers, 2001). Despite intense lobbying from a number of organizations to reinstate minimum care levels (OHC, 2007), recommendations to provide additional funding to support increased staffing standards (Sharkey, 2008), and the reinstatement of the requirement to have at least one registered nurse (RN) on staff at all times (OHC, 2008): legislation of minimum staffing standards has yet to be reinstated in Ontario.

The regulatory context of Ontario LTRC is thus seemingly characterized by a problematic disconnection. On the one hand, an emphasis on strengthening regulation and enforcement through new legislative provisions regarding reporting, facility inspections, and compliance with governing legislation, ostensibly to assure “a more accountable compliance inspection program that focuses on risk issues, quality of life and resident care outcomes” (MOHLTC, 2008b). On the other hand, deregulation in terms of staffing standards (alongside the insufficient funding models discussed above) has reduced the human resources available to actually accomplish care work.<sup>8</sup> The two facets of this disconnection are in line with a market model of care in two ways. First of all, in the Ontario regulatory context, accountability has developed in the form of recording the quantifiable tasks of care: assessing whether a preordained measure of services have been

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<sup>8</sup> This is not to say that the answer to improving Ontario’s LTRC system simply lies in a matter of “more staff”. Passing legislation that mandates staffing standards does not automatically make it possible for facilities to meet these standards without addressing the funding needs of facilities to meet these standards. So too is it meaningless to address staffing levels without also investigating the additional myriad issues that affect the conditions of work and care in LTRC settings – see for instance the work of Andrea Campbell (2013).

delivered. These measures provide evidence that “care” has been provided – albeit care that is narrowly defined only as that which *can* be counted (Baines et al., 1992). This quantification-based approach to accountability provides a means for formularizing care delivery, fitting well with market-based managerial models that emphasize efficiencies and targeted service provision (Armstrong and Armstrong, 2010). Secondly, deregulation in the form of removing minimum staffing standards means that facilities have one less regulatory threshold to consider in the pursuit of said efficiencies and targeted service provision. Thus while apparently contradictory, Ontario’s LTRC regulatory context of both enhanced regulation (counting of care) and deregulation (removal of staffing standards) can both be understood as elements of a market model approach to care.

Alongside the contradictions in provincial (de)regulation trends, the outright absence of regulation in Ontario is of further importance to understanding the provincial context of LTRC care work. As Sky (1995: 11) has observed, “deregulation is not aimed simply at the structure and financing of our health care system”, but also of health care workers themselves. Enter the unregulated health care worker, or “generic worker” (Sky, 1995): a role that has emerged as tasks and responsibilities are shuffled down the professional hierarchy to positions of lesser pay, lesser training, and fewer licensing requirements. In Ontario, personal support workers are considered unregulated workers, meaning there is no overarching regulatory body, and thus there is no single unifying code of practice standards. As unregulated health care workers, the work of the PSW is considered unskilled and auxiliary to health care (Armstrong et al., 2008), and is accordingly poorly compensated, undervalued and poorly recognized. This undervaluing of PSW work is further underscored by the fact that in Ontario’s LTRC settings, personal

support work is overwhelmingly performed by women, and a significant number of these workers are also immigrants and/or racialized – reflecting both gendered notions of care as “unskilled” work as well as the limited opportunities available for migrant workers (Armstrong et al., 2009).

At the same time, increasing pressures for public accountability and legislative compliance have meant that the work that unregulated health care workers perform in the LTRC setting is all the more heavily monitored. With rising concerns over passing inspections and meeting targeted quality measures, personal support workers in particular are increasingly under the scrutiny of managerial surveillance (Kontos et al., 2010b), while their work is reorganized to fit with new standards of accountability and regulation (DeForge et al., 2011). The Ontario government has recently moved to enhance this scrutiny through the creation of a province-wide PSW Registry, initially established as voluntary but with the intention to eventually be mandatory for all workers. Touted as a way to “better recognize the work [PSWs] do for Ontarians, while helping to better meet the needs of people they care for”, the registry was announced in 2011 as a part of the Ontario government’s plan to “provide more access to health care services while improving quality and accountability for patients” (MOHLTC, 2011). However, two of Ontario’s largest care workers’ unions have pointed out that a worker registry is far different from being registered. Concerned that the registry will facilitate employer discipline of workers, these stakeholders have argued that Ontario’s planned PSW registry “has all of the prejudicial aspects of professional regulation while conferring none of the benefits” (CUPE Ontario/OCHU, 2012: 5). The creation of a registry is thus a far cry from a formal required registration process, which would confer specialized

credentials to workers and accord PSWs a measure of professional power. Instead, the province's move to establish a worker registry fails to recognize the underlying contexts of poor-quality care (under-funding, privatization, lack of care standards, etc.) in favour of further scrutiny of workers rather than of workers' working conditions, leaving PSWs with less control compared to registered professionals.

The regulatory context pertaining to PSWs in Ontario is not solely one of problematic regulation (through narrowly defined accountability measures), deregulation (removing staffing standards) or failure to regulate (creating the unregulated health care worker and substituting registries for registration) as has been explored above. Despite the absence of an overarching regulatory body for Ontario's PSWs, some recent regulatory changes have occurred towards standardizing the training of the province's PSW workforce<sup>9</sup>. With the passing of Ontario's *Long-Term Care Homes Act*, guidelines for PSW training programs were established that came into effect in 2010 (see Appendix G). Concern over a lack of standardized training has long been identified by the Ontario Personal Support Worker Association as an issue for quality care (OPSWA, 2011). In the absence of a regulatory body, there is a great deal of variability in PSWs' training experiences, and depending on where one is trained as a PSW in Ontario the program components can be quite different (PSNO, 2011). In terms of PSW training, workers may receive certificate training at community colleges, private career colleges, boards of education, or other non-profit organizations, and programs vary widely between these settings in terms of average hours and training standards used (PSNO, 2011). To address

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<sup>9</sup> Attempts have also been made at the national level to set more consistent standards in the education of Canada's PSWs. In 2012, the Association of Canadian Community Colleges published a series of recommended national education standards, based on the results of a study funded by Health Canada; however, these standards are "intended for voluntary adoption" and meant as a guide for developing curricula, rather than a mandatory requirement (ACCC, 2013).

this variation, the Ontario *Long-Term Care Homes Act* now stipulates that, in order for an LTRC facility to be licensed for operation by the province, its PSWs must have now completed a PSW program that meets one of three approved vocational standards (the Ontario's Ministry of Training, Colleges and Universities, the National Association of Career Colleges, or the Ontario Community Support Association), and that includes 600 hours of class time and practical experience (combined). While these requirements can still clearly result in a great deal of variability in terms of the education experience that PSWs will receive (for instance, no requirements are laid out in terms of how to divide the class time between hands-on practicum experience and in-class learning), the *Act's* specifications could still be considered movement towards enhancing education standards - particularly given findings that many of Ontario's PSWs have, in the past, simply been trained on the job rather than completing formal education requirements (Armstrong et al., 2009).

In the absence of a single regulatory body, the education standards for programs sanctioned by the Ontario *Long-Term Care Homes Act* provide a useful means of assessing the role definition of the PSW. In all three of the program standards approved by Ontario's *Long-Term Care Homes Act*, a person-centred model appears to underlie the approach to care. In a 2009 PSW role statement published by the Ontario Community Support Association, the PSW's goal is defined as being "to optimize their consumer's/client's independence, expression of preference and participation in daily activities" (OCSA, 2009a: 3). In modeling care, theoretically the "client" (resident) is placed at the centre of care activities, with the PSW providing a supportive care role. Similarly, "client-centred and client-directed care" is also an official aspect of the Ontario

Ministry of Training, Colleges and Universities' Personal Support Worker Program Standards (MTCU, 2004: 2). Finally, in the Association of Canadian Community Colleges standards that the National Association of Career Colleges is using to revise its PSW program (NACC, 2012), a core competency is to “provide client-centered care across the life span, with a focus on physical, psychological, social, cognitive, cultural and spiritual support” (ACCC, 2012: 11). Thus the PSW's role is understood to be providing supportive care for the whole person, beyond mere physical need.

However, in clarifying the care role of the PSW, boundaries of care are also defined, for the PSW is “not expected to diagnose, assess, or respond to acute or unexpected situations (beyond any emergency assistance which might be required)” (OCSA, 2009a: 3), thus drawing official, profession-specific boundaries between what care workers are expected to do (support, with a focus on the client) and prohibited from doing (diagnosing). The support-focused role of the PSW is further defined by the Ontario Ministry of Training, Colleges and Universities as being to carry out the quality improvement plans determined by their employer (MTCU, 2004: 3). In this sense, the PSW's supportive care role is also connected to a broader care team, but in a position that involves carrying out pre-determined measures of quality care – measures developed by others. While PSWs do not contribute to the official definition of required care in terms of formal diagnosis or care planning, they are expected to participate in the process of carrying out the care plan through reporting, observation and record-keeping (MTCU, 2004: 11), as well as to “document and report relevant information objectively, accurately, concisely, and in a timely manner” (ACCC, 2012: 14). In line with this expectation, Berta and colleagues (2013) have found evidence that “critical thinking and

decision support” are increasingly being emphasized in PSW role preparation, encouraging PSWs to take part in the care team’s inter-professional collaboration as “knowledge workers”.

The official role definitions and expectations embedded within the legislatively-required training standards point to three interesting points of tension for PSWs, in light of the above discussion of Ontario’s LTRC (re)structuring, policy trends and regulation. First of all, there emerges a tension between the expectation for PSWs to provide client-directed care on the one hand, but on the other to also carry out employer-/manager-directed care as supportive members of the care team. Given the emphasis on documentation, inspection, and surveillance that workers increasingly are subjected to under new measures of accountability, it is unclear how the worker is expected to both navigate the preferences of those they care for while also carrying out the proscribed and monitored care activities of the care plan – whose definition of care needs takes precedence, and how does the worker decide? This tension is further complicated by the fact that when care is deemed inadequate, it is often re-interpreted as the product of individual resistance or personal failings on the part of care workers, rather than as a product of problematic workplace barriers (Kontos et al., 2010a). Workers increasingly face personal risks in the struggle to perform the activities of their job under enhanced managerial scrutiny, while structural conditions that contribute to this struggle go unaddressed (De Forge et al., 2011).

A second tension lies in the clashing of concepts central to PSWs’ support-focused role with the organizational realities of PSW work. Supporting residents’ needs as “whole persons” requires workers to have the time, resources and knowledge required

to address potentially widely varying degrees of care needs among LTRC residents, with varying degrees of acuity (CUPE, 2009). However, as noted in the financial structure of Ontario's LTRC system, it is not individual care needs that determine the funding (and therefore resources) available to facilities, but rather average measures of resident acuity against which facilities are measured, obscuring the specificities of residents' needs. Furthermore, residents' care needs are defined very narrowly in medical/physical terms, enshrined in legislation through the funding and accountability systems applied to Ontario's LTRC system (Weintraub, 1995) as well as in the low wages accorded to PSWs for what is understood to be unskilled *physical* labour (Armstrong et al., 2009). Finally, the removal of legislated minimum care standards also leaves facilities free to reduce levels of frontline care staffing. Thus while the role of the PSW is conceptualized as providing full-spectrum support for residents' care needs, LTRC financing, regulation, and policy shifts have had implications for rendering this task increasingly narrow as well as increasingly difficult to accomplish in practice.

A final tension exists in the disjuncture between the person-centred care outlined in education standards, and the conditions that constrain care work: such as the above-discussed slimming-down of care resources under the market model that characterized Ontario's LTRC context, and the failure of regulatory requirements to account for the social and emotional work involved in the direct care work performed by PSWs. As Donna Baines (2004) has noted, the impetus to provide unpaid care beyond the official requirements of one's job is symptomatic of a market context that is increasingly characterized by a flexible workforce, a reliance on irregular shift work, minimal staffing, and precarious jobs with few benefits and little security. This context gives rise to a

“compulsion-coercion continuum” experienced by care workers, who struggle to perform the social and emotional work that is implicitly required by their care jobs, but that is neither captured by official, task-based definitions of necessary care activities, nor documented by regulatory accountability measurements that define quality on the basis of physical, task-oriented care activities.

Together these tensions suggest that the regulatory context underlying Ontario’s LTRC system is itself characterized by a fundamental contradiction in models of care. On the one hand, a market-based approach to care is evident in the province’s problematic regulatory trend towards enhanced accountability through surveillance, inspection and documentation of quantifiable, medically-defined care tasks. Additionally, deregulation in the removal of care standards and the failure to develop regulation for care workers provides a means of providing care at the lowest possible cost. On the other hand, the education standards legislatively mandated by Ontario’s *Long-Term Care Homes Act* appear to be informed by a very different model of care: one that emphasizes the PSW is to address the care needs of the “whole” resident, and that understands care as a product of inter-professional collaboration. This approach is more suggestive of a *social* model of care – an understanding of care as a social process (Neysmith, 1991) – rather than a market or medical model. However, as the above discussed tensions reveal, it is unclear how the personal support worker is to enact the care role envisioned in Ontario’s mandated education standards amidst the broader financial and regulatory context that characterizes Ontario’s LTRC system. In the final following section, I explore the working conditions that have been reported by personal support workers in order to

understand the implications that contradictory models of care have for work organization and work experiences in the Ontario LTRC context.

### **Working Conditions in Ontario LTRC Facilities**

The work organization of Ontario's LTRC facilities has been cited by direct care workers as being one of the most concerning aspects of LTRC work, rather than the nature of the work itself (Armstrong and Daly, 2004). In a survey of Ontario direct care workers, Armstrong et al. (2009: 46) found that there were divisions among care workers in LTRC settings in the form of "clear labour hierarchies" among different types of staff, with tasks being "specifically allocated among job categories". In Ontario LTRC settings there is a wide array of different types of workers who can be involved in running the facility: PSWs, registered practical nurses (RPNs), registered nurses (RNs), cleaners, dietary staff, laundry staff, activity staff, social workers, therapists, and so on. While PSWs, RPNs and RNs all perform hands-on care in LTRC settings, the bulk of this direct care has increasingly fallen to PSWs, and there are differences between categories of workers in terms of what this work entails as well as differences in power, status and perceived skill.

For PSWs, the primary tasks are daily personal bodily care such as bathing and feeding, RPNs tend more to medicalized bodily tasks such as injections and administering medicine, and RNs tend to occupy more specialized managerial or delegation roles (Armstrong et al., 2009). This highly segregated work organization has numerous implications for sustaining a workplace hierarchy in which PSWs occupy lower positions. Furthermore, we can understand this work organization not as products of specific facility-based staffing processes, but rather in relation to the broader financial,

regulatory, and restructuring contexts explored above. PSWs are tasked primarily with the “bodywork” of care (Twigg, 2000): work that is imagined as requiring few technical skills or extensive training and little medical expertise, thus accorded lower status in the medical hierarchy (Gordon, 2006). This lower status is further reinforced by the above-noted lack of regulation applied to the PSW, ensuring their status as a “generic worker” to whom tasks can increasingly be delegated in order to save on labour costs (Sky, 1995). In being deemed unskilled labour, PSW positions pay less than their regulated counterparts (Armstrong et al, 2009). The hierarchical ordering of workers is further reinforced by the differentiation between registered and unregistered workers: while RNs and RPNs are required to be registered and therefore are understood as having specialized credentials, the lack of similar registration requirements for PSWs reinforces the notion that providing personal daily care is an unskilled job (Armstrong and Banerjee, 2009). Finally, the vast majority of Ontario’s LTRC PSWs are women, and a significant number of these workers are from immigrant communities (Armstrong et al., 2009), reflecting broader trends in the gendered division of care work as well as the above-noted processes of economic globalization that encourage the importation of care labour. Thus the segregated organization of job tasks in the Ontario LTRC context not only produces clear divisions between types of workers in terms of their roles and work, but also sustains hierarchical notions of skill and status, as well as broader divisions in gender, race and class.

The financial, regulatory and restructuring contexts discussed earlier also have important implications for the working conditions reported by Ontario’s PSWs in LTRC settings. Across Ontario, PSWs report having to work short-staffed (Armstrong and Daly,

2004; Armstrong et al., 2009; Banerjee et al., 2008; NUPGE, 2007; Smith, 2004), and this short staffing takes place amidst overall provincial staffing levels that are second-lowest in all of Canada (OHC, 2008). Workers report having insufficient time to do their work, and as a result social and emotional tasks are left undone in favour of more pressing, basic physical needs (Armstrong et al., 2009). Workers also report that the “less visible, but equally important” aspects of care become compromised, as time pressures and short staffing require physical care tasks to be rushed with no time to socialize – despite social interaction being noted by workers as crucial to providing quality care for residents (Armstrong and Jansen, 2006: 26). However, it is not only these less-visible care tasks that are cut, as workers report not always having time for even physical tasks like bathing and toileting (Armstrong et al., 2009). Thus workers in Ontario LTRC settings experience conditions that constrain both relational as well as essential physical care.

While these conditions clearly have consequences for the health and wellbeing of residents, they also have dire consequences for workers themselves. Workers report emotional distress at having to rush through care, while the fast pace and physically demanding nature of the work takes its toll on workers’ bodies (Armstrong and Jansen, 2006; Armstrong et al., 2009). Ontario’s PSWs also report experiencing high levels of violence by residents as a result of having to rush through care and cut corners on care tasks (Armstrong and Daly, 2004; Banerjee, 2010; Banerjee et al., 2008). Further studies have found that violence against Ontario’s LTRC workers is normalized as an everyday part of the job by the workers themselves, managers and regulatory structures alike: LTRC workers view the experience of violence as ordinary and expected when working

with the elderly, while complaints about resident-to-worker violence are ignored by managers and unreported in Ontario's official datasets on LTRC facility complaints (Daly et al., 2011). These working conditions suggest that Ontario's PSWs must not only navigate time constraints and staff shortages in performing their jobs, but also daily risks to their personal health and wellbeing – risks that are rendered invisible at the managerial and regulatory level.

The working conditions reported by Ontario's PSWs are not merely the results of problematic facility-level policies or work organization – while there is surely variation across Ontario's facilities, the studies cited above indicate province-wide experiences of insufficient staffing, insufficient time to care, and hidden risks to workers in Ontario's LTRC settings. These conditions can be considered the product of broader trends in the financing, regulation, and structure of Ontario's LTRC system – itself embedded within a specific national and global context. Thus while this section has focused on facility-level working conditions of Ontario LTRC, from a feminist political economy perspective the preceding discussion of provincial, national and global contexts may be also considered the “working conditions” of LTRC workers more broadly, as these are the contexts which shape local experiences and work organization.

### **Concluding Thoughts: Themes for Thinking About Workers' Decision-Making**

This chapter has sought to clarify the provincial, national, and global context in which Riverside Home, as an Ontario LTRC facility, is situated. The purpose in examining these “nested” contexts is to understand how the decision-making processes of the workers at Riverside Home are embedded not only within the facility-level processes of Riverside Home, but rather to see those facility-level processes as themselves situated

within broader processes of regulation and accountability, care restructuring, LTRC financing, and economic globalization – as well as the various and at times conflicting models of care which underlie each of these contexts. The movement of care labour across borders can be contextualized as a product of both economic globalization and economic inequality. The Canadian LTRC context is characterized by decentralization and the downloading of care from public to private responsibility, reinforcing a family model of care. In Ontario, the funding of LTRC has developed in ways that encourage cost-cutting in both for- and non-profit facilities, sustaining a market- and medical-based approach to care delivery. This approach is further bolstered by the province’s regulatory landscape, characterized by medicalized task-based accountability measures, trends in the deregulation of care standards, and a failure to develop regulation to the benefit of workers. Finally, the legislatively-mandated education standards for workers reveal role expectations that contrast sharply with the regulatory context, financial structures, and working conditions experienced by Ontario’s personal support workers.

Amidst these broader contexts, a number of questions arise for the specific case of Riverside Home. To answer these questions, I apply the same line of inquiry that began this chapter to the facility-level documents that form the “official texts” of Riverside Home. How is Riverside Home funded, and what is its ownership and profit status? Who lives at Riverside Home, and who works there? How have Riverside’s own policies developed: what are the facility-level regulations that workers must follow in terms of rules and organizational requirements? How is the care work of PSWs imagined in Riverside’s training manuals? How does Riverside organize its workers? I now turn to a

facility-level analysis of my Riverside Home case in order to understand this workplace context as having been shaped by the broader trends explored above.

## **CHAPTER 4**

### **The Site-Specific Context: Exploring Riverside Home**

Having previously explored the global, national, and provincial landscape of long-term residential care, the following chapter now explores Riverside Home as a particular site embedded within these nested contexts. From a feminist political economy perspective, this site cannot be understood outside of the macro-level structural processes (i.e. funding, (re)structuring, regulation) and underlying conceptual models (i.e. medical and market models of care) that shape the organization of Riverside Home. In this sense, Riverside Home offers an opportunity to examine the ways that the macro-level global, national, and provincial processes of the previous chapter have shaped the organizational- and micro-level context in which workers' decision-making takes place.

In the previous chapter I applied a broad lens to four “nested” contexts that are central to a feminist political economy analysis of personal support workers' decision-making: LTRC (re)structuring, work organization, regulatory requirements, and models of care that impact the direct care work of PSWs – ending with a discussion of working conditions. In this chapter, I apply a narrower lens to the specific case of Riverside Home itself in order to take up the implications that these four contexts have had at the organizational level. This chapter begins with the organizational structure of Riverside and recent trends in its funding and finance. To contextualize Riverside's sense of “place”, I briefly discuss the physical space of the residence and how its settings link to broader themes of regulation and workplace organization. I then turn to a discussion of resident characteristics and a more detailed examination of workplace organization to produce a profile of who lives and works at Riverside. Finally, I explore the models of

care underlying the organizational values of Riverside, as evidenced in organizational value statements, employee training manuals and practice guidelines, and suggest some tensions and contradictions that arise for personal support workers as a result. Ultimately, this chapter aims to understand the context of Riverside Home in terms of implications for PSWs' *working conditions*, while understanding these working conditions themselves as being shaped by the broader multi-layered contexts explored in Chapter 3.

This chapter draws on textual artifacts provided by the management of Riverside Home, intended for both the public (i.e. brochures, annual reports, corporate website materials) and internal use (i.e. quality reports, resident statistics, employee orientation guides). Like all other licensed long-term care homes in Ontario, Riverside is required to produce numerous different types of reports in order to receive funding from its Local Integrated Health Network, such as strategic plans and financial statements. Riverside is also required to conduct quarterly assessments of residents (as well as assess residents on admission) using the Resident Assessment Instrument – Minimum Data Set (RAI-MDS); while this information is considered confidential, the residence does collect and report aggregate data on residents such as acuity, occupancy, and some demographic information. In line with the methods of rapid ethnography discussed in Chapter 2, I gathered these various types of textual information prior to entering the site for interviewing/observation in order to give myself and the other members of the *Re-imagining Long-Term Care* research team a better understanding of not only key features of the residence, but also a sense of the “official” accounts of the care and care work involved in this setting: products of the “relations of ruling” (Smith, 1989; 1990) that can obscure the knowledge and experiences of personal support workers.

## **Organizational and Financial Structure of Riverside Home**

Operating under the Ontario Ministry of Health and Long-Term Care's definition of a long-term care home, Riverside Home is licensed to provide 24-hour nursing services to residents with higher care needs compared to the other categories of long-term residential care in Ontario (i.e. supportive housing and retirement homes). It is a non-profit long-term care home, and is owned and operated by a non-profit organization called Riverside Continuing Care. In addition to Riverside Home, Riverside Continuing Care owns and operates multiple other types of urban-situated care sites, employing over 2000 people in total and hosting hundreds of volunteers (Riverside Continuing Care Annual Report, 2012-2013). Given the large size and multiple sites encompassed by this organization, a complex organizational "chain of command" in managerial positions governs Riverside Continuing Care as a whole. Since there are multiple long-term care homes run by this organization, not only does Riverside Home have its own Director of Care that oversees the operations of this individual residence, but also multiple managerial positions overseeing the various residential programs owned by the organization. Thus at the managerial level there are multiple levels of accountability, but also a high degree of vertical organization.

In terms of labour organization, there are four different unions at Riverside Continuing Care: the Ontario Nurses' Association (ONA, representing registered nurses), the Canadian Union of Public Employees (CUPE, representing a diverse range of employee categories, including registered practical nurses, personal care attendants, meal helpers, maintenance workers, physiotherapy and occupational therapy aides), the Ontario Public Service Employees Union (OPSEU, representing specialized care

workers, including physiotherapists and occupational therapists, psychological associates, clinical psychologists, dieticians, and social workers), and the International Union of Operating Engineers (IUOE, representing operating and maintenance engineers). These unions offer an important form of protection for workers – but most especially for PSWs who, in being unregulated, do not have the benefit of professional protection accorded to regulated health care workers (i.e. RNs, RPNs, and physicians).<sup>10</sup>

Due to the Riverside Home being situated within the wider organization of Riverside Continuing Care, members of these unions are not specific solely to the residence itself, but rather are spread throughout the various sites of the organization as a whole. For instance, the CUPE local that represents personal support workers at Riverside Home also includes PSWs that work at hospitals owned by Riverside Continuing Care; this is also the case for the ONA local that represents the RNs of Riverside Home. This means that despite belonging to the same union local, under the same collective agreement, employees of the same job category may be working in very different contexts (residential long-term care vs. hospital care). This union overlap between workers at Riverside Home and Riverside Continuing Care’s hospitals is important to consider in relation to personal support workers’ wages. In 2011, the starting hourly wage for a PSW under the CUPE agreement that includes PSWs at both Riverside home and Riverside Continuing Care’s hospitals was \$20.286. Given that the pay range for this group of workers in Ontario is between CAD\$12.50 to \$23.00 per hour (PSNO, 2014), Riverside Home’s PSW wages are on the higher end of the PSW pay range. This suggests that workers at the residence benefit not only from the bargaining leverage

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<sup>10</sup> However, all workers regardless of being regulated or unregulated are encompassed under the broader framework of Ontario labour standards regulation, as well as provincial regulation informing occupational health and safety.

provided by unionization, but specifically from the overlap between hospital and residence settings, as hospital-based PSWs tend to be better paid relative to those who work in facility- (or home-) based long-term care (Armstrong et al., 2008; Lilly, 2008). Higher wages may also be a product of Riverside's non-profit status, as one of the few ways available to increase profit margins in for-profit long-term care is to decrease wages (OHC, 2002).

While overlap between hospital and LTRC sites may benefit Riverside Home's workers in terms of wages, there are other financial aspects to this link that may be less beneficial. There are numerous signs that the staff at Riverside Home are working within a wider organizational context that has experienced ongoing funding constraints and, subsequently, restructuring in ways that impact both care workers and those they care for. This context is directly linked to provincial funding cuts and broader processes of health care restructuring explored in Chapter 3. In the fiscal year that encompassed our December 2012 site visit, Ontario's Ministry of Health and Long-Term Care announced new funding formulas for the province's hospitals, freezing the amount of base funding allocated to hospital budgets. Upper management at Riverside Continuing Care warned that "cost containment" measures could be in the works as a result (Ontario Coalition for Accountability, 2012), and shortly after our site visit to Riverside union representatives for personal support workers warned that these measures could take the form of bed eliminations, service cuts, and job losses (CUPE, 2013). Corresponding with this period, the most recent Annual Report (2012-2013) of Riverside Continuing Care reflects an overall theme of fiscal constraint. Noting the year had been a "challenging" one, the Board Chair describes Riverside as having redesigned select programs and services to

meet recent fiscal challenges (Riverside Continuing Care Annual Report, 2013). Furthermore, while acknowledging that tightened provincial budgets are likely to be an ongoing trend, the organization's President asserts that Riverside Continuing Care will emphasize "fiscally responsible" in pursuing its care goals (Riverside Continuing Care Annual Report, 2013). The meaning behind these statements was made clear in an April 2013 news release, revealing planned reductions in PSW staff, the expansion of a stroke rehabilitation outpatient clinic "to allow patients to transition home sooner", and additional hiring of registered nurses to produce a staff mix reflecting "the increased complexity of conditions in the patient population" (Riverside Continuing Care Organization Website, 2013).

As the provincial purse strings tighten, restructuring for the sake of "fiscal responsibility" at Riverside Continuing Care has taken the form of staff cuts and moving elderly patients out of care as soon as possible. While these decisions have clear implications for hospital and outpatient work at Riverside Continuing Care, it is less clear as to the meaning for the workers at Riverside Home specifically – how many staff will be lost and from which aspects of the broader organization is not indicated. However, given the union overlap between sites of care, the loss of any PSW staff weakens the wider union local to which PSWs at Riverside Home belong. Additionally, this reduces the number of available staff that can be called upon to fill temporary staffing gaps, while pushing elderly patients to return to the community as soon as possible contributes to the broader trend of increasingly complex care needs LTRC residents – and thereby impacting the working conditions of personal support workers.

Examining the organizational and financial contexts of Riverside Home requires understanding how this LTRC facility is intricately tied to the wider organizational and financial structures of the non-profit health care organization by which it is owned, Riverside Continuing Care. These organizational and financial contexts constitute particular working conditions for the personal support workers of Riverside Home in terms of managerial organization and worker representation, workers' wages, and financial restructuring in response to the province's financial decisions under a slimmed-down, market model approach to care. While PSWs at this non-profit long-term care home are unionized and paid better relative to the reported provincial pay range, they are also working in a context characterized by multiple levels of vertically-organized managerial accountability, as well as one in which heightened concern over budgetary constraints places services and jobs at risk. That this risk disproportionately affects PSWs illustrates one aspect of the precarious nature of personal support work – job insecurity (Vosko, 2006). Thus the roles that protection, pay, management, and restructuring play in workers' decision-making processes will be considered in the analysis to follow this Chapter's contextual exploration.

### **The Physical Features of Riverside Home**

Before examining resident and worker profiles at Riverside home, it is useful to first briefly describe the physical setting of Riverside Home itself. As mentioned previously, Riverside Home is located in a large, urban Ontario setting. More specifically, the site is located in the city's urban core, on a short street shared with aging brick single-family homes and duplexes. A mere block away, the homes give way to a busy downtown commercial area. This location is considered an attractive feature of the

home, as Riverside’s brochure notes that its residents can take advantage of downtown shopping and cultural opportunities, and is described as an ideal location for facilitating residents’ visits with family and friends (Riverside Continuing Care, 2012). The site is also on a major city transit route, with a bus stop directly at its front doors. In these ways, Riverside Home’s location within the urban core is not only framed as being ideal in terms of the surrounding amenities, but also a convenience for the sake of keeping residents and families/friends connected.

While Riverside Home is connected organizationally to the various sites comprising Riverside Continuing Care, it is also connected in the physical sense. Rather than being a free-standing, self-contained facility, Riverside Home is actually located on two floors of a larger building complex that houses other sites owned by Riverside Continuing Care, including various care centres and offices. As a result of this location, there is substantial overlap between the residence of Riverside Home and these other care sites/offices. First of all, the residence features amenities that are actually shared among the entire building complex. A cafeteria, boutique, hair salon, library, pharmacy, outdoor seating area, parking space, and faith room are all features of the larger building complex itself – and therefore used not only by Riverside Home’s residents, employees, volunteers and visitors, but also by the patients, employees, volunteers and visitors of the many other programs and services provided at the centres and offices surrounding the residence. Furthermore, in being located on two separate floors of the building complex, residents, visitors and workers of Riverside Home must travel “outside” of the residence itself to make use of any of the shared features elsewhere in the complex. There are multiple ways to come and go from the residence floors; however there is no main

reception area that is specific to the residence itself. One can arrive on either of the two floors of the residence directly via stairs or elevator from the main floor of the building, or indirectly through doors connecting the residence floors to other parts of the building complex.<sup>11</sup> Finally, a loudspeaker system connects the floors of Riverside Home to adjoining spaces in the building complex; as a result, announcements intended for these adjoining spaces are occasionally broadcast throughout the residence floors. These physical features are a constant reminder that the residence is embedded within a wider non-residential setting.

The age of Riverside Home has implications for the regulatory standards to which the design of the residence must adhere. According to the Long-Term Care Home Service Accountability Agreement that Riverside Home has signed with its Local Integrated Health Network, no renovations have taken place since the two floors were opened for residential care more than 20 years ago. The age of the building also means that Riverside Home's design pre-dates the current design standards for long-term care homes set out in 2009 by the Ontario Ministry of Health and Long-Term Care. These are standards to which all Ontario long-term care homes built from March 2009 onward are to conform in both building and retrofitting residences, and include specified design requirements for the provision of resident, staff, visitor, and common space, building safety features, maintenance and housekeeping space, and heating/lighting/ventilation/cooling systems (MOHLTC, 2009). However, due to its age, Riverside Home only has to conform to building regulations as determined by the *Long-Term Care Homes Act* and broader

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<sup>11</sup> However, all entry points to the residence are considered "secure" entry: all stair doors and the elevator require a numeric code to operate, and an alarm sounds if doors are held open too long.

provincial building code regulations, and not the currently mandated “home-like” standards outlined by the MOHLTC.

Furthermore, the age of Riverside Home and the lack of major renovations since its opening means that many of the spatial features of the residence floors are remnants of an earlier design that is no longer in use due to changes in work organization and policy. For instance: each floor has an open nursing station desk/reception area which now no longer functions as an open office space. All nursing station work is instead conducted in closed rooms on each floor of the residence, while the open station desks remain unused at the end of the two hallway floors. Each floor also has a kitchen with cooking appliances and meal preparation areas, which are now no longer used to prepare meals on-site<sup>12</sup>: all meals now arrive to the residence prepared and portioned for each resident in advance at Hillside Hospital, a hospital that is also owned by Riverside Continuing Care. Renovation to remove these unused features would require additional spending in the residence’s budget, while renovation to increase the space of the residence is additionally restricted as the residence is not located on the ground floor. Additions cannot be made to the residence without encroaching on that of adjoining spaces in the building complex, or eliminating existing rooms within the space that comprises Riverside Home.

The physical design of the residence also has implications for the types of resident rooms and, as a result, the funding that the home receives in terms of resident accommodation fees. Riverside Home has more than 60 beds in total; without revealing the specific number of beds, its size is roughly comparable to the average bed size of government- and religiously-owned LTRC facilities across Canada (average size of 77

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<sup>12</sup> This change in work organization will be explored in greater detail in Chapter 5.

and 74 beds per facility, respectively), but is much larger than the average bed size of lay nonprofit and for-profit Canadian facilities (average size of 30 and 50 beds per facility, respectively) (Berta et al., 2006). The number of rooms is divided evenly between the two floors of Riverside Home, comprised of a mix of room types. The majority of rooms are one bed (some with private washrooms and some with a shared washroom between two one-bed rooms), although some of the rooms are two bed (with a single washroom in each), and a small number have three beds (also with a single washroom in each). This mix means that Riverside offers private, semi-private and basic accommodations according to the Ontario Ministry of Health and Long-Term Care's accommodation co-payment rates. The Ministry sets two rate options for charging "preferred" accommodation (private or semi-private rooms) according to how new the residence is. This increase was explained by the Ministry of Health and Long-Term Care as being necessary in order to "reflect the higher costs of building and maintaining the [newer] home" (MOHLTC, 2013). However, as Riverside Home is an older facility, the lower rate scale applies – making Riverside a cheaper residence per day compared to a more recently constructed facility. Thus daily accommodation co-payments for Riverside's residents are as follows: \$56.14 for basic rooms, \$64.14 for semi-private rooms, and \$74.14 for private rooms.

In sum, the physical setting of Riverside Home holds numerous implications for the care work experience. It is embedded within a larger building complex comprising multiple other kinds of care sites and offices, and is an older residence that provides long-term residential care at the lowest possible rate under Ontario's long-term care homes regulation. This physical setting is an important context for working conditions – not only

in terms of the material environment in which care work takes place, but also in terms of work organization, applicable provincial regulations, and funding that the home receives. Thus the ways in which place and space shape the experience of workers' decision-making can be understood as multi-faceted and informed by processes beyond the walls of the facility itself.

### **Resident Profile: Who Lives at Riverside Home?**

To understand workers' decision-making processes, it is important to consider who workers are dealing with on a daily basis – not only in terms of resident demographics, but also the patterns of how residents are admitted to (and leave from) the facility, and what kinds of care needs residents have. Riverside Continuing Care has an internal department that collects the information generated in workers' documentation of the patients and residents across its various care sites. Selected information is reported by the organization in the form of a "Corporate Balanced Scorecard" for the purpose of internal decision-making, as well as a publically-available annual report on Riverside Continuing Care as an organizational whole.

Both of these sources provide some sense of the demographics of Riverside Home's residents in terms of age, gender ratios and linguistic/religious background. The average age of residents at Riverside Home is 81.5 years old, and while the vast majority of residents are over the age of 65 (94.44%), the age range of residents is between 46 to 94 years old (Riverside Continuing Care Annual Report, 2011-12), reflecting the reality that not all persons residing in long-term residential care are necessarily the frail elderly (Hay and Chaudrey, 2013). Women comprise the majority (67%) of the resident population at Riverside Home (Riverside Continuing Care Corporate Balanced

Scorecard, 2010-2011). These age and gender breakdowns compare closely with aggregate data on Ontario’s LTRC residents, as the average age of Ontarian LTRC residents is 82 years old (7% of all residents are younger than 65 years old), and 69% of all Ontarian LTRC residents are women (CIHI, 2013).

Where Riverside’s resident data differ somewhat from Ontario statistics is in terms of case mix index score, which measures the severity of resident acuity. For fiscal year 2010-2011, the Ontario average case mix index score was 0.7323, while Riverside Home’s was 0.9026 (Riverside Continuing Care Corporate Balanced Scorecard, 2010-2011), indicating slightly higher than average resident acuity. Furthermore, Table 1 demonstrates that, in recent years, Riverside Home does appear to be experiencing similar trends as that of Ontario as a whole: increasing resident acuity (OHC, 2008).

**Table 1: Resident Acuity at Riverside Home, Fiscal Years 2006-2007 to 2010-2011**

	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
Case mix index score*	0.7141	0.807	0.859	0.9454	0.9026

\* using MDS/RUG 44 (Minimum Data Set/Resident Utilization Group)

**Source:** Riverside Continuing Care Corporate Balanced Scorecard, 2010-2011.

It is important to keep in mind that case mix is not necessarily a measure of resident care *needs*, but rather an average measure of resources used in the care of residents – more specifically, clinically-defined supports and services for residents’ health care. Thus case mix does not necessarily reflect a complete picture of the work, skills and time required to care for residents, and “acuity” measured in the case mix index score provides only a very narrow, biomedical definition of the resources used to care for residents, as this score is calculated on the basis of resident assessment using the RAI-MDS tool.

Nonetheless, the trend of increasing resident acuity in terms of complex and multiple

biomedical conditions has been noted to have significant implications for LTRC workers in Ontario, given the discussion in the previous chapter that these acuity trends have not been accompanied by similarly increasing staffing levels to relieve the workload associated with caring for more acutely ill and dependent residents, nor increased funding to ensure sufficient resources for meeting even narrowly-defined biomedical care needs (CUPE, 2009; OHC, 2008). Thus Riverside Home's trends in resident acuity form an important context in terms of the working conditions – and, subsequently, their decision-making amidst this context.

The health records of Riverside's residents are not accessible for the sake of confidentiality, so it is not possible to provide either a sense of residents' diagnoses or the proportion of residents requiring high levels of help with activities of daily living – information that would help to contextualize personal support workers' workloads. However, there are indirect ways of understanding the complexity of residents' care needs. First of all, residents are divided into two units at Riverside Home on the basis of their physical and cognitive impairments: one unit is for more cognitively-aware but less physically-capable residents, while the other is for residents requiring specialized dementia care. Further insight on resident acuity can be gleaned from the admission sources of Riverside Home's residents, summarized in Table 2. While there is variation from year to year, in total the bulk of admissions in the past 13 fiscal years (the years for which data are available) has been from acute care settings. Far fewer residents have been admitted from home, from other long-term residential care facilities, or from other settings.

**Table 2: Sources of Resident Admission to Riverside Home, Fiscal Years 2000-2001 to 2012-2013**

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012		
	-	-	-	-	-	-	-	-	-	-	-	-	-		
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	TOTAL	
Acute Care	3	2	12	17	18	11	10	12	19	7	7	10	4	132	36%
Home	6	7	3	0	4	8	9	6	1	8	7	3	10	72	20%
Long-term Care	7	9	5	2	8	3	3	6	5	3	3	3	3	60	16%
Other	4	4	13	11	3	7	6	9	10	11	4	8	10	100	27%
<b>Total admitted</b>	20	22	33	30	33	29	28	33	35	29	21	24	27	364	100%

**Source:** Riverside Continuing Care Health Information and Client Services Department Statistics fiscal year records.

On average, 28 new residents are admitted to Riverside Home each year. That most residents are admitted from acute care settings indicates that many residents of Riverside Home enter into long-term care after having been treated elsewhere in the formal care system. This is unsurprising given the complex physical and mental health conditions that Ontario’s LTRC residents tend to have<sup>13</sup>, as well as the pressures caused by hospital restructuring and budget cuts (as explored in Chapter 3) to push patients out of acute care and into other, less-costly (to the public) care settings as quickly as possible. The large proportion of residents transferring from the hospital could also reflect lengthy wait times for LTRC placement (CUPE, 2009): amidst downsizing and cuts to available LTRC beds, persons who were originally low-priority may now be waiting so long for LTRC placement that their conditions deteriorate to the point that they enter LTRC only through the hospital. In any case, the proportion of residents entering long-term care via hospital settings is particularly concerning for resident wellbeing given that, as Doupe et al.

<sup>13</sup> A major province-wide study found that the physical and mental care needs of Ontario’s LTRC residents are substantial (PriceWaterhouseCoopers, 2001). Across the province, LTRC residents were found to have numerous complex clinical diagnoses, including: dementia/Alzheimer’s (53%), arthritis (30%), stroke (22%), diabetes (19%), and atherosclerotic heart disease (12%). The study also found that 70% of Ontario’s LTRC residents are incontinent, while 47.9% of residents require high levels of assistance with activities of daily living (e.g. eating, toileting, bathing, dressing). In terms of mental health, 30.5% of Ontario’s LTRC residents suffer from minor or major depression.

(2011) have demonstrated, residents transferring to an LTRC facility from hospital settings tend to be particularly at risk for certain adverse events (pressure ulcers and non-hip fractures) compared to residents admitted from elsewhere. Thus despite the lack of diagnostic information for residents at Riverside Home, the available indicators of resident acuity suggest that the residents of this facility have diverse, numerous and complex care requirements.

It is also instructive to examine residents' discharge status at Riverside Home to gain a sense of its employees' working conditions. Table 3 demonstrates that most often, the turnover in residents for Riverside Home's workers is due to residents dying.

**Table 3: Resident Discharge Status at Riverside Home, Fiscal Years 2000-2001 to 2012-2013**

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012		
	-	-	-	-	-	-	-	-	-	-	-	-	-		
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	TOTAL	
Acute Care	1	5	2	3	0	1	2	4	2	3	0	2	2	27	7%
Deceased	17	16	25	18	24	20	15	22	20	19	15	20	15	246	68%
Home	0	0	1	0	1	0	2	0	0	2	3	0	0	9	2%
Long-term Care	2	0	5	10	7	9	9	6	14	4	0	3	8	77	21%
Other	0	0	0	0	0	0	0	0	0	1	2	1	1	5	1%
<b>Total Discharged</b>	20	21	33	31	32	30	28	32	36	29	20	26	26	364	100%

**Source:** Riverside Continuing Care Health Information and Client Services Department Statistics fiscal year records.

On average, 28 residents are discharged per year at Riverside Home. Of these, 19 residents on average pass away at the home per year. About one fifth of total discharges over the past 13 years have been to another long-term care facility, and only a very small number of residents have been discharged to acute care, and fewer still to home or elsewhere. Given the match between average yearly discharges and average yearly admissions, Riverside Home was operating at an occupancy rate of 98.8% for the 2012-2013 fiscal year in which my site visit occurred with the *Re-Imagining Long-Term*

*Residential Care* project – a higher rate than that reported for the province of Ontario as a whole, at 94.3% (Statistics Canada, 2011).

In terms of residents’ length of stay, Table 4 makes use of available data on the average yearly length of stay to illustrate a sense of how long residents tend to stay at Riverside Home. Data for the years available demonstrate an average length of stay ranging from 667.4 days (about 1.8 years) to 1111.0 days (about three years).

**Table 4: Average Resident Length of Stay (Days at Riverside Home), Fiscal years 2003-2004 to 2012-2013**

	2003 - 2004	2004 - 2005	2005 - 2006	2006 - 2007	2007 - 2008	2008 - 2009	2009 - 2010	2010 - 2011	2011 - 2012	2012 - 2013
Average LOS	667.4	711.1	N/A*	679.7	1073.0	693.6	1103.0	1111.0	930.4	689.7

\*Data not available for this fiscal year.

**Source:** Riverside Continuing Care Health Information and Client Services Department Statistics fiscal year records.

The gender, age, care needs, and pathways of entry/discharge of Riverside’s residents are central to understanding the work of Riverside’s personal support workers, providing numerous implications for working conditions and, thereby, workers’ decision-making. In terms of gender and age: most of the residents are elderly women, but there are some younger residents as well as men of various ages at Riverside Home, reflecting broader trends in LTRC resident composition. The residents at this facility have a higher acuity score relative to the provincial average, suggesting that the workers of Riverside are caring for residents with care plans that reflect diverse and complex care needs. When residents arrive at Riverside Home, most arrive from acute care settings; residents seem to stay for roughly 2-3 years, and then pass away or, less often, are transferred to another site of care. About 28 new residents are admitted each year, while 28 depart, meaning that workers continually have numerous new residents to become familiar with while also losing residents to death or transfer. While the quantified, aggregate data above provide

only limited insight into the resident composition at Riverside Home, it is nonetheless useful for raising questions as to who exactly personal support workers are caring for in this setting.

### **Staffing and Division of Labour at Riverside Home: Profile of Personal support**

#### **Workers**

The PSWs of Riverside Home are but one category of worker amongst a wide range of different types of workers at this facility, as is characteristic of Canadian LTRC settings (Armstrong et al., 2009). These workers perform direct resident care alongside both registered nurses (RNs) and registered practical nurses (RPNs). Other types of paid support staff encountered on a daily basis at Riverside include cleaners (responsible for housekeeping services) and meal helpers (responsible for assisting at mealtimes by distributing meal trays, feeding residents, and collecting empty trays). Physicians are not a daily part of the residence operations in terms of everyday care, but attend to residents as needed for care beyond nursing roles (i.e. for diagnosis and prescription). Other specialized care services for residents are provided by physiotherapists, social workers, dieticians, and recreational therapists employed by Riverside Continuing Care. There is also a sizable volunteer presence at Riverside Home, performing unpaid care in the form of special activities and events for the residents. Finally, Riverside Home allows residents to privately hire (and pay for) a “private duty caregiver”; however, at the time of the *Re-Imagining Long-Term Residential Care* site visit to Riverside, there was only one such privately-paid worker caring for one resident, suggesting that the vast majority of residents at this facility do not have the financial means to pay for this form of additional care.

In terms of staffing levels, the most recent data available on care hours at Riverside Home indicate 48.36 full-time equivalents (calculated by dividing employee paid hours by the hours of a full-time work schedule), with all direct care staff (PSWs, RPNs and RNs) lumped together in this calculation.<sup>14</sup> When the number of patient days at Riverside Home is accounted for, these data translate into 3.7 nursing care hours per resident day (Riverside Continuing Care Corporate Balanced Score Card 2010-2011: 27) – however, in lumping all nursing staff together, it is unclear what proportion of these 3.7 hours are made up of PSW care. As noted in describing the project methodology, the daily staffing of PSWs (as well as RNs and RPNs) is divided into three shifts: 7:30AM-3:30PM for the day shift, 3:30PM-11:30PM for the evening shift, and 11:30PM-7:30AM for the night shift. However, staffing levels are distributed differently throughout the day/night: in accordance with the *Ontario Long-Term Care Homes Act*, at least one RN is required to be on-site at all times, but there are no legislative or internal regulatory guidelines for the level of RPN or PSW staffing at Riverside Home. PSWs working on a casual basis may be called in to cover a shift within an hour’s notice, while part-time and full-time PSWs are scheduled for shifts with two weeks’ advance notice.

In order to develop a portrait of how PSW work is understood at Riverside Home, it is useful to turn to job descriptions and orientation materials that outline the roles, working conditions, and shift flow of PSWs – particularly when situating these descriptions of personal support work in relation to those of other types of care workers in this setting. Examining the role descriptions of care staff at Riverside Home reveals

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<sup>14</sup> However, the expression of care hours in full-time equivalents is somewhat misleading as this does not mean that these hours are performed by full-time staff. While the breakdown of staff types is unavailable for Riverside home itself, fewer than half (45%) of the employees comprising the total workforce across Riverside Continuing Care’s various sites are full-time, while the majority of employees are either part-time (27%) or casual (27%) (Riverside Continuing Care Corporate Balanced Scorecard, 2010-2011: 25).

that there is significant formal division of labour between RNs, RPNs and PSWs, reflecting the broader patterns in assistive vs. regulated care staff that have been described by others (Armstrong et al., 2008; Armstrong et al., 2009). Text Box 1 outlines in detail the tasks of PSWs as evidenced in Riverside's Human Resources' role description.

**Text Box 1: Role Description: Personal Support Worker**

- Provides aspects of personal care and basic nursing care as assigned by a RN or RPN. Examples may include personal hygiene, dressing, grooming, feeding, toileting, ambulation and transfers.
- Promotes the autonomy and the independence of patients/residents according to their functional abilities in the activities of daily living such as: bathing, dressing, grooming, feeding, toileting, mobility.
- Promotes patients/residents physical and mental integrity in meeting basic needs, always ensuring privacy and demonstrates a patient/resident-centered approach.
- Uses current knowledge of the patient/resident's condition at all times within the limits of his/her role and maintains strict confidentiality.
- Recognizes unusual occurrences, sudden change of behaviour, condition and appearance related to the patient/resident and reports these changes directly to the Registered Nurse or Registered Practical Nurse.
- Provides for the safety and well-being of the patient/resident by applying all established and relevant policies and procedures.
- Understands and complies with all relevant policies and procedures, as well as the Nursing philosophy and vision and assumes responsibility for own actions and seeks guidance when necessary.
- Ensures optimal use of supplies and equipment by guarding against waste by handling equipment properly and with care and reporting any malfunctions promptly.
- Participates in quality improvement activities on the unit and attends staff meetings and educational sessions.
- Records findings on appropriate forms as instructed by the RN or RPN.
- Performs other supportive duties as assigned by the Unit Manager or Director of Care.
- Acts as a preceptor to PSW students and newly hired and novice PSWs.

*Source: Human Resources Job Description, Riverside Continuing Care, 2005*

Job role descriptions characterize PSWs as playing a supportive role in care relative to RNs and RPNs. PSWs are described as delivering care as determined by RNs and RPNs. While the care that PSWs perform is variously referred to above as "personal care", "basic nursing care", "activities of daily living", and "basic needs", the examples of this care are all defined narrowly as being hands-on bodily care activities: bathing, dressing,

grooming, feeding, etc. Reporting and recording are also central to the PSW role, situating them as sources of information for RNs and RPNs on resident status. Interestingly, PSWs are also responsible for “guarding against waste” in the facility, rendering resource management an explicit part of PSW work and personal responsibility. Resident safety, privacy and quality improvement are also responsibilities of the PSW role, linking PSWs to regulatory compliance and public accountability.

Missing from this role description, however, is an understanding of care as a social relationship. Framing personal support work as “bodywork” (Twigg, 2000) sustains the notion that the job is physical, simple, and therefore requires little skill to perform. As Banerjee (2010) argues, the failure to acknowledge the complexity of frontline care work is implicated in the lack of support and resources for these workers. In turn, cuts to support and resources place worker and resident health and wellbeing at risk (OHC, 2008), and necessitate difficult decisions on the part of care workers struggling to produce positive care outcomes within a constrained environment (Armstrong et al., 2009). Missing also from the role description is acknowledgement of the “extra role behaviours” that Berta et al. (2013) note is increasingly characteristic of personal support workers’ jobs – i.e. staying beyond the boundaries of one’s shift in order to provide adequate care.

A failure to recognize the complexity of personal support work is further reflected in the orientation materials provided for new staff at Riverside Home. As Text Box 2 demonstrates, the shift flow of care work is imagined as a series of tasks which workers move through in sequential fashion.

**Text Box 2: Description of Shift Flow**

At beginning of shift:

- arrive on unit on time (ready, prepared to start)
- obtain assignment
- sign in
- go to designated area to meet with other team members
- read documentation for last 24 hours (or since last saw patient for regular staff)
- check orders for last 24 hours (check MAR)\*
- read plan of care
- prioritize care with other team members
- go see assigned patients, residents to ensure presence and well-being
- document any issues for physician in communication book
- begin providing care

Breaks or Education

- inform partner
- communicate any important information about patients, residents
- inform patients, residents

At end of shift:

- document all relevant information in patient, resident health record
- complete report (as specified by unit)
- communicate verbally any critical information to person taking over accountability
- leave only when a person taking over assignment has arrived
- see all assigned patients to ensure presence and well-being

\*medication administration record

*Source: Riverside Home Nursing Orientation Binder, 2012*

In this simplified, sanitized account of shift flow<sup>15</sup>, care work is understood as following an orderly flow of stepwise tasks, beginning and ending at the doors of the facility.

Reflecting and sustaining the “generic worker” model (Sky, 1995), the skills of care work are removed from this description of the daily care routine: workers move through the shift in a way that emphasizes “process and order” over meeting care needs (Lee-Treweek, 1997: 53). Missing too is a recognition that crisis, conflict, competing priorities, and interruptions are central features of everyday direct care work in LTRC

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<sup>15</sup> Unlike other descriptions of care work and roles in the Nursing Orientation Binder, this description of shift flow is not labeled as applying to a specific type of care staff, and so there is some ambiguity as to which type of worker this description applies (RNs, RPNs, PSWs, or all three). However, there are two clues that suggest it may in fact specifically refer to PSW shifts: first, this description appears immediately following role descriptions for PSWs and prior to describing the roles of another type of care staff (practice support nurses), suggesting that the shift flow is meant to be a part of PSW orientation specifically. Second, the description mentions informing one’s partner at breaks, and PSW work assignments are made in pairs.

facilities (Daly et al., 2011; Diamond, 1992; Foner, 1994) – an absence that is all the more stark in comparing descriptions of different types of care workers’ working conditions, as illustrated in Text Box 3:

**Text Box 3: Comparison of Working Conditions Between Job Types**

**RNs and RPNs**

- Frequent involvement in complex, emotionally charged, stressful interactions/situations.
- Environment where interruptions and need for changing priorities frequently occur.
- May have exposure to illness/disease situations, toxic chemicals, fumes, dust, biological products/ blood and body fluids, and antineoplastic agents or other chemical/medication preparations.
- Potential risk of physical and/or mental harm from patients, visitors, material and or equipment.

**PSWs**

- May have exposure to illness/disease situations, toxic chemicals, fumes, dust, biological products / blood and body fluid.
- Potential risk of physical and/or mental harm from patients, visitors, material and or equipment.

*Source: Human Resources Job Description, Riverside Continuing Care, 2005*

As with RNs and RPNs, PSWs are warned that their jobs may expose them to health risks in the environment and potential physical/mental harm. However, missing from the PSW description of working conditions is the warning of complex, emotional or stressful interactions involved in providing direct care, as well as acknowledgment of changing demands and competing priorities. In this sense, PSWs’ direct care work is characterized as being less stressful, less complex and, ultimately, less risky than that of regulated care workers – despite taking place in the same environment. The failure to recognize job-based risk and the similar complexity of PSW’s work has implications for the kinds of supports that are made available to workers and the way in which their work is organized – and subsequently, as others (Armstrong and Daly, 2004; Banerjee et al., 2008; Daly et al., 2011) have extensively noted, produces working conditions in which personal support workers are regularly exposed to emotional stress.

Finally, Text Box 4 illustrates how formal decision-making also differs between types of care staff, with PSWs characterized as having the least amount of control over the process of resident care:

**Text Box 4: Comparison of examples of decisions made or duties performed without reference to supervisor:**

**RN:**

- Decisions pertaining to prioritization of daily work activities
- Decisions related to assessment of patient conditions, implementation and evaluation of interventions and referrals to members of the interdisciplinary team
- Decisions pertaining to patient assignment

**RPN:**

- Decisions pertaining to prioritization of daily work activities
- Decisions related to assessment of patient conditions, implementation and evaluation of interventions and referrals to members of the interdisciplinary team
- Decisions regarding the need and timing of consultation with a RN
- Decisions pertaining to initiation of nursing techniques in accordance with level of knowledge, skill and judgment and the opportunity to maintain competence

**PSW:**

- Prioritization of daily work activities
- When to report changes in patient condition and other pertinent information to RNs and RPNs

*Source: Human Resources Job Descriptions, Riverside Continuing Care, 2005*

While PSWs, like their regulated counterparts, are expected to be able to prioritize their daily work, they are not similarly considered involved in assessment, evaluation and implementation of care strategies. Thus PSW decision-making is narrowly framed as being a matter of deciding “what to do when”, further reinforcing an understanding of personal support work as task-oriented. From this description, it would seem that investigating PSW decision-making would make for a limited analysis as these workers have very little formal input in formal care planning or organizational processes. However, as Armstrong and Daly (2004) found, direct care workers – including PSWs – report having some flexibility in not only deciding “what to do when”, but also *how* to perform care. These “how” strategies for care are based on workers’ direct knowledge of

residents, yet are rendered invisible in formal decision-making processes (Kontos et al., 2010a) and neglected by supervisors (Henderson, 1994). In framing PSW decision-making as merely a matter of prioritizing tasks and reporting patient conditions, this knowledge and their strategies for providing care are once again rendered invisible from formal accounts of PSWs' direct care work. Furthermore, minimizing the contributions of these direct care workers serves as a form of "corporate rationalization" for cost-cutting strategies that impact working conditions, such as staff reductions and conversion of full- to part-time work or casual labour (Konrad, 2011).

In sum, PSWs work amidst a wide variety of different types of staff at Riverside Home. The work of PSWs is imagined in the official texts of Riverside as being bodily-oriented and task-focused, while PSWs' working conditions are understood as less-complex and less-risky relative to regulated care workers (RNs, RPNs). With this portrait of PSW care work in mind, I now turn to a discussion of how "good care" is characterized in public and internal representations of care at Riverside.

### **Conceptualizing "Good Care" at Riverside Home**

In exploring the meaning of "good care" in the official texts of Riverside Continuing Care, a number of contradictions arise for personal support workers as the idealization of good care contrasts with official accounts of their roles, work and working conditions at Riverside Home. It is described on its official website as a residence that provides care in ways that address residents' physical, social, psychological and spiritual needs (Riverside Continuing Care, 2013). In its brochure, the goal of Riverside Home is described as promoting the social, physical, psychological and spiritual functioning of residents (Riverside Continuing Care, 2012). Reflected in these goal statements is a sense

of care as being multidimensional: care addresses the “whole” person, while care workers are conceptualized as maximizing residents’ functional abilities in these multifaceted aspects of personhood. This understanding contrasts sharply with PSW role descriptions explored above, in which a focus on the body and reporting/recording the tasks of physical care takes precedence.

Furthermore, these “whole person” care goals are not captured in public nor internal measures of reporting care quality. As a part of its accountability agreement with the Local Integrated Health Network, Riverside Home is required to produce Corporate Balanced Scorecards to report on facility operations and resident care. These reports reflect the medically-focused measures collected by the RAI-MDS resident assessment tool that has been legislatively mandated for licensed long-term care homes. As such, the Corporate Balanced Score Card for Riverside Home reports the only measures of care quality that can be medically-defined and quantified: the percentage of residents with falls, weight loss, declining ability to perform activities of daily living, worsened behavioural symptoms, daily restraints, and pressure ulcers (Riverside Continuing Care Corporate Balanced Score Card, 2010-2011).<sup>16</sup> Thus there is a disjuncture between the ways in which Riverside Home envisions good care for residents, and the ways in which evidence of care is measured and reported.

In addition to these required reporting and recording practices, Riverside Continuing Care as an organization has produced a number of formalized value

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<sup>16</sup> Interestingly, worker wellbeing is similarly medically-defined and quantified in these reports, with annual counts of the number of sick hours, work-related incidents, and work-related health care claims serving as the only measures of quality in terms of working conditions (Riverside Continuing Care Corporate Balanced Score Card, 2010-2011). As Messing (1998) has argued, such measures are particularly poor for capturing the occupational hazards experienced by women who, in attempting to claim compensation and sick leave, tend to face barriers to having their health understood as connected to their work environments.

statements, intended to inform the public as to its vision for resident care, as well as to guide employee practices and organizational activities at Riverside as a whole. These value statements have also been used in a series of employee workshops to help educate workers on how they can “live” these values (i.e. how to enact these values in their daily work). Employee responses were then used to develop an employee guide book (Riverside Continuing Care, 2009). From this guide a number of themes emerge that give a sense of the organization’s model of care work: an idealized notion of how care should be performed by its workers. Given that the workshop series was entitled “The Power of Personal Responsibility”, it is perhaps unsurprising that the subsequent employee guidelines emphasize how it is the individual worker who is responsible for upholding the organization’s core values in providing care. As a result, in emphasizing worker responsibility the instructions for upholding Riverside’s approach to care are completely decontextualized from many of the above-noted aspects of the workplace context itself.

First of all, care is understood as being *resident-centred*, tailored to the individual needs and preferences of each resident. Workers are expected to attend to the “wishes and choices” of residents as much as possible, and to provide a “personalized and personable” (Riverside Continuing Care, 2009). This implies that care is meant to be flexible and tailored on an individualized basis, requiring workers to know or anticipate differences in residents’ needs and desires, but also to have the flexibility, resources and approval to carry this “personalized” approach for residents who, as profiled above, have diverse and complex needs. The emphasis on personalized, client-centred care echoes that of the previously discussed mandated education standards for Ontario’s personal support workers (see Chapter 3), and clarifies how workers are to enact Riverside’s nursing

model in which residents are placed at the centre of care. However, considering Riverside also specifies that the role of the PSW is to carry out the care plan as instructed by the registered care workers above them in the workplace hierarchy (i.e. RNs, RPNs), it is not clear how workers are supposed to balance residents' individualized preferences with the proscribed care plan. This tension, as noted in the previous chapter, is made all the more complicated by managerial surveillance (DeForge et al., 2011), and the above-noted emphasis on reporting and recording as tasks central to the personal support worker's job role.

The timeframe in which workers are expected to accomplish care is also entirely the responsibility of the worker, who is instructed in the value guidelines to follow up on requests, start and complete work and respond to anticipated or expressed needs in a "timely manner" (Riverside Continuing Care, 2009). However, "timely" completion of care depends upon numerous factors, including workload, scheduling, and staffing levels. Constraints on workers' time are entirely absent; indeed, the worker is instructed that "*there is always time* to say 'please' and 'thank you'" (Riverside Continuing Care, 2009; emphasis added). Finally, workers are expected to work as a team and to "be inclusive" by involving "residents, family members and co-workers in the plan of care" (Riverside Continuing Care, 2009) – erasing the above-noted differences in the division of labour and job roles that assign greater formal planning power to some workers (RNs, RPNs) and less to others (PSWs).

Invisible from these guidelines are thus the myriad ways in which the experience of care work is shaped by a particular organizational context (characterized by increasingly limited resources, workplace hierarchy and division of labour, and

increasingly complex resident care needs), which itself is shaped by broader macro-level processes in and ideologies underpinning the funding, restructuring and regulation of long-term residential care. The idealized notion of care underlying Riverside's employee guidelines emphasizes relationships between workers and residents, and thus is an approach to care that goes beyond the biomedical, task-focused approach of the medical model, or the "slimmed down" approach to care of the market model. However, by rendering invisible the ways that both the medical and market models of care have shaped the particular organizational context of care work, the aspects of "good care" as outlined in Riverside's values are understood as a product of individual efforts. In other words, providing personalized, attentive, timely, and collaborative care is understood to be a worker's responsibility – rather than that of the organization to supply sufficient funding and, subsequently, resources and a workplace environment to sufficiently support care. As Kontos et al. (2010a) have noted, the flip-side of conceptualizing good care as a product of individual efforts is that inadequate care is often framed as a product of individual failure. This may further lead to workers' fear of reprisal from supervisors should they act upon their knowledge and experience in providing care (DeForge et al., 2011).

### **Concluding Thoughts**

This chapter has sought to contextualize the work environment of Riverside Home in relation to its organizational and financial features, physical settings, resident profile, staffing and division of labour, and conceptualization of "good care". Understanding this context helps to explicate the features of Riverside's personal support workers' working conditions. These conditions are understood not simply as the isolated

product of an individual organization, but rather in relation to broader processes of care restructuring, regulatory requirements, and notions of care work. In so doing, a number of questions arise for the decision-making of personal support workers of Riverside Home: how to navigate amidst multiple layers of vertically-organized managerial oversight; the impact that an environment of heightened concern with fiscal constraint has on work organization and staff support; the work involved in caring for a resident population with complex care needs; and the ways in which the characterization of PSWs' work as being bodily-oriented, task-based, less risky, and less complex contrasts with idealized notions of "good quality" person-centred care. With this context and these questions in mind, I now turn to my analysis of observational and interview data in the following chapters.

## **CHAPTER 5**

### **The Decisions in “Making it Work”: Experiences of Personal Support Workers at Riverside Home**

The previous chapter sought to understand the work environment of Riverside Home, as contextualized by broader processes in LTRC (re)structuring, regulation, work organization, and models of care. In this chapter, I now turn to the experiences of personal support workers themselves in providing daily/nightly care for the residents at Riverside Home, drawing on both interviews and observations conducted by myself and fellow researchers who comprised the research team of the Riverside Home site visit. I refer to a collective “we” when presenting excerpts of interviews and field notes (e.g. “we observed that...”) in order to capture the fact that observations and interviews were conducted by an array of research team members, using the team-based methods of rapid ethnography as detailed in Chapter 2. However, the following analysis of what was seen and heard by our team at Riverside Home is my own.

My analysis in this chapter is focused upon workers’ experiences with four activities that are central to the direct care work of Riverside Home’s PSWs: 1) mealtimes and feeding residents, 2) bathing and grooming residents, 3) toileting and continence care, 4) laundry and clothing. This does not mean that these activities are the *only* things that PSWs’ care work entails, nor the only activities that are relevant to understanding PSWs’ decision-making. Rather, my focus on these four activities is intended to present a micro-level portrait of the primary events that we observed during fieldwork and heard in workers’ interviews as being central aspects of their daily/nightly experiences at Riverside Home. Examining workers’ experiences with these activities

allows the factors that shape their decision-making to emerge. To articulate PSWs' decision-making as a process, I focus my analysis of each activity through three questions:

- At what points can personal support workers make decisions, and where is their decision-making restricted?
- What factors shape care workers' capacity to decide?
- What factors shape the decisions that care workers make?

As in the previous two chapters on the broader and site-specific contexts that shape personal support workers' working conditions, I explore these questions through a feminist political economy lens. This perspective informs the goal of my project overall, which is to understand personal support workers' decision-making process amidst five contextual layers: intersections of gender/race/class, work organization, regulation, restructuring, and multiple models of care. Using this lens, my analysis in this chapter demonstrates how LTRC restructuring, regulations, work organization, and tensions between contradictory models of care are factors that simultaneously restrict the capacity of PSWs to make decisions about their daily work and shape the decisions that workers do make in providing resident care. PSWs' experiences with feeding, bathing/grooming, toileting, and clothing reveal the numerous ways in which workers struggle to "make it work" amidst the capacity-restricting contexts of insufficient time, pre-set schedules, insufficient staffing, overwhelming workloads, regulatory requirements, managerial oversight, and resident and family-member choices. In turn, these contexts reveal how workers make decisions about managing the tempo of their work, (re)arranging their assigned workloads, prioritizing tasks, and breaking rules. Thus, the present chapter is

concerned with understanding the *meaning* of the previously-explored nested contexts for the everyday/everynight decision-making of PSWs at Riverside Home.

Furthermore, in this analysis of PSWs' experiences I will be adding in an additional layer of analysis by examining the impact of social location on workers' decision-making. Previous chapters have examined more broadly how LTRC work is contextualized by the intersecting inequalities of gender, race and class. Personal support workers in LTRC settings are predominantly women, and their poor remuneration for this work reflects the assumption that care is the unskilled product of women's inherent capacities (Armstrong et al., 2009). Furthermore, as care labour flows from the global South to the global North amidst neoliberal economic restructuring, LTRC work is increasingly performed by racialized migrant labour (Eckenwiler, 2012). Economic restructuring and subsequent changes to the labour market have also resulted in increasing numbers of men (and especially migrant men) among personal support workers in long-term care (Hussein et al., 2014). This chapter seeks to address the meaning of these intersecting contexts for workers' decision-making. My analysis of PSWs' experiences at Riverside Home suggests that both gender and race inform residents' and family members' choices, which in turn shapes workers' decisions about how to organize their work.

### **Some Orienting Observations on Staffing: Formal vs. Informal Work Organization**

Before I begin exploring the four central activities of PSWs' work, I want to highlight that throughout this chapter, it is important to keep in mind not only the working conditions analyzed in the preceding chapter on Riverside Home's organizational context, physical structure, resident population, and formal patterns of

work organization at the broader organizational level, but also workers' experiences with daily on-the-floor staffing patterns at this residence. This information helps to contextualize PSWs' decision-making in terms of understanding their daily/nightly workload, as well as the amount of help and space that is available for these workers to draw upon when caring for residents. From our observations in our site visit to Riverside Home, care worker staffing levels at this residence vary significantly over the three shifts that comprise the 24-hour staffing requirement. Firstly, in the day shift (7:30AM – 3:30PM) there are 5 PSWs on each floor, 2 RPNs on each floor, and 1 RN shared between the two floors of the residence. In the evening (3:30PM – 10:30PM) we found there were 4 to 5 PSWs on each floor, 2 RPNs on each floor, and 1 RN shared between the two floors. At night (10:30PM – 7:30AM) we observed only 1 to 2 PSWs on each floor, an RPN on the floor for the cognitively impaired, and again 1 RN shared between the two floors. These staffing levels may vary but they are a product of both regulatory compliance (i.e. the requirement of the *Ontario Long-Term Care Homes Act* to provide 24-hour nursing care) as well as managerial decisions about resource allocation amidst a context of funding constraints and underlying notions about care work (i.e. how much work there is and what is involved in caring for residents) and care workers (i.e. what constitutes “sufficient” staffing levels for the assumed workload).

We also found through interviewing workers that while staffing levels are an important context for understanding care activities at Riverside Home, an additional aspect of work organization to keep in mind is the method of staff assignment for each shift. Unlike RNs, PSWs at Riverside Home do not rotate between units within the same shift: whether casual, part-time or full-time, a PSW will arrive to a shift on either the

cognitive-impairment unit, or the physical-impairment unit. Unless the PSW is a casual hire (i.e. called upon on an as-needed basis to fill in gaps in shift staffing), workers tend to work consistently on the same unit of Riverside Home. However, workers *do* rotate *within* the unit on which they work, and this rotation switches every two weeks. Each unit is contained within one floor of the building that houses Riverside Home, but each floor is divided into three staffing assignment “zones”: north, south, and central. As a PSW arrives on shift, she or he will be assigned to care for the residents of a particular zone, and this assignment will be consistent for two weeks. For instance: a worker will be assigned to care for residents on the south side of the cognitive-impairment unit for two weeks, and then be switched to residents on the north side the next two weeks, and so on. Clearly this pattern of assignment is only relevant for PSWs when there is more than one PSW present to divide up the work (i.e. for a night shift PSW who works alone, the entire floor of a unit is the worker’s assignment), but it also means that, although we observed up to five PSWs present on the floor overall, any one PSW was working in his or her assigned zone with only one (or, at most, two) other PSW(s) on hand in the same zone at any given time.

However, despite a formal work organization that assigns multiple PSWs to a zone on a shift (for day and evening shifts), we found that within this context PSWs have developed their own strategies for working their assigned zone in terms of how the work is divided up between and among workers. This informal division of labour seems to depend on interpersonal relationships between workers and established work patterns over time; however, it also depends upon which floor a PSW works on. Consider for instance the difference between two PSWs (1 and 2) who work on the cognitively-

impaired unit, who described working alongside each other as a team to care for one resident, versus the experiences of two PSWs (3 and 4) who work on the unit for physically-impaired residents:

I: So does this mean that you mostly... when you say there are two people working together what is it you're working together on then?

PSW3: I don't know about them but us we don't.

PSW1: Us we really work in pair. That means my assignment, let's say my assignment this one side is my assignment like this one, right? And we took a priority. So while I'm starting washing a patient [PSW2] will pick the clothes out. She's got to make my bed and while I'm starting the patient, shaving if it's a man and all of that. When she's done that she pick up after me like any towels, dirty towels, and we change room. All my patients. Sometimes we don't count is it mine, is it hers. We just... we're so used to do it that we don't count like you know. And we do that.

I: Do you always get to work together?

PSW1: We do it.

PSW2: Yeah.

PSW1: We got the same rotation and even rotating on the floor if I'm in the south and she's put in the north we do it because we're used to it and down the road okay, it's long. We say we're back with some patients they feel more comfortable because sometimes they don't want to get up. The approach, sometimes it doesn't work with me. It's going to work for [PSW2]. Sometimes it's the opposite. So things get done and you're not stressed and overtired and stuck in the room looking for someone, spending time to look for someone to help you. Different people got a different opinion about that but it's not with everyone. I would not see myself working with everybody like this.

I: So it depends on the personality and you know each other, you trust the way you work so that helps?

PSW2: Mmhmm.

I: Whereas you two work alone?

PSW3: Well our clientele is not the same. They're more independent. And for them usually us, if we go two we talk about our weekend. We don't really pay attention to our clients. We talk more about what happened, what we did and, you know, we kind of forget sometimes the patient.

I: You mean if you're working in pairs?

PSW3: Yeah.

PSW4: There's some of our residents don't like that we go in two because they've said 'No. I only want one person here. I don't even want students to come in.'

I: Because they're afraid that you won't pay enough attention to them?

PSW4: That, and they feel like they're just being stared at instead of taking care of them. Like the other one is not working. I guess they're shy too.

[Interview 1: 6-8]

With residents who are more cognitively-aware, working in pairs may be a problem for PSWs in that residents would feel uncomfortable with more than one care worker in their room or assisting them at the same time – which does not seem to be as much of a problem for PSWs working with residents who are less cognitively-aware. However,

working together also seems to depend on workers' individual preferences and relationships, as PSW2 articulates she might not work with everyone in the same way. Similarly, in another interview two PSWs described for us how tensions between individuals can influence the sense of "teamwork" among PSWs on the same zone assignment:

PSW5: On our floor more so is we all work as a team. We all work together. We don't say 'I'm not putting her on because she's not mine.' If it's hers and I know she's busy with someone else and that person has to go...

PSW6: But our floor is totally different.

PSW5: ... I will put her on, you know.

PSW6: We've got a couple on [the physical-impairment unit] that you do everything. Like you help this person and this person takes advantage and, you know, it's hard. Some people just stop working together and you do your own group and I'll do my group because you're doing your group and you're doing part of her group too for the most part. So we just stopped doing it.

PSW5: I guess we're lucky we don't have...

PSW6: No, you guys don't have that.

PSW5: We all work together. We all sort the clothes together. We sort all the socks together. We leave it for evening.

PSW6: We don't.

PSW5: We say 'Hey. Enough is enough. We're not going to sort it and start putting it away now.' You just start doing that and then someone down there wants something. But we work as a team and that kind of helps for the end of the day saying okay, you know, you and the other person you did what you could for the day. We're not machines. We're not robots. Sometimes they expect you to be but I mean come on.

I: It sounds like it's different on [the physical-impairment unit].

PSW6: Totally different floors. Yeah. [On the physical-impairment unit] we have a few problems with our staff. And like I can work with somebody and me and her can work together no problem. But, you know, what they say: one bad apple in the barrel makes the whole barrel rotten, right? So it kind of changes everything for everybody on the floor when you have that one person.

I: Like in terms of?

PSW6: In terms of helping and picking up and, you know, just na-na-na-na-na all the time.

[Interview 7: 20-21]

While formal staffing patterns between the two floors of the residence are the same, there are clearly differences in how PSWs work within these patterns. Alongside the previously-explored "nested contexts" of the preceding chapters, these observations as to on-the-floor staffing levels, formal work organization, and informal divisions of labour are important to keep in mind when exploring PSW decision-making given that, as

Armstrong et al. (2009) have noted, official information on staffing can hide the realities of how many people are actually at work throughout the day/night. As illustrated above, reporting only the number of staff present on a unit for a given shift would mask how this work is divided between the zones of the unit, as well as workers' own strategies for dividing up the shift assignments. Furthermore, while Riverside Continuing Care reports that residents receive 3.7 care hours per resident day (Riverside Continuing Care Corporate Balanced Score Card 2010-2011: 27), this information tells us little about how the work of those hours of care is actually organized – nor what kinds of activities those care hours encompass. With these contexts in mind, I now turn to an analysis of the four central PSW activities that comprise residents' care hours, starting with mealtimes.

### **Mealtimes and Feeding Residents at Riverside Home**

In this section, I analyze PSWs' experiences with mealtimes and feeding residents at Riverside Home – the activity that was most prominent not only in our interviews with workers, but also in our observational field notes. Multiple and overlapping factors that shape PSW decision-making are revealed throughout the mealtime process, as well as in other food-related activities involved in PSWs' work. I begin by explaining how meals take place at Riverside Home – where do residents eat, which workers are involved, and where are the meals produced. I then discuss the main themes that arise in workers' mealtime experiences, first exploring how PSW decision-making at mealtimes involves a complicated “balancing act” amidst challenges posed by restructuring food production, regulations about meal services, and a growing emphasis on resident/family choice. These factors shape the prioritizing work of PSWs, as they make decisions about which residents to bring to meals and when amidst a context of too-little time to do their work,

and the timing of a set mealtime schedule. I then explore the aspect of work tempo, analyzing how PSWs strategize to control the tempo of mealtime work in ways that fit with both residents' capacities and the need to ensure residents are fed. This theme reveals a conflict between the market model of care under which PSWs' work is organized, and the relational model of care that workers employ to "get the job done". Finally, I examine how an expanding emphasis on accountability narrows PSWs' capacity to shape their own work and informs the ways workers document evidence of both care and compliance.

#### *Where and How Do Meals Happen at Riverside Home*

Meals at Riverside Home are by far the busiest, most active times in the residence, and are major daily events for both workers and residents. The communal dining room system of Riverside Home allowed us to observe how meals unfold and the role of PSWs before, during and after each meal service. Unlike continence care, bathing, or dressing residents, meals provided the most opportune moments for observing interactions between PSWs and residents, as our ethics protocol prevented us from observing care that takes place in areas other than the "open" spaces of the facility. Aside from residents and PSWs, mealtimes also involve a number of different types of staff, including meal helpers (paid workers who are hired for 2-hour shifts for only the breakfast and supper services) and RPNs (who distribute medications as residents eat). Occasionally we also observed three other types of persons feeding residents or helping them to some degree: persons who formally volunteer at Riverside Home, visitors of residents (most often family members), and the one privately-employed paid companion. Each of the two floors of the residence has multiple dining rooms, and where residents

eat depends on their level of independence: a larger dining room for residents who need varying degrees of assistance with eating, and a smaller dining room for residents who can eat independently. On the physical-impairment unit there is also a third small dining room for residents who are completely dependent on assistance with eating (i.e. they must be fed by someone). On both units we observed that some residents also eat in their own rooms or in lounge areas, either independently or with assistance from paid staff, a volunteer or a visitor.

To understand how mealtimes are experienced at Riverside, it best to begin by first understanding where the food comes from. Three meals are served per day for all residents: breakfast (8AM), lunch (12 noon) and supper (5PM). The meal service system has been centralized to an offsite location, such that meals are now prepared and packaged at Hillside Hospital (another hospital owned by Riverside Continuing Care). The timing of the meals refers to the precise time that the meals arrive via service elevator on the two floors of Riverside Home: at 8AM, 12 noon and 5PM, large metal service trolleys arrive on both floors with pre-made meals packaged on plastic trays. Each tray is assigned to a specific resident and contains everything for the service: food in sealed plates, beverages in sealed containers, and plastic utensils on each individual tray. Meals are chosen from a 21-day “corporate menu”, with two choices for each meal offered per day, as well as snacks. Residents (or their family/proxy decision-maker) make their selections at the release of each new 21-day menu – meaning that what a resident receives on a meal tray on any given day may have been decided upon weeks in advance. A dietary service worker from Hillside Hospital brings the trolleys loaded with hot trays

to the residence floors, and comes back two hours later to take them away again once the trays have been reloaded onto the trolley by either PSWs or meal helpers.

Our research team learned that this method of food preparation is actually a change to the way meals used to operate at Riverside Home. Previously, all food was cooked in-house for the residence [Field notes 12b: 4], and would arrive to the two residence floors in large containers to be heated in the kitchens and served to the residents individually [Interview 1: 25]. From a managerial perspective, the tray system may be appealing for the sake of resource management, cost savings and financial accountability. Centralizing food preparation at one site allows Riverside Continuing Care to save money on labour costs, as well as costs associated with equipping and maintaining multiple on-site kitchens across its hospitals and residential care homes. Furthermore, having meals pre-portioned, packaged and delivered in predetermined amounts allows for greater control over waste. The tray system thus exemplifies how food production, as “ancillary” to care work, is increasingly restructured in ways that remove it from the local context under a market-based logic of providing packages of care services at the lowest possible cost (Armstrong et al., 2008). This process is further contextualized by insufficient provincial funding for long-term residential care (CHA, 2009), prompting even non-profit residences to seek ways to reduce operating costs by restructuring services.

### *Restructuring, Regulations, and Resident/Family Choice: The Balancing Act of Mealtimes*

The first major theme in PSWs’ experiences of mealtimes at Riverside Home is the way in which getting mealtimes to “happen” for residents involves a complicated balancing act amidst a context of restructured services, regulations about how meals are

to be served, and resident and family member choices. Examining workers' experiences with mealtimes reveals how these contexts present challenges in the form of insufficient time, the timing of a set mealtime schedule, and an expanding emphasis on providing care according to individuals' preferences. These factors present overlapping complexities for PSWs as they make prioritizing decisions at mealtimes.

Firstly, while the restructuring of service delivery may be a money-saving strategy for Riverside Care, this change has not been without consequences for personal support workers. The system of outsourced meal production at Riverside Home has an enormous impact on the work of the PSWs on whose shifts they occur. This impact is felt most keenly by workers in terms of *time*. For PSWs at Riverside Home, time is a resource of which there is simply not enough: indeed, as one PSW put it, mealtime entails "working against time" [Interview 4: 4] in order to make meals happen for residents. Insufficient time is indicative of insufficient staffing to match direct care workers' workload (Armstrong et al., 2009) – a workload which, as previously discussed, has only intensified in the context of LTRC restructuring under neoliberal principles (Armstrong and Jansen, 2006). As such, workers' experience of insufficient time at Riverside Home is comparable with the widespread findings of others that personal support workers in Ontario are working amidst insufficient staffing levels relative to the demands of their job (Armstrong and Daly, 2004; Banerjee et al., 2008; NUPGE, 2007; Smith, 2004). However, mealtimes at Riverside Home reveal additional layers of complication on top of the time/staffing dilemma: when it comes to meals the problem of time is further compounded by *timing*. The schedule by which the trays arrive and must be ready for pick-up is something over which PSWs have no control, and thus workers must organize

their activities around when trays will arrive and when they will have to be taken away again on the trolley back to Hillside Hospital. Examining this daily process of “working against time” in relation to both the time workers have and the timing of meal tray arrival reveals a number of complexities for PSW decision-making.

This daily process begins with the day shift PSWs and the work of waking and readying residents for breakfast. Recalling that the day shift for PSWs begins at 7:30AM, this leaves only a half hour between the changeover from night to day staffing and the arrival of the breakfast trays at 8AM. Thus, after receiving a report from the outgoing night staff, the immediate focus for day shift PSWs is on readying the residents they have been assigned to for the arrival of the breakfast trays. Some of the more physically-able residents will ready themselves and arrive at the dining room independently or with minimal assistance; as one PSW put it, “they decide when they get up and we follow” [Interview 1: 5]. However, for other residents who require waking and more physical assistance with dressing and transport, PSWs prioritize the order in which to ready the residents among the group to which they have been assigned care for the shift. An interview with three PSWs, two of whom work together as a team in the same zone of a unit on the day shift, reveals how complicated this process of prioritizing can be:

PSW1: So between the 15 clients we really have to look at the list and figure out our priority and even with the mealhelper often we're missing one so there's only one to feed all these people so we try to okay, this one has to be in the dining room lounge early so the mealhelper could start to feed, you know. If they're short at the time you arrive there and they're missing a girl that means you have to sit down and take over, right? Which is finishing at ten.

I: So are you short a lot?

PSW3: Yes.

PSW4: Almost every day.

[Interview 1: 3]

PSWs' work is organized such that when a shift is short on meal helper staff at breakfast, it falls to PSWs to double-up on first waking, dressing and transporting residents to the dining room, and then helping residents to eat once their meal has arrived. To what extent the resident requires assistance with eating, and whether or not there are a sufficient number of meal helpers available to assist the resident are thus important factors in PSW decision-making around waking and transporting residents to the dining rooms for the timed arrival of the trays. The direct care work of PSWs is increasingly organized under principles of "corporate rationalization" whereby care tasks are unbundled and parceled out as the jobs of "ever lower paid, more marginal workers" (Konrad, 2011: 59), such as the meal helpers who work at Riverside Home. This fragmentation of care work at Riverside Home reflects broader processes of cost-cutting and downsizing in the neoliberal restructuring of Canadian health care more broadly (Armstrong et al., 1997).

However, an additional consequence of this process is that, as "generic workers" to whom tasks may be delegated in the hierarchical arrangement of care labour (Sky, 1995), PSWs are required to fill in the gaps when the staffing levels of other types of auxiliary care workers are insufficient. This re-delegation along hierarchical lines is starkly expressed by another PSW who noted that PSWs "end up picking up" due to an insufficient number of meal helpers, or when a meal helper is missing from a shift due to sickness [Interview 7: 44]. Thus short-staffing is restrictive not only in terms of an insufficient amount of PSWs available to wake, dress and transport the residents for meals, but also in terms of the amount of the additional auxiliary (i.e. meal helper) staff upon whom PSWs rely. When there are too few meal helpers (or no meal helpers at all,

as is the case at lunch), it is PSWs who feed residents. As a result, we found that residents tended to eat in informal “shifts” despite the arrival of breakfast trays at 8AM [Field notes 3a: 2], such that more independent residents end up eating first (either due to being able to independently move to the dining rooms on their own, or due to having been prioritized by workers as requiring the least help and, therefore, can be most quickly brought to the dining rooms to start eating), while residents needing greater assistance arrive and are fed later.

A further complication on top of the set timing for meal tray arrivals and insufficient staffing is that PSWs must adhere to regulations requiring residents to be up, dressed, and in communal dining spaces in order to eat breakfast. Given the set dining schedule, this means that all residents must be dressed and up for breakfast between 8AM and 10AM, and it is only with “special orders” that a resident would be fed from bed with a tray [Field notes 12b: 1]. However, PSWs noted for us that despite the regulatory requirement to have residents up, dressed, and fed in communal dining spaces within a set schedule, a trend towards enhancing resident choice means that workers are increasingly under pressure to organize their work around both the requirement to have residents up and in the dining room while also meeting individual resident preferences about when to be woken up and brought to meals. One PSW expressed for us the conflict this creates for workers as they try to juggle morning tasks:

PSW4: I think it's a lot here is they're trying to give them more and more control and so as a worker it makes it harder for us because they want us to have them up and washed and in the dining room by a set time and whatever, but giving that choice to the resident. Like for example my gentleman yesterday normally wants up at nine. He wanted up at ten so I left him and he's ringing [the call bell] at ten to ten. He wants to get up now and I'm in the middle of a bath. So it kind of makes it hard that way.

I: There's this tension between what you have to do and...

PSW3: Yeah, because you're going to replace it to do something else but then you can't... you know. Like sometimes they should split you into two [laughter] and go there and go there, you know.

[Interview 3: 11-12]

The ideal of “good” care is associated with personalized care that is tailored to the individual care recipient (Nakano Glenn, 2000). This ideal manifests in the form of an emphasis on worker “flexibility” and resident choice/preferences, and as the PSW expresses in the above excerpt, workers are increasingly under pressure to organize their day around this model of care – a point further illustrated in the training manuals explored in the preceding chapter, in which workers are instructed to provide a “personalized and personable approach to care and service” (Riverside Continuing Care, 2009). However, the tight schedule around which mealtime work is organized, and the regulatory requirements to have residents up and eating by set times, directly conflicts with the notion of supporting individual resident choice and preferences.<sup>17</sup> It is in this conflict that the complexities of PSW decision-making in relation to mealtimes are further revealed: workers are making decisions not only based on how many hands are available to do the work, but also amidst conflicting models of care. As Lanoix (2011) has argued, the parceling of care work into tightly scheduled tasks reflects and sustains the notion of paid direct care labour as an “assembly-line” process. Within this model of care, the complexities of PSWs’ direct care work are reduced to executing preprogrammed orders, while the care recipient is characterized as the passive object of care. Despite workers’ observations of increasing emphasis on expanding resident control

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<sup>17</sup> We also found other ways in which workers’ ability to support residents’ choices was restricted with regards to mealtimes outside of the issue of time. For instance, due to the tray system, workers can no longer provide residents with additional helpings of a specific type or amount of food: all food that is brought up on the trolleys is pre-assigned to each resident, along with a limited number of unassigned “extra” trays. If a resident wants more food, then workers can only provide a whole meal [Interview 1: 26]. This inability to tailor mealtime preferences illustrates the conflict between models of care underlying the ideal of resident choice versus how care work at Riverside Home is organized and, increasingly, restructured in ways that fit a market-based logic.

over the care process, workers themselves have not similarly experienced a shift in the organization of their work that would allow them to support this model of care. Instead, the requirement to have residents up and in the dining room for set times continues to reinforce an understanding of the resident as an object which can be moved into the dining room following an unvarying schedule. As a result, workers' daily experience of working against time is thus not only shaped by a pre-determined meal schedule and being understaffed relative to the number and varying needs of residents requiring assistance, but also by a tension between having to adhere to the regulatory requirements of a market-driven approach to care and care work on the one hand, while simultaneously attending to residents' individual preference under a notion of expanded resident choice on the other.

The "balancing act" of mealtimes is additionally complicated by the fact that PSWs are also often struggling to accommodate the preferences of family members. Indeed as one PSW phrased it, it is "the family more than the residents sometimes" [Interview 1: 9] whose preferences workers are asked to carry out in having residents up and in the dining rooms by a specific time. Here it is useful to consider the concept of care as the "multi-directional" relationship articulated by Lanoix (2010). While Lanoix seeks to break apart the dichotomy between paid and unpaid care in envisioning the care relationship as multi-directional, we might further apply this model to understanding the ways in which care workers' decision-making is complicated by the multiple (and potentially conflicting) preferences of those involved in the multi-directional relationship – such that providing "good care" is not only a matter of attending to residents' choices, but also those of a resident's family. Furthermore, given the conceptual link between

family and positive care outcomes (Tronto, 2010), the persons involved in the multi-directional care relationship are each differently positioned with regard to whose preferences and concerns are accorded more value.

*Mealtime Tempo: Speeding up, Slowing down, and Meeting Needs*

Given these multilayered pressures related to merely one aspect of mealtimes at Riverside Home – gathering residents and bringing them to the dining room – it is thus not surprising that that we observed PSWs having to work very quickly in the effort to make meals “happen” for residents. Indeed we found that before meal trays have even arrived, the floors of the residence are very busy with workers transporting residents to the dining room, as one of our team members described in her observations of the residence hallways before a breakfast service:

When residents are ready, most are pushed in their wheel chairs by a PSW into the larger dining room. They are pushed down the hall quickly, like they are on a mission. There is no talking between the PSW and the resident while they are travelling.

[Field notes 3a: 1]

PSWs simply do not have time to carry on a conversation with residents – the primary focus is on working as quickly as possible to move residents into place for the arrival of trays – even to the point that a resident was still putting her dentures in while being pushed in her chair to the dining room [Field notes 10d: 5]. We also observed PSWs beginning to move residents into place for meals very early prior to tray arrival: for instance, we observed PSWs bringing residents in wheelchairs to dining rooms as early as 4:15PM for the 5PM supper service [Field notes 3b: 2]. While this produces a lengthy wait for residents, it further illustrates just how long it can take PSWs to transport the more physically-dependent residents to mealtimes, even without the additional activities of waking and dressing that are associated with breakfast time.

To this point I have explored primarily the questions of timeframes and timing in relation to meals: two aspects over which PSWs have limited capacity to control, and which require workers to make decisions about which residents to prioritize and how/when to move residents to the dining room in order to meet the set schedule. As Barbara Adams (2004) has argued in her analysis of the “industrial timescape”, control over time as an objective resource has permeated all temporal aspects, such that “the variable, rhythmic times of life are regulated and disciplined to conform to uniform, invariable temporal patterns” in order to serve the modern industrial relations of a capitalist economy (145). Hence, PSWs’ time at work is measured out into rationalized shiftwork of timeframes not of their choosing, regulations require meals to take place within a set time frame to which workers must adhere, and the timing of tray arrivals is fixed and unvarying. However, examining the array of strategies workers use in the *tempo* of mealtime work suggests that this is one area in which workers appear to retain a greater measure of decision-making control.

In terms of tempo, our observations of workers feeding residents at mealtimes were mixed. After the rush to gather residents to fit with the mealtime schedule, some workers were observed similarly rushing to get through the process of feeding residents. Mealtime rush may manifest in the use of force to get residents to eat; for instance, one PSW was seen forcing a spoon into a resident’s mouth [Field notes 6a: 5]. However, we did not observe all PSWs rushing/using force as they assisted residents to eat: even for residents who were entirely dependent upon a PSW to feed them, we observed some PSWs slowly spooning their food and talking softly to them as they were being fed [Field notes 9c: 11]. These mixed observations suggest that, once residents are in the dining

rooms, PSWs have developed a number of different strategies for managing time constraints that do not necessarily involve speeding up the tempo of their work. Our observations give further insight into the various strategies that PSWs use at mealtimes to assist residents. For instance, we learned that workers may use their experience with and knowledge of residents in order to make decisions about which residents to allocate their help:

There are no meal helpers for lunch – I ask one of the PSWs why – she says that there are a lot of things you don't understand why at this place. On the other hand, there does not seem to be much of a rush. I ask a PSW whether she is helping those residents she was helping to get up in the morning. She says that they can help anyone, and that they try to share those that are hard to feed. She prefers to start with those that she helped in the morning (with eating) – then she knows whether they had a good breakfast and might not be so hungry.

[Field notes 5d: 8]

The PSW observed in the above excerpt uses her knowledge of previous meals to determine how hungry a resident may be, and to then delegate her assistance – a limited resource – accordingly. Other strategies we observed included the use of wheeled office chairs in the dining rooms, allowing PSWs to move between residents they are assisting to eat without having to take the time to stand up and move around the dining room [Field notes 2a: 1], and multi-tasking by assisting multiple residents at the same time [Field notes 10c: 2]. Some residents simply have to wait until there is a PSW available to help them eat, as there is not enough staff to help all residents at once [Field notes 6a: 3]. Finally, PSWs told us that they will also break particular rules around feeding residents due to time pressures:

PSW6: You're not supposed to. You're not supposed to mix everything anyway according to the Ministry. You're supposed to let them taste each individual...

PSW5: But you know what? We don't have time for that all the time with the people we feed upstairs. And it comes piping hot so you can't let each tray sit for 15 minutes, 15 minutes, 15 minutes. You'd be there until 2:30. We have some with choke risk and they don't swallow like the other one. So we have to mix it together, mix milk in it to cool it off because we don't have time to do it.

[Interview 7: 37]

The need to have residents fed within a certain amount of time takes precedence over regulations as to how residents are supposed to be fed – a decision further contextualized by the fact that residents have varying levels of physical capacity, such that some residents take longer to feed than others (i.e. due to choke risk), and cannot be fed quickly without risk of physical harm. Thus while the above time-saving strategies we observed workers using during mealtimes might be understood as evidence of complex, often invisible “adaptive behaviors” that workers develop in order to get the job of mealtimes done (Henderson, 1994: 20), it is important to realize that these strategies take shape amidst not only the “mismatch between time, tasks and official rules” of the organization of care work (Lopez, 2006a: 68), but also the realities of residents’ varying degrees of physical limitation. As LTRC residents are increasingly older, sicker and frail (Menec et al., 2002), this clearly has implications for the kinds of decisions PSWs have to make around tasks such as feeding, which cannot always be accomplished by simply speeding up the work. Hence, workers develop strategies for saving time in other ways.

However, not all of PSW decision-making at meals is focused upon saving time, and succeeding at the job of mealtimes is about much more than meeting a set schedule and/or strategizing to assist as many residents as possible. Many PSWs expressed to us the importance of mealtimes/food in relational terms. As one PSW put it, meals are about “hot food and human warmth” [Interview 6: 8], not simply ensuring that residents were fed. Others were concerned that the tray system created a sense of mealtime service resembling one that is “more like a hospital than a home” [Interview 1: 25], revealing a disjuncture between the idealized notion of “homelike” residential care and the realities of how PSWs’ mealtime care work is organized. Finally, the decisions PSWs make about

mealtimes and feeding residents are not just about time-saving and distributing human resources: they are also about developing a relationship. In the following excerpt, a PSW illustrates how important the process of developing a relationship is to the work of feeding residents, as he recounts his experiences with trying to feed a particularly difficult resident:

PSW10: There is a man on that side when I came here it's very difficult to feed him because he like women. He like women.

I: To feed him?

PSW10: To feed him, everything. But he's my good friend right now. He's my good friend.

I: So you can feed him now?

PSW10: Yeah, he's my good friend now. It's my good friend because I am telling you that depend on you to create that environment with that person. He don't want men but those women who feed him, did they do the right things for him? I don't hate nobody but I'm going to create my own to see if I can win this guy's heart, you know. Because I have to do my job. So when I got there I tried to feed him.

I: Sounds like you're talking about care work as emotional work it sounds like.

I: And relational work.

PSW10: Exactly. We try to create a good relationship with them. This man when you feed him [makes a knocking sound] use his coffee. I teach everybody here how he is after I discover that. Most people use this old... I'm telling you. Some people make him upset. You know why? After they feed him they pull the tray. He is not happy. You know what? Eat without coffee. Eat without coffee.

I: And you discovered that.

PSW10: Yeah. I give him his coffee. Every after two spoon I give him his coffee. Relax. Take your coffee. I give him his freedom, I got my freedom too, you know. That's a fair deal, you know.

[Interview 4: 13-14]

This PSW had to find a way to accomplish his job of feeding a resident whom workers had found particularly difficult to feed, especially by men (illustrating the role of gender in care work decision-making, which will become all the more salient in discussions below on bathing and continence care). By sustaining a tempo that gave the resident “his freedom” (i.e. interspersing spoons of food with sips of coffee to help the resident relax), the PSW developed a good relationship with this resident and was eventually able to feed him – a strategy he then communicated to his fellow workers. This PSW’s experience illustrates how workers’ decisions around mealtimes are shaped by the specificities of care work. Unlike the products of other forms of industry, “care” is a product which

resists formulation, as the process of producing care is interactive and rooted in personal relationships (Armstrong and Armstrong, 2002). In this sense, feeding a resident is not the same as working on an assembly line: being successful at the job (i.e. getting residents to eat) requires relational work, such as finding out residents' preferences for eating and using this information to "create a good relationship". The relational aspect of care work is rendered invisible in the medicalized accounts of formal care records (Kontos et al., 2010a) and neglected in task-based emphasis of personal support workers' job descriptions (Banerjee, 2010; see also Chapter 3). However, the above-noted example of how central relational work is to feeding residents further illustrates how, as numerous authors (Armstrong, 2013; Diamond, 1986, 1992; Foner, 1994; Weinberg, 2006) have argued, meeting physical care needs is work that requires a great deal of skilled relational labour and problem-solving to accomplish.

#### *Accountability and Risk Management in Feeding and Food*

Problem-solving in order to ensure that residents eat is particularly important for PSWs given the high degree of monitoring associated with mealtimes at Riverside Home. As PSWs explained to us, each individualized meal tray comes with a chart for each resident, and regulations require workers to fill out exactly how much food and liquid was consumed by every resident at every meal. We were told that this record-keeping is a change from how things used to happen, and PSWs resent the time-consuming process of counting and recording resident intake:

- PSW8: And we got the nutritional intake sheets to record that I find ridiculous.  
I: Tell me more about that.  
PSW8: To me when you're sick you should only record intake and output but every day is the same thing. You know they'll receive a tray. We're all there feeding a patient. To me you report the one who refuse to eat. It's paperwork that's putting us behind because you have to calculate that there. You are right at the desk, you still have to record it in your binder so you're doing the same thing times two. Nobody look at it.

I: So even those residents who are eating and drinking well, you still need to record it?

PSW8: Yes. Everybody. I don't know where it come from. In the old age you just record intake and output for patients who were sick, you know, or you know there is a problem.

[Interview 2: 11]

At Riverside Home, mealtimes have not only been restructured in terms of food preparation, but also in ways that expand data collection. Records of food and liquid intake provide quantifiable evidence that care has been completed, and thus can be understood as a product of a market-based approach to accountability under which care has become increasingly formularized (Armstrong and Armstrong, 2010). Furthermore, in focusing on precise amounts of food and liquid intake, evidence of “care” is defined narrowly in physical terms (Lanoix, 2011). As such, the meaning of care work is restricted to how much food/liquid was consumed, thereby erasing the complex processes involved in transporting residents to meals and assisting them with eating, reducing workers’ mealtime labour to a charted percentage of food the resident ate, the milliliters of liquid the resident drank. Thus while the work of mealtimes is increasingly under managerial surveillance in the form of expanded charting, this surveillance is completely decontextualized in failing to capture PSWs’ skills and strategies behind the numbers. This makes mealtime records an example of what others (Armstrong et al., 2009) have found to be the “meaningless paperwork” that personal support workers in the Ontario context are increasingly required to produce.

Recording food and liquid intake for all residents also takes a great deal of time, which could explain our observation that sometimes PSWs do not make notes on food and liquid consumption as they go about feeding residents, but rather fill in documentation from memory afterwards [Field notes 5d: 2]. Making notes as they go can slow workers down, impeding the multitasking and other time-saving strategies that

PSWs use at mealtimes. However, having to record from memory due to time constraints also raises questions around the accuracy of these records. Furthermore, in the process of picking up trays at the end of the meal to have the trolley ready to return to Riverside Hospital, workers often chart the food/liquids consumed for residents that they themselves did not assist at the meal, such that they are often filling in the charts for someone else [Interview 1: 21]. Our observations highlight how problematic this process may be: for instance, residents were observed spooning food from one container to another rather than eating it, as there were too few workers available to ensure food was actually being consumed rather than simply being moved about the tray [Field notes 2a: 2]. This means that the post-meal estimates of the percentage of food “eaten” based on the emptiness of food containers may not be at all accurately reflecting how much food a resident consumed – especially if being filled out by a worker who did not actually observe the resident during the meal. Additionally, some residents simply did not eat at all due to a lack of help [Field notes 3a: 2]. Without this additional context, charting around food at the end of the meal fails to capture how the amount of food a resident consumes can be directed related to whether or not there was someone available to assist and/or supervise them. As PSWs are written out of the paperwork that they themselves are increasingly tasked with filling out, not only is PSWs’ care work rendered invisible (Armstrong et al., 2008), the challenges that workers face in terms of insufficient resources, work organization, and work intensity are also obscured (Armstrong et al., 2009; Campbell, 2013). Thus while mealtime recording and data collection serves the organizational goals of monitoring and accountability, it does not capture the

complexities of PSWs' work at mealtimes, and only serves as an additional time-straining factor around which workers must strategize.

In addition to mealtime intake sheets, PSWs also report on resident food and liquid intake between shifts. Personal support workers are not only the best sources of information about residents for other workers in the hierarchical division of labour, they are also important sources of information for each other in providing accounts of their observations and experiences with residents. The following observations made during an evening snack round with a PSW illustrates how this type of documentation around food is crucial in order to ensure continuity between care worker shifts – but also, in order to provide evidence that her work was indeed done:

We walk around the North side delivering snacks; I notice she goes only to certain doors to knock, like E [another PSW] did the other night when I watched her giving out snacks on the evening shift. T goes to a door, knocks – he's not here, away at bingo. She goes to another door, knows that the resident is away at bingo "but I will leave him some snacks because this one always takes snacks, he's a young man and still has an appetite, so I like to leave him something because he will always eat it, he likes that if I leave it for him." She goes into the room with some cookies and juice, comes back out and closes the door behind her. She tells me "the room was so dark, I don't know why so dark, they need light! So I just opened his blinds for him and leave his snacks how he likes it." I follow her back to the kitchen; she says "oh no, I have too much leftover, that's not good" [sounds dismayed]. I ask her why, and she says if there's too much left it can cause problems. T says she will need to write up exactly why there was so much food left, says that this is very important. I ask why and she says this is because if there's too much food left then the next shift might make assumptions: either that she didn't do it and the residents are now hungry and missed their snack, or that the residents themselves are not eating "and why are they not eating, are they sick? Why no appetite, you know?" So reporting is important here.

[Field notes 9c: 5]

PSW "T" used her knowledge of a resident to make sure not only that he received enough food, but also to do so in a way that she knew he would prefer. This exemplifies the important ways in which personal support workers' draw on their proximal knowledge of residents in order to make decisions that support the wellbeing and comfort of residents (Kontos et al., 2010a). However, this worker's concern with recording why she had so much leftover food at the end of her snack rounds also underscores how PSWs rely on

each other to communicate residents' conditions in order to make appropriate care decisions – in this case, to avoid feeding residents twice or misreporting changes in resident appetite. Thus, unlike the “ridiculous” time-consuming work of recording the amount of food/liquid intake after every meal [Interview 2: 11], communication between-shifts is far more meaningful for enabling PSW decision-making. It is further significant that, in the above excerpt, the PSW was anxious to record an explanation as to why there was so much food in order to avoid the assumption that residents had not been fed – in other words, the assumption that she did not do her job. As noted previously, enhanced accountability has been a central emphasis in changes to the Ontario LTRC regulatory context (Banerjee, 2009). Amidst legislative changes to enhance accountability, PSWs in LTRC are increasingly under scrutiny to comply with the requirements of documenting daily care, including minute details of food and drink intake (DeForge et al., 2011). In this sense, record-keeping around food also illustrates how PSWs are required to demonstrate accountability in providing both evidence of care *and* evidence of their compliance with regulatory requirements (however narrowly that evidence is defined in quantifiable terms [Baines et al., 1992]).

This broader regulatory context is further evident in the ways in which PSWs' work around mealtimes and feeding is shaped by an underlying managerial concern for risk management. As noted in the previous chapters' portrait of Riverside Home, while each floor of the residence has a small kitchen, these kitchens are not in use for actually cooking food, having been made obsolete by the outsourced tray system. In our observations, we learned that workers are required to lock these kitchens when they are not currently being used as a base for storing and distributing the meal trolleys and trays

during meal services. Residents cannot access the kitchens on their own, and visitors can access the kitchen only with a code, due to an incident in the past when a family member tried to warm a muffin in the microwave and the appliance caught fire [Field notes 7a: 4]. We also observed PSWs “shooing” a resident out of the kitchen when she had wandered in during a meal service, indicating that the kitchen is clearly a prohibited space [Field notes 9d: 3]. Furthermore, PSWs noted for us that kitchen supplies and equipment are restricted in both the name of safety as well as concerns for cost-cutting: for instance, knives are not allowed in the kitchen due to concerns for both resident and worker safety [Interview 5:13], and we were told by workers that ovens have been removed from the kitchenettes as this was preferable to upgrading the residence’s fire safety system [Field notes 12b: 4]. As noted previously, the management of “risk issues” has been emphasized in the Ontario Ministry of Health and Long-Term Care’s new legislative provisions on residence inspection and public accountability (MOHLTC, 2008b), and thus the restrictions around space and use of kitchen equipment reflect Riverside Home’s broader managerial concern with MOHLTC compliance. This emphasis on risk management has significantly shaped the role of PSWs such that workers are made responsible for monitoring the prohibited kitchen space, while equipment restrictions place limits on the kitchen activities workers can do – and thus, limits on their capacity to shape the work of mealtimes and resident feeding.

*Summary: Decision-Making at Mealtimes*

In many respects, PSWs at Riverside Home experience a very narrow capacity to make decisions around mealtimes, and this is shaped by a number of factors. First and foremost among these factors is the way in which mealtimes have been restructured to an

outsourced tray system, requiring workers to adhere to a strictly-timed schedule. This pressure is further enhanced by a regulatory context that mandates meals be served in a particular way (i.e. communally), a growing emphasis on attending to resident/family preferences, and a work organization context in which there is simply an insufficient amount of staff to go around relative to the amount of residents who need assistance with eating. As a result, workers develop numerous strategies for managing and saving time as they organize their mealtime work in response to this narrowed capacity to decide.

However, workers' decisions are not solely shaped by the need to manage time, workloads, conflicting preferences, and insufficient resources: their decisions are also informed by the need to develop a relationship with residents in order to feed them. In drawing upon a relational model of care to make important decisions about feeding residents, PSWs' experiences at mealtimes illustrate the problems of organizing care work according to market model logic. Finally, workers' experiences with an expanded record-keeping workload, the need to demonstrate evidence of resident feeding, and restrictions on both the spaces and equipment associated with meals and resident feeding illustrate the ways in which workers' capacity to decide is further shaped by a growing emphasis on accountability and risk management.

### **Bathing and Grooming Residents**

The second prominent theme in PSWs' experiences with direct care work was bathing and grooming residents. In this section, I explore how PSWs' experiences with these activities illustrate three influences on the decision-making process. First, I examine how new regulations have increased the bathing workload, and how this context has shaped PSWs' decisions to "carry-over" grooming work or eliminate aspects of care

altogether. I then discuss how workload increases are even greater for some workers due to informal rearranging of bathing assignments. Residents and/or family members often refuse care from certain workers based on PSWs' gender, race, and staffing status, requiring workers to shuffle the assigned workload. Finally, I examine the role of supervision in maintaining an emphasis on task completion in bathing care, and the ways in which workers encounter resistance when trying to make care decisions that fall outside of a streamlined, regulated bathing protocol.

#### *Where and How does Bathing/Grooming Happen at Riverside Home*

Unlike mealtimes and feeding residents, bathing and grooming are activities that take place outside of the open spaces of the residence, and ethics-wise were not possible for our research team to witness firsthand in our time observing at Riverside Home. However, the topic of bathing/grooming residents was brought up unprompted in the vast majority of PSW interviews, raising numerous important issues for PSWs' decision-making processes. Furthermore, throughout our time at Riverside Home, bathing and grooming were discussed by the workers we chatted with as we went about our observation shifts. Thus while we could not observe first-hand the processes involved in bathing and grooming residents, the PSWs we spoke and interacted with in our time at Riverside Home were keen to ensure that we understood their experiences with these aspects of direct care work.

Bathing at Riverside Home takes place as either a tub bath in the residence bathrooms, or as a bed bath in a resident's own room. Each of the two units in Riverside Home has two bathrooms equipped with a tub and toilet, as well as lifting equipment for transferring residents into the tub. We found that some residents decide for themselves

when to schedule their bath, and that some residents that are physically-able to do so even bathe on their own [Interview 4:6]. However, all other residents' baths are assigned to PSWs as a part of the work shift (i.e. when distributing workers between zones on a given shift). Unlike the set schedules of mealtimes, there are no set bathing schedules in terms of when baths must take place – instead, workers are assigned to bathe particular residents on a shift-by-shift basis. The type of bath (tub or bed) for each assigned resident is written into residents' care plan.

### *Bathing Workloads Under Regulatory Changes: Carry-Over and Cutting Corners*

It is first important to understand how bath assignments themselves are shaped by a regulatory context which mandates a minimum number of baths per resident per week. A major issue that arose in PSWs' discussions of bathing residents was the way in which this activity has been affected by changes to this regulatory context: the *Long-Term Care Homes Act* now requires that each resident be provided, at minimum, two baths per week (MOHLTC, 2007), doubling the previous required minimum of one bath per week. As a group of three PSWs explained for us in an interview, these changes were made without any accompanying supports to accommodate the increase in work that raising the minimum bathing standards entails:

PSW3: You know when they add on that second bath, they never put any time for us to do it. We kept the same time. Just put it in your schedule. So that's why it's so crazy in a way.

PSW1: We even changed time. We used to start at [unheard].

PSW3: That's right. We started now later plus we have an extra bath.

PSW1: We've got the same routine and extra bath.

I: And basically given how much time it takes, that added 15 to 20 hours more work every week.

PSW3: Exactly, but they didn't add up any time for us.

[Interview 1: 19]

For workers at Riverside Home, regulatory changes have resulted in an increasing workload, as it is up to workers themselves to find ways to somehow fit the additional

bathing requirements into the daily routine. As a result of this increasing workload, workers spoke of struggling to fit double the amount of baths into the same timeframe, with the same amount of staff, and the same bathing equipment (i.e. only two tubs per unit). In the following excerpt, two PSWs explain how this change has affected the timing of their bathing routine, as well as the ways in which both workers' time with residents and bathing equipment are too constrained in relation to the bathing workload:

- I: If you had more than one bathroom would that make anything easier?
- PSW3: Yes, because there's days we have eight baths and we've got two tubs. So that's why like I'm saying everything is scheduled so that's why in a point, yes, the residents feel maybe like they're numbers because it's like go, go, go and I wish I had a half an hour to, you know, take my time in the tub and chat. It would be so nice. But we don't. There's four others waiting and we have to go at 11:30 for lunch, you know.
- PSW4: What we used to do was all our baths were just given after breakfast so between 10:30 and 11:30 and so with doubling up the baths, like getting two a week, so we have like eight baths a day to be given in that time period. So then we slowly went to giving some before breakfast. And now we all try to get them done before breakfast because it works better because some of the other staff work slower and they're stuck more in your way.

[Interview 3: 15]

Where previously the time between residents' breakfast and workers' lunch break would have been used for bathing, PSWs now try to fit as many baths as possible into the pre-breakfast period (in these workers' cases, this is also to avoid being slowed down by other PSWs perceived to be slower and "more in [the] way"). But dealing with double the baths is not just a matter of shifting when bathing takes place, as workers also have no time to chat with residents while bathing them, having to "go, go, go" to get through the bathing assignments for the shift. As a result, workers feel that bathing residents has become "like a chain. There's no quality you know, with patients and talking with them and, you know. It's just 'No, you have to go, you have to go', you know?" [Interview 1: 19]. Reflecting just how intense this "chain" of bathing care can be, PSWs explained to us that bath assignments have to be spread out over both the day and evening shift each

day to be able to fulfill the twice-weekly requirements – but also, that more than just chatting may be skipped in order to get through the workload:

- I: Because you've got 15 people to do so you have to... a bed bath or tub?  
PSW1: A big tub. We ask they increase the tub because they all have one bath per week, now it's two per week. So it was another we had to rearrange everything because evening too they have to take out their lifts for their bath.  
I: So you have to distribute it over the two shifts?  
PSW1: Yeah. We've got [more than 30] patients on this unit. They all have to have two baths a week.  
I: So [more than 70] baths.  
PSW1: It's a lot.  
PSW2: Some of the baths are given in bed though too. Like some of the residents don't want two baths so they'll take one in bed and one in the tub.  
PSW1: We've got one on the unit. One is on evenings. The rest all go in the tub. It's a lot.  
PSW2: Depending on the day it could be two baths per person.  
I: How long does a bath take?  
PSW3: A good half an hour.  
PSW2: We have a few that are an hour but most are..  
PSW1: Because of the lift, mechanical lift, it's long. And we have to remove these. A wet sling under them. That's another story.  
PSW3: And some don't have adaptive clothes. You have to put them back to bed, dress them, put back your sling, that's the one hour bath we have because she refuses to have adaptive clothing.  
I: So do you have to do other grooming at that time, like do you do foot care?  
PSW3: No, we have somebody does it. Just the hands, fingernails.  
I: And the hair?  
PSW1: The hair sometimes.  
PSW1: [unheard]. Sometimes skip. Sometimes we don't have time. We make a decision.

[Interview 1: 12-13]

Baths are extremely time-consuming activities – even more so when residents require a mechanical lift to transfer to the tub, or when they refuse to wear the adaptive clothing that is quicker for workers to put on and take off. With double the number of these time-consuming baths, PSWs will skip certain aspects of grooming care in order to save time: in this sense, workers decide to prioritize the completion of bathing residents over grooming.

As a result, grooming work is often carried over into other shifts, or skipped altogether. For instance, one PSW told us that shaving male residents is a time-consuming task that tends to be neglected over multiple shifts, so that the workload

continually adds up in being carried over repeatedly [Interview 7: 21]. Others told us that they simply no longer have the time to “sit down, put curlers, nail polish, [do] the hair” of residents anymore [Interview 2: 2], and this was spoken of clearly as a change in PSWs’ work:

PSW9: We used to be able to put makeup on them, you know, and fix their hair nice and all that. Not anymore. We can’t do that. We don’t have the time.

I: Yeah. Yeah.

PSW9: They’re like a number. Next, next, next.

[Interview 2: 6]

This theme of change was echoed by a PSW in another interview, who explained that “before, after a bath you have time to groom the woman a little bit, curlers, make their hair look good. Today they go out they look like a wet cat” [Interview 1: 23]. Thus while workers do not get to decide how many baths must be given, they do make decisions about how they bathe/groom residents, streamlining the bathing process by skipping other aspects of resident grooming in order to get through their assigned bathing workload.

#### *Gender, Race, and Rearranging: Resident and Family Refusal of Bathing Care*

In addition to making decisions about what activities to skip in the context of an overly heavy workload, PSWs also spoke of frequently having to make decisions about rearranging bathing assignments due to residents refusing to be bathed by certain workers. Family members may also similarly refuse PSW care for their relative, requiring workers to adjust to their preferences. PSWs identified three factors that shape this workload rearrangement: PSW’s gender, race, and staffing type (permanent or casual). Of these themes, gender was the most frequently cited issue in workers having to switch-up the bathing assignments on a given shift. Workers told us that male PSWs are often refused by residents for bathing care, requiring their female coworkers to pick up the excess. As two women workers explained for us, this experience significantly impacts the

rest of their day, as taking on extra baths for coworkers who have been refused by a resident means that they will have less time to care for their own assigned residents:

PSW4: Well sometimes what happens too is that if we have a male on this floor we're taking on our workload plus theirs because they'll start their shift and then you find out oh, so-and-so won't accept them so then they're after you to pick up that bath on top of what you've done. So that part is not too much fun.

I: You know, because then what does it mean for the rest of your day?

PSW3: We're all going behind.

I: Yeah. Yeah.

PSW3: And that person is limited of doing whatever, you know.

[Interview 3: 8]

Already dealing with the increased workload of having doubled the baths under new regulations, women workers also face additional constraints in having to add more baths than they were assigned on a given shift when residents refuse to be bathed by men. This means that some workers are perhaps more likely than others to have to make decisions about streamlining the bathing process by skipping grooming care in response to a heavier workload – perhaps explaining the fact that all of the excerpts above on the decision to skip grooming care were expressed by women.

Another group of female PSWs explained to us how refusing a male PSW for care is related to the ideal of supporting resident choice and the setting of the LTC residence as a home, but also that the extent to which residents refuse care varies alongside staffing levels throughout the day:

PSW3: I know in a hospital you don't have a choice. I mean if you're in a hospital if you have a male, you're going to take it. You're not going to say. But here it's their home so they have the right to choose.

PSW1: It's another reorganization.

PSW3: But like I said, downstairs we have men and we try to make a group of the men and the men don't want the men. So we're really stuck on [the physical-impairment unit].

I: So even the men?

PSW3: Even the men don't want the men. They get angry.

PSW1: We had one like that [unheard].

I: So what happens then? Do the male caregivers, do they have less to do?

PSW2: Some do. You're stuck going in extra... like you might have two baths but because they refuse that one they still try to get us to do it so our workload would add up and they'd be walking the hall.

PSW3: Their hands in their pockets because there's nothing for them to do.

- I: It's not so much their fault.
- PSW3: No, but it's not suitable for the floor. I mean you don't put a male there when you know men doesn't want them and women doesn't want them. What do you want that guy to do?
- PSW2: Sometimes it's their approach because on nights and evenings they will accept a man, residents, but on days if they can get away with it.
- I: They're not doing personal care then as much, eh?, if they're on nights.
- PSW2: Yeah, they still have to go in and change them twice.
- PSW3: And the full time on [nights in the physical-impairment unit] it's a man.  
[Interview 1: 33-34]

These workers similarly experienced taking on the extra bathing work when residents (both men and women) refuse male PSWs, as their initial strategy of creating an all-male group of residents for men to bathe did not work. However, it seems that this experience caused by refusing men may be more relevant to daytime workers, when there are more PSWs (thus, more likely to be at least one woman) available to rearrange care and take on the extra workload.

Finally, an interview with three more female PSWs reveals that the stressful and complex task of having to rearrange bathing assignments is not only due to residents' refusals, nor is gender the only factor in refusing PSW care. Family members too may insist on certain workers for their relatives, and their refusal of care may additionally be based on a worker's staffing type (permanent vs. casual) or a worker's race:

- PSW5: Like families will come in. We have families [on the cognitive-impairment unit] that don't want a male for their mother and there is male nurses. That's the way the world is running today. You don't have all female staff and/or they don't want somebody that's new. It has to be a regular staff. Well some days there's only me and her that's regular staff. Well I can't split myself and there's five new ones.
- PSW7: You're wasting your time to, you know, explaining to them because they have to ask you what to do, you know.
- PSW5: But not only that, they'll assign you're in a certain group and we get assigned to that group which you've probably already been in it for four days and they're sticking you in it again because you're regular and that person is not regular and that family member does not want their mother to have... We all do the same thing. We all know how to wash. We all know how to do the same thing but 'You're new and I do not want my mother with that new person.' So it causes conflict with the staff too. It causes conflict with some staff. Some staff don't mind. They'll keep their group and just switch somebody from that group and take that one.
- I: And just sub out?

- PSW5: Yeah.
- PSW6: And I'm on [the physical-impairment floor] and that problem is huge. They are women that don't want a man and last week we had two men on the floor so of course I was on this side. I had to switch all my group to take all the ones that... it's a mess.
- I: So you had to do the reorganizing on the floors.
- PSW6: Yeah. So it's very, very tough and I have talked to my director about it and said 'Something has to be done.' These men they come here to work. They're PSWs. They're trained. And I respect where the women are coming from. They don't want a man washing them. I respect that. Back in the old days I mean you wouldn't hear of that. But we're stuck with trying to re-arrange everything. And what happens if you've got three guys on one day. They have to take somebody or the care is not done. You stay in bed all day.
- PSW7: I had that problem before that [name] wants me to go down because one staff downstairs I think a few residents in that group that doesn't want that person. And RPN there wants me to go down to change from upstairs to go downstairs to take over. It's very hard for me.
- I: So the team leader would have you come downstairs just to be able to get another woman.
- PSW7: To be able to change, you know. And then that person they want her to go upstairs because they think that people upstairs that okay, you know, anybody coming there because he doesn't know. But it's not that way anyway.
- PSW6: It's just frustrating for the staff because we've brought it up a lot of times and nothing is being done about it and it's getting worse and it's just frustrating.
- PSW5: It puts all the staff in a different mood respective in the day and then you're switching patients and you're giving this one to this one and that one to that one. It just causes a havoc sometimes.
- I: So it's caused both by the casual people who come in and by this 'I won't have a man doing the work.'
- PSW5: Yeah.
- I: What about race? Does that come up?
- PSW5: Oh yes. More so on [the physical-impairment unit] because they know whether you're black or white or whatever. Upstairs not so bad [in the cognitive-impairment unit]. There's certain patients that their behaviour comes out when they see the different colour. But sometimes [unheard]. Sometimes the girl can be black or it doesn't matter, you can be white and her behaviour is still the same. It all depends on how that frontal lobe wants to work that morning because we've been scratched and bitten, whatever. At first they thought it was colour but with her it's not. It's just the behaviour all the time. But there is some that, yes, do not want.
- PSW6: And we have a lot on [the physical-impairment unit].
- PSW5: So then you're again sometimes switching again, taking a certain patient because that doesn't happen too often. But it's the family understanding that they have to understand that in this world today if you want your parent looked after it's male or female. And if you were at the [city's] big hospitals, you would not have that choice. You wouldn't be able to go to the counter and say 'I don't want my mother to have him.' 'Well I'm sorry but you know what? Your mother is going to be here for a week and he's on for a week. So do you want her not to be washed or looked after?' Like I think families think of it in a sexual way that they're going to think of her as a... and it's not. That mentality is not there. They're a nurse. They're a professional. It's like a male doctor doing surgery. What are you going to say? 'My mother is not having surgery because he's a male.' They have to open up and get rid of that thought.

[Interview 7: 6-8]

The need to reorganize bathing assignments is not only due to resident resistance/refusal, but also family members' preferences – especially for workers who are “regular” hires (i.e. permanent rather than casual workers, who may be unfamiliar). Gender is also compounded with race in terms of residents refusing care, requiring workers to switch up assignments at the risk of physical injury from the resident.

Additionally, workers may risk more than physical injury when residents/family members refuse their care. A PSW who is black and male expressed to us just how precarious his position was with regard to family members refusing to allow him to care for residents:

PSW14: They don't understand. Just me a man in morning team this is problem, all this problem. Not only me this problem but I need protection because is very, very problem to be man to work here. Two, three man is good but alone everything problem. Sometime you give care but you don't feel good, you know. They think you, suspect you to do something.

[Interview 8: 4-5]

This PSW's experiences suggest that workers' efforts to rearrange the assigned care workload may not only be a matter of protecting workers from physical harm when residents refuse care, but also out of a need to protect their jobs, as family members are more “suspicious” of men performing hands-on bodily care than women. Suspicion of male care workers can be explained by the long-standing association of care work with “women's work”, such that care is understood to be a product of the natural capacity of women rather than acquired skills (Armstrong, 2013). To manage this risk of being perceived as suspicious, workers will rearrange bathing care for residents who refuse male PSWs. Another male PSW similarly explained to us that, as a man, he has to be very careful in performing bathing work, as well as respecting residents' refusal of his care:

PSW10: The way you are going to work with some men they might don't want you. You should learn how to do this. The way you approach a woman it's not the same how you are going to approach the men, you know. The way you are going to give a woman a bath not the same way you are going to give a man a bath.

I: What's the difference?

PSW10: It's very simple, you know. When you are going to touch a woman, you know, you should be careful, you know. The woman might say you touch her too sensitive, you know. You know what I mean.

I: Yeah.

PSW10: But you have to know how. Even I explain to you, you can use that conversation, you know, to teach people but when you are in the field it's different. When you have a man you can do a tub bath. Naked you give him a bath, you know. You should study how to touch private parts, you know, and then put soap over. You have to be careful to do it in the right way.

I: So you would have to be showing people.

PSW10: Exactly. Some people alert, okay? When you come to private parts you ask that person 'Can you wipe her private?' That's it. If that person, you know, got some sickness he can't, okay?, you ask that person first, okay? You are going to wash his privates, okay? Very simple. Very simple. That's it. If you do it the right way, that's it. You're free. You have no problem.

I: Is it men your residents here that refuse men?

PSW10: Oh yeah. Every day. There is a man here who refuse me, you know. But this is the job, you know. This is the job. You have to respect that person. He can make any decision he want, you know. That's nothing wrong, you know. There's a woman who don't want me but they like me. They don't want me to do the private care but they like me, okay? They like me. There is one woman here, no, she don't want any man to do any private care but she called me. She said '[PSW's name], when you come in on my side?' I said 'In the next few days I'll be with you.' But that's a good relationship. That's enough. She said 'No, you can't do that but you can do everything.' You know what I mean?

[Interview 4: 17-18]

Echoing the need for “protection” expressed by PSW14 in the preceding excerpt, PSW10’s experiences suggest the importance of risk management for male PSWs in bathing care. A male worker must be careful in touching a female resident, and careful with male residents to wash them in “the right way”. Communication is also an important part of being careful in this process – but so too is showing “respect” for residents’ refusal of bathing care. These experiences of risk management, combined with the above examples of how race and staffing type also shape informal processes of workload rearranging, point to a number of intersecting factors that shape this process of PSW decision-making. Although very little research has been done on male workers in LTRC settings, there is some evidence to suggest that men are entering care work and other

forms of “non-traditional” labour in response to labour markets changes as areas of male-dominated labour disappear (Bagilhole and Cross, 2006; Lupton, 2006). Migrant men are also entering into the PSW workforce (Hussein et al., 2014), as migrant workers are increasingly recruited to fulfill Canadian demand for direct care labour (Bourgeault et al., 2009). Finally, restructuring care labour in response to neoliberal funding cuts has resulted in the increasing casualization of care work, with an emphasis on part-time and casual positions to create a “flexible” workforce (Coyle, 2005; Grinspun, 2008). While drawing on sources of readily available, cheaper, and flexible labour is positioned as a “solution” to the Global North’s long-term care workforce issues, these patterns expose workers to a workplace context that is fraught with racism, gendered notions of care, and hiring practices that foster worker discontinuity. Working at the intersection of these broader patterns in LTRC, PSWs’ decisions to rearrange the assigned bathing workload are thus a strategy for managing the risks associated with their precarious employment. Furthermore, PSWs’ decisions about how to rearrange their bathing workload in response to this context is neither captured in records of bath assignments, nor in official data on staffing levels and care hours – and as such are a part of the invisible labour of PSWs’ direct care work (Armstrong et al., 2008).

#### *Supervision and an Emphasis on Task Completion*

Finally, talking with PSWs about their bathing experiences reveals how the decisions involved in this work take place within a particular supervisory context that emphasizes the completion of tasks in accordance with a set protocol as top priority. Alongside the workload pressures caused by both changing regulatory requirements as well as informal patterns of workload rearranging, PSWs are under pressure from

supervisors to both prioritize the “essential” bathing care outlined in regulatory requirements, as well as to provide baths in ways that fit with the assigned care plan. For instance, in conducting an observation shift at Riverside Home, one of our research team members spoke with a PSW who recounted an experience of being reprimanded for washing “too much” of a resident when giving a bed bath:

I recognized a PSW from the unit as I was walking out of the building, and I approached her to see if she would be interested in participating in an interview, and explained the research objective. She very frankly stated that I would not want her input because her nursing is not the same as today’s nursing. She told me that she trained with the nuns and was 30 years at [Riverside Hospital], and it is not the same anymore. I can see the pain and anger in her eyes. She repeated that I wouldn’t want her opinion because her nursing is not my nursing. She explained that things are changing too fast. It’s not about the person anymore. Everything is rushed. Care is NOT about tick, tick, tick (as she makes a check mark motion with her one arm in the air). And they spend all of their time checking boxes. She said, “Do you know what? I got in trouble for washing too much of a person in bed” by someone in charge. She told me that she looked the person in the eyes and said, “Which part would you like me to wash?” (with tears and anger in her eyes as she is telling me this) to which the person who was reprimanding did not respond. She described the small square they are given to wash a person in bed now, and years ago they were able to ‘drape’ the person with a sheet to cover them up during a bed bath. She said that she used to be able to sit on the residents’ beds and talk with them. She said, “this is not their home”, but rather a ‘home’ with limitations that are caused by policies and regulations that stop it from being their ‘home’.

[Field notes 10e: 2]

The PSW’s reference to care being about “checking boxes” refers to the residents’ charts that must be filled in to indicate whether bathing and other tasks were completed – which, as we saw in our observations, literally consist of a column of check-mark boxes to indicate completion of bathing care, with only one-word descriptions to indicate *how* this care was done (i.e. self-care vs. assistance given) [Field notes 12a: 3]. In being reprimanded for washing “too much” of a resident, this PSW’s experience reveals there is an underling expectation that workers will work in ways that prioritize the completion of essential bathing tasks and be complicit in streamlining bathing care – in other words, the completion of care (i.e. bathing) is emphasized over *how* that care is provided. Similarly, other PSWs noted for us that supervisors will also “push” PSWs to complete a resident’s

prescribed bathing routine even when an alternative strategy would better suit that resident's mood, hindering PSWs' abilities to make decisions about how best to perform bathing care:

- I: So are there any areas where you think, um, you should be able to be involved in making the decision and aren't? Anyplace where you think 'How come they didn't ask me about that?' or 'How come I can't decide when to do that?'
- PSW13: Yeah, maybe like at a certain point. I mean what kind of care you give them I mean we could decide because it's us that we give the care to the patient.
- PSW14: Who to do bath or CBB [complete bed bath].
- PSW13: Yeah, because sometimes the RPN you've got to tell them 'Hey listen. This person there. She's sleepy or agitated.' And it's the bath. You have to put them in the tub bath. So me I don't ask anymore. I go by my judgement. If I see the person is agitated, sleepy, it's a CBB. I don't say anything anymore because then they push. They push. 'No, sorry. You have to give a bath.'
- I: Because that's what you're... Yeah.
- PSW13: So me, no. I don't work that way.
- I: It makes me think of all these new regulations they brought in, right? On baths and feeding and everything. Does that make a difference to your work and how much you can decide?
- PSW13: Yeah. That's not right, you know. No. That's the Ministry, eh? Like I mean they're not here, eh? They don't know how we work and what kind of work we do. Them, they're just writing down. I would love they come here and just see us go, what we do, you know. Maybe they would change things, you know.
- I: Or maybe they would have to be a resident. [laughter]
- PSW13: Yeah, see how it goes and see if when you're sleeping if they like that putting them in the bath tub, you know. You have to be human too, eh? And have a heart there. Come on.

[Interview 8: 9-10]

PSW13 has to avoid communicating with supervisors in order to make her own decisions about what type of bath to give. If a resident is sleepy or agitated, a bed bath may be far preferable to the lengthy, labour-intensive process of transferring the resident for a tub bath. This would not only be kinder to the resident, as this PSW suggests (allowing the worker to "have a heart" in performing care), but also safer for workers as well in allowing them to avoid escalating resident aggression. However, supervisors insist that PSWs follow the assigned bathing method rather than allowing PSWs to decide the types of baths on a case-by-case basis. The above experiences with bathing and supervisors thus reveal how PSWs are working within a supervisory context that compounds

regulatory constraints by emphasizing the completion of tasks and adherence to the parameters of a predetermined care plan.

*Summary: Decision-Making in Bathing/Grooming Care*

PSWs' experiences with bathing and grooming illuminates how workers' decision-making processes are shaped by and in response to a number of intersecting processes, raising themes that both overlap with and differ from those raised in an examination of feeding and mealtimes. There is no set schedule for when bathing has to happen, but as with meals and feeding, time is nonetheless a major issue in bathing work. Due to a mismatch between time and workload, PSWs make decisions about prioritizing completion of their daily bath assignments over grooming and chatting with residents. These findings are comparable to others (Armstrong and Daly, 2004; Armstrong et al., 2009) who have reported that time-constrained and short-staffed direct care workers are most likely to skip tasks seen as less "essential" to resident care in order to focus on meeting the basic bodily needs of residents. As the experiences of PSWs at Riverside Home suggest, these processes of streamlining care are not solely a product of the failure to provide sufficient staffing levels, but are additionally the direct result of regulatory shifts that double the workload without similarly enhancing worker capacity to meet these new requirements. Within this context, workers struggle to find their own ways to fit more baths into the day. Furthermore, workers make daily decisions about rearranging this assigned workload in response to resident and/or family member's resistance on the basis of racism, gendered understandings of care, and worker discontinuity. These experiences thus illustrate how broader patterns of LTRC care that shape the composition of the LTRC workforce additionally expose workers to a precarious work environment in

which their safety and job security may be at risk. Finally, the supervisory context in which bathing work takes place is one that limits PSWs' capacity to decide on the "how" of bathing, emphasizing completion of tasks and adherence to a care plan in which personal support workers do not have input (Kontos et al., 2010a).

### **Toileting and Continence Care**

A third major activity of central importance in PSW interviews and observations is toileting and continence care for residents. In contrast with prior research, it appears that PSWs at Riverside Home have enhanced capacity to make decisions about continence care in terms of responding to residents' needs for diaper changing. Within this context, PSWs articulate how they are able to draw on their own knowledge and experience in the process of decision-making in continence care, rather than having to base decisions on managerial oversight or constrained material supplies. However, despite this ability to make their own decisions about how and when to perform this care for residents, PSWs must also contend with residents' refusal of care based on workers' gender and race. I examine workers' experiences with abuse in performing continence care in order to understand how workers' decision-making takes place amidst the need to care for abusive residents while protecting their precarious jobs.

#### **Where and How does Toileting and Continence Care Happen**

As with bathing, our research team could not directly observe the work processes involved in toileting and continence care. However, we did learn a great deal from workers about their experiences by following them on their "rounds" of residents' rooms, chatting with workers as they moved from one room to another. Although we do not have access to residents' personal records, we learned from PSWs that most of the residents at

Riverside Home are incontinent, and thus rely on diapering. Some residents require assistance with toileting (i.e. transfer to and from the toilet), which is also a PSW responsibility. Unlike feeding and bathing, which are activities that take place during both the day and evening shifts, toileting and continence care take place at any time when a resident requires assistance. However, as a proportion of the total work, continence care makes up the biggest part of night shift workers' activities – indeed one night shift worker told us that changing residents' diapers “is 75 percent” of nighttime work [Interview 9: 2]. Thus nighttime workers' interviews provide the most detailed insights into how this work takes place, alongside some of the challenges that toileting and continence care poses for these workers who, as noted in this chapter's opening discussion on staffing, experience the lowest staffing levels of all the shifts.

*The Capacity to Decide: Shaping Continence Care Based on Knowledge/Experience*

The first main theme that arises in PSWs' experiences with continence care is the relative latitude that workers seem to have in shaping this care work at Riverside Home. To explain this analysis, it is perhaps best to begin by discussing an observation that was universally present in the field notes of each member in our research team upon entering the floors of Riverside Home: the absence of smell. This was quite remarkable to us; despite the majority of residents being incontinent, Riverside Home does not generally smell of urine, nor does it smell of harsh hospital-like chemical cleaners. Indeed, “bad smell” was an observation that appeared only infrequently in our field notes – as an exception rather than the norm. This was often followed by a notation some time later that the smell was gone. We learned that the lack of smell is partly the result of the kinds of supplies that PSWs have to work with: for instance, as one nighttime PSW explained

in setting up his evening routine, having two garbage disposal bags – one on either end of the North and South zones of each of the residence floors – helps workers to avoid spreading around bad smells [Field notes 9b: 12]. Additional conversations also suggest that PSWs’ decision-making plays a central role in this feature of Riverside Home. For instance, a chat with one PSW – a young woman, “E” – on our first evening shift at the residence revealed workers’ strategies for maintaining the environment:

We also talk about the near lack of any smell we noticed during our visit, and how it doesn’t smell like a hospital here at all (this is true, there is no hospital smell at all. There was only a brief stinky smell but the PSW removed it right away, and otherwise there’s been nearly no smell, other than the resident’s nice perfume when she came by!) E says right away that yes, they try very hard to make sure if there’s a smelly diaper to remove it right away; she says that sometimes they will not keep it in the hallway garbage cart but rather will put it in the utility room garbage instead, this is how they try to keep things smelling nice “because they don’t want to be in that, and you don’t want to have to work in that”. [Researcher] says since she’s so busy, she must be so tired after work – that she must feel it in her body. E says that yes she does, she gets tired.

[Field notes 9a: 11]

Despite having a disposal on each end of the hallway zones, workers will also walk soiled diapers to the closed-off garbage room to contain bad smells, although it is more work to have to do so (as there is only one garbage room and it is located in the Central hallway). As PSW “E” notes, this is for the wellbeing of both residents who “don’t want to be in that” as well as workers themselves.

These observations regarding the clean smell of Riverside Home may also be related to the most frequently referenced experience among Riverside Home’s PSWs regarding continence care: workers are not limited to a set number of diapers per day. Diaper rationing was something that our research team specifically asked about, given previous findings from Ontario research that in some long-term care homes, diaper supply rationing is a major problem for direct care workers, requiring workers to devise such strategies as hiding extra supplies from supervisor staff who act as “diaper police”

(Armstrong et al., 2009; Cornish and Pickel, 2007). However, this was not the case at Riverside Home, as the PSW named “E” explained to a member of our research team amidst conducting a diapering round on an evening shift:

[Researcher] asks E about how work is like here; she says what’s great is that she doesn’t have to hide towels here – there are always fresh towels for her, she doesn’t have to hide some to save for the next day, because there will be more when she needs them.

[Researcher] asks about diapers, ever problem getting enough or needing to hide/ration those? E says no it is not a problem, the ward clerk here is very good, understands that people need them, it can’t be helped, if someone needs changing then what can you do?

[Field notes 9a: 11]

Similarly, an interview with two night shift PSWs described workers’ efforts to make sure there are sufficient continence supplies readily at hand for daytime PSWs – and that, interestingly, this task is actually a relatively new one for PSWs to perform, having been reassigned from a duty of floor “orderlies” to being a PSW responsibility:

I: When did it change?

PSW12: The diapers, in the rooms?

I: Yes.

PSW12: We’re the ones who do it now. When we do our rounds, we put five diapers per room for the day shift and the night shift.

I: Yes, but when did this change?

PSW12: Two years ago. Before that it was the orderlies who did everything, who put the diapers in the rooms. Now we do it. When we do our rounds, we make sure there are five in every room. If there are three, we put two more. If there are two, we put three more. We make sure that the next morning, there are five diapers.

[Interview 6: 1]

Later in this same interview, PSW12 further expressed the importance of continence care to providing good care, marking Riverside Home as a place of better quality in comparison to privately-owned residences:

PSW12: Here, it’s better. There are residences where it’s worse. This is really five-star. The residents are respected. They have clean diapers. I have friends who work in residences where before they change the diaper, it really has to be soaked, wet, because it’s private, so they calculate how many diapers are changed per day and you are reprimanded if it is not really wet. Someone who is sitting in acid – urine burns and it’s not funny. Even when we have a little bit of pee in our underwear, it’s uncomfortable.

[Interview 6: 9-10]

These experiences suggest that PSWs at Riverside Home have relative latitude in decisions around continence care, in that they do not have to base the decision to change residents on how wet their diapers are, how many diapers are left for the day (or how many diapers workers have been able to secretly stash), or what consequences there will be for workers in going over a daily diaper limit. We did, however, learn that there is some restriction as to how PSWs can access these supplies: unlike extra linens and towels, which are openly stored in wire racks in the hallways for easy access, diapers are kept in a locked storage room. To access these, PSWs must go through an RPN, who holds the room key. PSWs told us this was “not a problem” and that they could get more when they needed [Field notes 5a: 4]; however, the clear distinction between access to these disposable materials compared to access to linens/towels suggests that control over material resources follows a hierarchical arrangement to some extent. Furthermore, the fact that RPNs are the key-keepers further highlights the division of labour between PSWs’ work and that of registered staff, with RPNs acting in the managerial role of overseeing the supplies that PSWs require to perform continence care.

Despite this hierarchical access to supplies, the relative freedom that PSWs have to perform continence care unrestricted from having to ration supplies invites a closer look at PSW decision-making around how to perform the work of continence care. Night shift workers spoke of their own strategies for deciding who to change and when – not on the basis of whose diapers are most wet or how many supplies are left, but rather on the basis of workers’ knowledge of the residents. One night shift PSW explained to us that his strategy for performing continence care at night involves assessing how residents are

sleeping, arranging the work of diaper-changing according to when residents are awake so as not to disturb them:

- PSW15: I think night time [unheard] is to change diaper, you know, because they're sleeping. You have to keep them dry, you know, because this is the job. Change diaper is 75 percent night time.
- I: You said that you talk to them so you're talking through the night when they're awake? You know, they wake up and you're in there chatting?
- PSW15: Yeah, because is a human being. You're dealing with a human being, you know. You didn't come like that, you come in [unheard] like this. You have to say 'Good morning', you know. [Unheard]. You try to do something at least to make patient feel comfortable, you know. Me, I talk to them, you know. [Unheard]. If I see the patient is in a deep sleep, you know, so I said 'Okay, leave the person now for later.' Five o'clock, five thirty, six o'clock is still sleeping, I say 'Okay at seven o'clock [unheard].' This is my way. That way I deal with it.
- I: So you have some kind of flexibility in your work? Do you have flexibility in your work so you can decide when to do...
- PSW15: Yeah, I decide because you know why? Because even I make a plan because I suppose to change everybody but nobody said to me 'You have to change this one first.' No, no. I decide. So the person is sleeping well, why disturb the person for at five o'clock? This is the way I work.
- I: Good point.
- PSW15: Yes. Me, I go there, I go there, I look at the way. I see anybody up. This is the way I working.
- I: And you know the residents so you know how they are.
- PSW15: I know everybody here. Seven years I work with them every day, every day, every night.

[Interview 9: 2-3]

PSW15's assigned job is to "change everybody", but he has flexibility in terms of whose diaper to change when, allowing him to wait for a more opportune time to change the resident in order to avoid waking them unnecessarily. As a long-term, full-time employee he is also able to draw on his extensive knowledge of residents and chats with them to make them feel comfortable as he goes about his work – a strategy that may be particularly important given the resistance that male workers often face in providing continence care for residents (as will be discussed in greater detail below). This experience of drawing on personal knowledge of residents was similarly echoed by another night shift PSW, who explained that he and his fellow worker on shift organize their work around which residents require more frequent changing. This PSW also

describes continence care as being more complex than simply the “automatic” task of changing a diaper:

I: What is good care?

PSW12: Good care is knowing every resident has particular needs. Usually, when I used to do the day shift, every resident had a book. When I provide you with service, it's not as if I'm serving your colleague, because you have particular needs. Above all, we have to respect the residents, their privacy. When you say good care, it means doing something that will make the person who receives the care happy. There are people who like being powdered, and people who don't. There are people who like having lots of cream put on, and people who don't. You have to know the residents. What will give them pleasure, besides changing their diaper? What comes next? Changing their diaper is automatic. Everyone knows that. You can't leave people sitting in their pee and poop, but good care is care that meets the needs of the residents, and that's what I do: meet the residents' needs. That's what's important. The person – not all of them, because they are not all in their right mind – did the person like what I did?

I: In the evening, is it possible to know the particular needs?

PSW12: Yes. In this room, I know. But someone who doesn't know that this woman does not like to be turned on her left side, only on her right side, will turn her on her left. And she'll cry. I know from experience. We know that this one will ring at 2 a.m. for Tylenol. I know that it's Mr. Y who wants X.

I: Do the PSWs communicate with each other about preferences?

PSW12: We know. We talk to each other. We know that this one has to be changed at 11. When we do our rounds, we don't change everyone. We know who is dry and who urinates a lot. At that time, we change and at night, we turn them again and check the underwear. We might change them three times in a night because we know it's someone who evacuates a lot. That's how we get to know the residents.

[Interview 6:8]

PSW12's experience of continence care is that it is work that involves more than just the “automatic” task of changing diapers, but also chatting with residents and getting to know residents' preferences. By getting to know residents better, PSWs also know which residents need changing more often than others, and are thus able to organize their work accordingly. In this way, drawing on their personal knowledge of residents via prolonged experience in caring for them is important to PSWs in order to make decisions that keep residents comfortable and happy, and to give “good care”. These experiences contrast markedly with those of day/evening shift PSWs in bathing work, who regretted their inability to chat with residents and groom them. This contrast may be reflecting differences between the day and night workers in terms of time and workload – especially

given the informal patterns of rearranging and doubling-up that occur for some PSWs in bathing residents. Thus, it may be important to understand how these differences are not inherent to differences in the task itself (continence care versus bathing), but rather differences between the day and night shifts. In any case, what is clearly important for these night workers is that they perform continence care in ways that support a social model of care, as developing a relationship with the resident is central to their decision-making process in this activity.

*Vulnerable Workers: Race, Gender, and Nighttime Continence Care*

Despite PSWs' relative latitude in being able to shape the work of continence care in terms of when and how to change residents, workers also explained to us that this activity is more complex for some PSWs due to resident refusals of care. As with workers' experiences with bathing, residents frequently resist continence care based on workers' gender and race. However, while bathing takes place during shifts when there are many more PSWs available to rearrange the workload, continence care takes place 24 hours a day, with night shift workers facing the unique problem of being potentially the only PSW on the unit. When they cannot rearrange the care, what do PSWs do? In interviews with night shift PSWs, strikingly similar issues arose with regard to resident refusal of care. Workers tended to minimize residents' expressions of racism in order to carry on with performing the necessary care, while refusal of care based on PSW gender led to workers having to either seek out a female co-worker to take over (much like the re-arranging care of daytime bathing) or else leave the work for the day shift. For instance, PSW12 (who works together with another male PSW as a night shift team) explained to us in an interview how racism and refusal of care shapes his experiences as a

black man performing mostly continence care at night, and the strategies he uses for dealing with verbal and physical abuse from residents:

I: And is your work valued?

PSW12: I think so. It is the work that I do. I do what I'm doing, and over the years, I have acquired experience. I know exactly what I want to do. I know how I will provide the care I give. I don't have someone behind me explaining how I should do it. And [unheard] a very difficult job, very demanding. And sometimes we run into cases where we are insulted. Sometimes we are also beaten by the residents.

I: The residents insult you at night?

PSW12: Yes.

I: What kind of insults?

PSW12: They might say "Dirty Black," racist insults, like "don't touch me." They don't want to be washed. They don't want us to help them. We know they're sick. I don't take it personally. They might say it to me the way they would say it to anyone. I don't think of it as an insult to me personally. It's part of the job. And you know, generally, the residents we are taking care of today, they're people who were born at a time when they didn't have a lot of contact with Blacks. They're people who might never have had any contact with Blacks in their life, who never had Black friends, who never went to school with Blacks, never worked with Blacks. And when they get to a certain age, it's a culture shock, too. They have trouble accepting care from a Black person. They're not used to it. And there are some who are racist, too. It's culture shock. Baby-boomers, you know? At that time, there were no Blacks. Today there are Blacks at school, at work, everywhere. There are lots of Blacks now. There didn't used to be.

I: I was talking to the other employees here and they were talking about making jokes. For you, your strategy is to ignore it?

PSW12: Yes, I ignore it. I never take it personally. And when I leave here, I forget about it. I even forget what happens with the residents. When someone has Alzheimer's or dementia, they don't have the ability to think or say "okay, should I insult someone or not." We say they're not in the right minds. And when that's the case, I don't take it personally. That's [unheard]. There are also people who are angry, who find themselves in a condition they don't want to be in, who want to be washed and dressed. Sometimes they're angry, because of their ego. And they can turn that on us, you know what I mean? Like you, [unheard] we have young people too. We don't just have seniors. People who have been in accidents...[unheard] having your underpants changed by someone you don't know. Your self-esteem is threatened, do you see? We have cases like that. And sometimes, it's... They turn that on us. Sometimes it is the PSWs, because the PSWs are the first to come. The nurse comes after. We're really the front line. Between the resident, the nursing assistant and the nurse.

I: Yes. Do some people say things because you are a man?

PSW12: Yes. Some don't want to be changed by a man. I always tell myself that in their day, they might have had just one boyfriend their entire life. They think a man should take care of a man. They were too modest. It's not like young girls in our day, with their mini-skirts, who are half undressed. They were too educated, too modest, practicing Catholics. They believe in keeping their body private. And there, suddenly, someone you don't even know is going to see your body. No. Sometimes they don't like it. They refuse. They don't want to be cared for by a man.

I: But you are both men, at night...

PSW12: We go look for a woman downstairs, if there is one. Or we [unheard] the file for the day shift.

I: The day shift looks after it?  
PSW12: Yes.

[Interview 6: 2-3]

For this night shift worker, physical and verbal abuse from residents is rationalized as a “part of the job”, while racist insults are minimized as the product of residents’ sickness, age, or threatened self-esteem rather than expressions of racism. Refusal to accept care from a black worker is not named as racism, but rather as a product of “culture shock” or residents not being in their “right minds” – a strategy which allows PSWs to not take the insults personally. As Berdes and Eckert (2001) have argued, the decision to discount or minimize residents’ racism may be a way for personal support workers to maintain an “attitude of caring” towards abusive residents, creating a sense of distance between carer and cared-for in order to perform the care that residents need. The division of labour in long-term care is of further importance to attend to in workers’ experiences, as PSWs contextualize their use of this strategy on the “front lines” in providing continence care. Responsible for responding to residents’ bodily care needs, PSWs are the ones who see the resident first and are the first targets for resident abuse. These experiences exemplify the violence that personal support workers frequently report as being a central feature of long-term care work (Banerjee, 2010; Banerjee et al., 2008; Daly et al., 2011).

Furthermore, recalling the workload rearranging strategies of the previous bathing section, these workers similarly try to find a female co-worker when residents refuse care from them as men. However, given there may only be one or two PSWs available at night, rearranging the work may not be an option; instead, workers may shuffle the care between shifts. This strategy was similarly used by the other night shift PSW, who additionally explained for us the precautions he has to take around resident refusals by documenting that he did *try* to perform this care:

I: What would you do if a resident refused to get help from you because you are a man and you are two males that work? It's the nurse that's going in and help that patient? How do you do it?

PSW15: Mostly [unheard] one person. When one person doesn't want that what I can do if there is somebody upstairs I can call, come down, I going up.

I: Oh, so you switch.

PSW15: I do this one, you do this one. [unheard] [Cognitive-impairment unit]. I said okay 'Mrs. So-and-So...' I don't want to put nobody's name, you know, I said 'Okay, Mrs. So-and-So [unheard]. The only thing I do if it's something I can't do for you like [unheard] or something, waiting for day time [unheard] seven o'clock, I can tell them to start you first because you are wet.' If I see really the bed really need to change, really wet, I say to So-and-So 'I'm sorry. I can't leave you in that situation now because that situation can make you sick.' You know. It can make you sick. I can't leave the situation for all night, you know, like in the swimming pool, like that. I said 'No, you couldn't stay like that.' If some person said 'No, I don't want male, I just need only woman.' I say 'Okay, fine.' Because he has the right to refuse your care.

I: So you respect that.

PSW15: You have to respect that. You have to respect that. That's [unheard]. But I make sure the nurse to write it down for me.

I: Yes.

PSW15: She refuse completely, you know.

I: And then that way you've let everybody know.

PSW15: That's right. That's right. And the next shift I have to tell them to do that now because she is wet, you know. But is only one person. One person that I cannot [unheard]. Not everybody.

[Interview 9: 8-9]

This PSW tries to persuade residents who refuse his care by appealing to health concerns, but if this doesn't work he will leave residents for the start of the day shift. However, he will request that day shift workers prioritize the resident who refused his care, and also makes sure that the on-duty nurse records that the resident refused his care. These precautions ensure that the PSW's attempts to provide care are documented as a form of protection against the assumption that he did not do his job. This experience echoes that of the PSW performing snack rounds who had "too much" food left over, subsequently recording why (i.e. residents were not in their rooms for her to feed) in order to avoid the assumption by the next shift's workers that snacks were left undone. As residents sometimes refuse care based on both gender and race, it is possible that racialized, male workers must go to greater lengths to ensure there is recorded evidence of their care work in order to protect their jobs.

Summary: Decision-Making in Continence Care

PSWs' experiences with continence care provide useful insights into some unique aspects of these workers' decision-making processes. In their decisions about handling soiled diapers, PSWs not only maintain a more pleasant environment for residents, but also for their fellow workers at Riverside Home – a finding that was not similarly noted in discussions of feeding or bathing. Workers are given relative latitude to make these decisions, as continence care supplies are not rationed (albeit access to them is through registered nursing staff only). Rather than having to make decisions about changing residents on the basis of material supplies (or, as with bathing, on the basis of workload and time constraints), PSWs instead enact a social model of care in making decisions about meeting residents' needs – chatting with residents and using their knowledge of individual preferences to make them most comfortable. However, as these strategies were expressed by night shift workers, continence care thus also provides an opportunity to understand how decision-making can differ for workers depending on what shift they are working, as night time shifts entail not only differences in tasks, but also potentially differences in workloads. Continence care also reveals the unique challenges of night shift workers: similar to PSWs' experiences with bathing residents, workers deal with resident refusal of care based on gender and race. To cope with residents' verbal and physical abuse, PSWs dismiss racism and refusal of men's care as a product of cognitive disease or age. However, unlike bathing, which takes place during shifts with higher staffing levels, workers performing continence care at night may be all alone, requiring racialized and/or male workers to take special precautions when residents refuse care in order to protect themselves against the assumption that the work was left incomplete.

## **Laundry and Clothing**

Finally, PSWs at Riverside Home spoke of their experiences with dressing residents and their role in the process of meeting residents' laundry and clothing needs. These activities revealed two ways in which the assumptions about care and care work that underlie a market and medical model of care shape PSW decision-making. First, the differences between PSWs' strategies for getting laundry sorting done reveal market model assumptions that workers will simply find a way to fit additional tasks into their day, reflecting the ways in which the organization of LTRC services under a market model of care rely upon the re-delegation of labour to PSWs as "generic workers". Second, workers' decisions to break the rules in order to make sure residents have sufficient clothing are shaped by the failure of the LTRC system to account for inequality. Ultimately, both of these themes suggest that workers' decision-making processes around laundry and resident clothing are a product of models of care in which the assumptions about care labour and care needs that underlie the LTRC system fail to capture the realities of both care work and the full range of resident care needs.

### **Where and How Does Laundry/Clothing Happen**

Both of the two units of Riverside Home have a small laundry room with two machines each. We observed these facilities being used by some residents to do their own laundry, and also by some family members who prefer to wash their relatives' clothing themselves. Otherwise, all laundry is collected and sent out to large, hospital-based laundry facilities (also owned by Riverside Continuing Care) for cleaning – including all towels and linen/bedding used at Riverside Home. While this means that PSWs do not have to do the residence's laundry themselves, they do have to do the work of sorting

residents' clothing, as it all returns to Riverside Home in large bins and racks. PSWs are then responsible for sorting the clothing by residents' name and room number, and redistributing the clothes to their owners. PSWs also dress residents as a part of their work of assisting residents with everyday activities.

*Carry-Over as a "Solution": Laundry and the Limits of Worker Capacity*

We learned from interviews with PSWs that the work of sorting clean clothing, which we often observed PSWs doing in the hallways during our time at Riverside Home, is one that demonstrates clear differences in work organization between the two units of the home. On the unit for physically-impaired residents, sorting clothing is officially assigned to workers on a shift, but will often be bumped by workers themselves if they do not have the time to do it. As three PSWs explained to us, clothing sorting duty seems to be formally assigned to workers who have fewer bath assignments on a day shift:

- I: So what happens... so you do all of the baths and then you take your break and then you have to get them ready for lunch. What happens then?
- PSW3: Toilet. We have to bring them to the toilet before they come for lunch and then us on [the physical-impairment unit] we're assigned, it depends on the baths that you have. If you have one bath then you are assigned because we've got clothes to put away, we've got the bins, the personal clothes and face cloths.
- I: You mean the clothes that have been cleaned and they're brought back? Is that what you mean?
- PSW3: Yeah. And we have to put them in the room so we're assigned. So that's part of the morning too. And afternoon if you don't have time in the morning, you do it in the afternoon.
- I: Do the clothes get hung in closets or do they also have to be folded?
- PSW1: They have to be sorted by row on a rack.
- I: On the racks.
- PSW1: And distribute to the floor, each room.
- PSW2: But the socks and T-shirts go in their drawers.

[Interview 1: 11]

However, another interview with PSWs from the same floor revealed that the process of having to pass on clothing sorting to the evening shifts caused a great deal of tension

between staff on day and evening shifts – especially as day shift staff feel they have far heavier workloads than evening staff do:

- PSW6: And then if we try to pass some work over to evenings it's a big deal.  
PSW5: And they have more time than we do.  
I: Like it's a big deal from them?  
PSW6: A big deal. Like maybe we sort the clothes and they have to pass it. Oh no. Forget it. It's like a big deal. They'll hem and haw about it and it's like just... So days get the brunt of everything. We have to do everything.  
I: So how could that be changed then?  
PSW6: Share the workload.  
I: So there's some of those things you could do at night like sorting the clothes.  
PSW5: Of course you can.  
I: Distribute the work.  
PSW5: Because on our floor there's a lot of them they're in bed by six, six thirty. You have the odd one that knows enough still at a certain point that they don't want to go to bed at six o'clock. Well that's fine. Then leave them. The rest that are lifts and whatever okay, put them to bed. And then after that what do you do? All those patients are in bed sleeping. They don't ring the bell. They don't know enough to ring the bell.  
PSW6: On [the cognitive-impairment unit], yeah. [It] is quiet.  
PSW5: There's only [name of resident] and a couple of them that know to ring the bell. Other than that nobody rings the bell, you know. So they still have time.  
PSW6: There's a lot of work that can be passed over to evenings.  
PSW7: Sometimes during the days when we change their clothes, you know, and then some other clothes is mixed. That's the big problem for us too. We're getting the clothes. 'Oh this is not for her. This is for the other.' I don't know why that is happening because we sorted out already.  
PSW5: Because there's names on the wall and there's names on the clothes. So why is her clothes down the hall and three doors down?  
PSW6: Well that's people that's part time and they are casual and they get it mixed up.  
PSW5: They're not paying attention.  
PSW7: They're not paying attention but anyway, you know, there is a name in there.  
PSW5: So that's another thing that's put on days.  
I: How does that happen?  
PSW7: Some of the clothes is in there and it's not fit for her so we have to run to the clean utility and find something that they can wear.  
PSW5: You're running for nothing a lot of time.

[Interview 7: 18-19]

PSW6's and PSW7's experiences with sorting laundry reveal that the decision to pass work on to the evening shift is not at all a simple solution to their workload issues, but rather causes tensions between shifts. The work of sorting clothing is furthermore not a straightforward task, as workers have to deal with the mistakes of casual/part-time workers who do not know the residents as well and may make errors in distributing the laundry to residents' rooms. These experiences illustrate that the passing of work

between the shifts in order to informally redistribute the workload can have negative consequences for workers, both those doing the passing and those who are then requested to pick up the leftovers – as a strategy for “making it work”, therefore, there are drawbacks. Contrast this informal rearrangement of the workload with the experiences of PSW5, who works on the cognitive-impairment unit where workers appear to have an agreement between shifts that rather than having clothing work formally assigned to the day shift, it will be left for the evening PSWs to work together on as a team:

PSW5: We all work together. We all sort the clothes together. We sort all the socks together. We leave it for evening.

PSW6: We don't [on the physical-impairment unit].

PSW5: We say 'Hey. Enough is enough. We're not going to sort it and start putting it away now.' You just start doing that and then someone down there wants something. But we work as a team and that kind of helps for the end of the day saying okay, you know, you and the other person you did what you could for the day. We're not machines. We're not robots. Sometimes they expect you to be but I mean come on.

[Interview 7: 20]

While the different approaches to clothing sorting on both units may be reflective of interpersonal differences in working style, the broader issue is that both the decision to informally rearrange work and to work together as a team are a product of the expectation that PSWs will find ways to somehow “fit” laundry sorting into their workload. As PSW5 expresses above, the expectation is that PSWs are “robots” to whom work can be endlessly assigned, without having to build in the necessary supports – thus leaving workers to find their own ways to manage. In this sense, workers get to decide how to deal with laundry themselves: there are no formal rules as to how laundry sorting is to take place, hence the different approaches between the two floors. However, this capacity to decide can itself be situated within the assumptions underlying the organization of PSWs' care work. Under the cost-cutting measures of a market model of care, LTRC services such as laundry are increasingly removed to large, offsite facilities to reduce the

costs of having an on-site laundry service (Armstrong et al., 2008). This means that when laundry returns to the residence, there are no designated laundry workers available to take on the work of sorting and distribution. As unregulated direct care workers who are lowest on the work organization hierarchy, PSWs occupy the position of “generic worker” to whom the workload of such “unskilled” – but crucial – tasks can be re-delegated (Skye, 1995). In this way, laundry sorting becomes yet another obstacle to time and workload management that PSWs must account for in their efforts to manage the daily workload of feeding, bathing, and diapering/toileting residents.

### *Filling the Gaps in Insufficient Care*

PSWs’ experiences with clothing also reveal the ways in which these care workers often perform the role of “filling in the gaps” when care is insufficient. In our time at Riverside Home, we noticed a wide variation in the way residents were dressed in terms of the quality of their clothing. As we found in interviews, PSWs themselves have developed strategies for trying to make sure that residents have enough “good” clothing. PSWs answered the question “what makes you feel bad when you’re done your work day?” by explaining how they broke the rules around clothing in order to ensure that residents were suitably dressed:

- PSW1: You want to dress the patient and they got rag. They don’t have any visitors. So it’s us who try to get some nicer clothes. But you have to run to get these clothes. If you don’t care what the look of your patient you’re going to put the rag. If you don’t want them to look like this you’re going to run. You’re going to spend time.
- I: Are there some extra clothes?
- PSW1: Yeah. We build that.
- I: The staff do?
- PSW1: It’s our store.
- PSW4: And we’re not supposed to do it. A few months back they wouldn’t let us. If someone passed away we would keep the good clothes and we marked them but then they said ‘No, you can’t do that anymore.’ And then that went for a while and now they’re starting again. The ones that were telling us no are the ones doing it.
- I: Why did they tell you not?

- PSW1: [unheard].  
PSW4: Well the marking too. Downstairs didn't want all these clothes coming to them to get the names reworked on them.  
I: I thought maybe some family members complained.  
PSW3: Some does.  
PSW1: We know some family would not put these clothes but some, you know, they don't have any visitors. Nobody there for them. Sometimes you're the only ones taking care of them.

[Interview 1: 27]

Recognizing that some residents simply do not have enough good clothing, PSWs broke the rules around disposing of clothes from deceased residents, building up a store of extra clothes that they could draw on for residents in need. Other PSWs described playing more of an advocacy role in order to get the supplies they need for residents: when asked about problems that family members can pose, PSWs described having to “beg for clothes. We beg for like say a man, a razor. That should come with the man but it doesn't” [Interview 3: 10]. Clothing is not a line item in the funding of long-term residential care: the assumption is that residents will have enough/sufficient clothing to provide for themselves, and if not, that family members will provide for them. This assumption reflects one of the ways that care needs are too narrowly defined under a slimmed-down, market model approach to care (Armstrong and Armstrong, 2010). This model of care fails to recognize inequality between residents, erasing class differences under the assumption that all residents will equally have sufficient resources to meet their care needs. Furthermore, clothing is not “counted” among standardized measurements of residents' care needs, which primarily focus on medical and physiological conditions (Kontos et al., 2010a). However, recall that Riverside Home is itself a not-for-profit residence with the lowest possible accommodation rates; furthermore, we observed only one private-pay personal caregiver at this residence. Many residents at Riverside Home may simply not have the financial means of obtaining good clothing, nor sufficient family

support for ensuring they have enough clothes. PSWs' decisions to break the clothing rules and to advocate on behalf of residents thus fit amidst the "gap" between the assumptions of a medically focused, slimmed-down market model of care versus the realities of resident care needs.

*Summary: Decision-Making in Laundry and Clothing*

PSWs' experiences with laundry and clothing residents thus illustrate the ways in which personal support workers' decisions are shaped by the assumptions about both care work and care needs that underlie the organization of LTRC. First, the assumption that work can be endlessly delegated to PSWs results in workers struggling to fit the task of laundry sorting into their day, shaping a context in which differences in strategies for doing so have emerged between the two units of Riverside Home. Second, the assumption that clothing needs will be met by either the resident or an informal caregiver (family, friends) creates inequalities between residents, resulting in PSWs' decisions to fill the gap by breaking the rules. As others have observed (Baines, 2004), personal support workers are not only the "frontlines" of providing personal care for residents, but are also at the frontlines of filling-in gaps when care needs are too-narrowly defined. Thus while rule breaking has been observed in the context of working around regulations and organizational policy (Bowers and Becker, 1992; Jervis, 2002; Kontos et al., 2010b), the larger context of the LTRC system's failure to meet resident care needs provides an additional lens for understanding this decision.

**Concluding Thoughts**

PSWs' experiences with feeding and mealtimes, bathing/grooming, toileting/continence care, and laundry/clothing provide opportunities for exploring the factors that

shape both workers' capacities to make decisions about care, as well as the decisions that workers do make. PSWs' experiences reveal that the capacity of these care workers to make decisions about shaping resident care is, overall, very narrow. These workers do not have input into the broader structural, organizational or regulatory contexts that affect their workload and working conditions. Staffing levels, the timing of meals, recording and reporting requirements, regulations surrounding the number of baths per week – all of these are decisions that have been made *for* PSWs. However, amidst this narrowed capacity to decide, it is important to examine the decisions that PSWs *do* make throughout the course of their daily/nightly work in order to understand their experiences with direct care work from a feminist political economy perspective. This perspective begins with the assumption that social actors shape their histories, albeit not under conditions of their own choosing (Armstrong, 2001). Using this analytic lens, this chapter has sought to explore PSWs' decision-making processes amidst the broader contextual layers of regulation, restructuring, work organization, and models of care. Furthermore, this chapter has also demonstrated the ways in which PSW decision-making is shaped by both gender and race.

This chapter provides some qualitative insights into the existing survey data on *how* PSWs work. A survey of unionized PSWs working in LTRC facilities in three Canadian provinces (Ontario, Manitoba, and Nova Scotia) found that most workers (73.5%) report being able to affect the daily planning of their work from “sometimes” (49.7%) to “all or most of the time” (23.8%) (Banerjee et al., 2008). My analysis provides a clearer picture as to what these numbers mean in the context of workers' daily/nightly experiences. In “affecting the daily planning” of care, PSWs make decisions about

prioritizing the order of work, speeding up, slowing down, cutting corners, breaking rules, rearranging the workload, and coping with abuse. As this chapter has demonstrated, these decisions are shaped by factors that can be understood beyond merely an individual- or even organizational-level analysis. In the following chapter, I will further explore the ways in which direct care work is shaped by dominant themes in approaches to care, and will discuss the implications of these approaches for understanding care work – and, therefore, the conditions of care.

## **CHAPTER 6**

### **Locating Decision-Making in Approaches to Long-Term Residential Care**

In the previous chapter, I examined personal support workers' experiences with decision-making in four types of care activities at Riverside Home, and analyzed the factors that shape workers' decision-making processes: both in terms of their capacity to make decisions, as well as the form of decisions they make throughout care work. In this sense, the previous chapter "zoomed in" on observations made at Riverside Home and on workers' interviews about their work experiences in order to understand the *meaning of* the previously-explored nested contexts for worker's everyday/everynight decision-making. In this next and final chapter, I now refocus my analytic lens to "zoom out" from workers' experiences in order to further examine the contexts surrounding the decision-making explored in Chapter 5. In so doing, the present chapter brings together the dominant themes that have threaded through the previous three analytic chapters of this thesis: the broader contexts (i.e. the global, national, and provincial contexts explored in Chapter 3), site-specific contexts (i.e. the specificities of Riverside Home explored in Chapter 4), and on-the-ground experiences (i.e. processes of decision-making explored in Chapter 5). Now that we have a better understanding of PSWs' capacity to make decisions and the factors that shape the everyday/everynight decisions they do make, this chapter aims to locate these decision-making processes amidst the broader practices, policies and patterns that shape the experience of LTRC work.

In this locating analysis, three dominant themes emerge in the form of wider approaches to long-term residential care that, I argue, are crucial contexts for my case study of care worker decision-making. These approaches to LTRC in Ontario (and

Canada, and beyond) are important to consider as contexts for workers' decision-making, as they not only help us to understand the significance of workers' decisions beyond an individual or organizational-level analysis (as is the goal of my feminist political economy framework), but also the important implications for the wellbeing of both workers *and* the residents they care for. Using workers' decision-making experiences at Riverside Home as a starting point, I will explore the ways in which these processes are located within a specific LTRC context that:

- 1) is increasingly clinical, and increasingly (re)organized according to market logic;
- 2) suffers from incomplete implementation of "person-centred" care philosophies; and
- 3) is characterized by an enhanced emphasis on accountability.

I will first begin by examining how workers' experiences at Riverside Home are shaped within an LTRC system that has been (and continues to be) (re)-organized by medical and market models of care, and what this means for care worker decision-making amidst too-narrow definitions of care needs and insufficient supports and resources to adequately care. Second, I will examine the tensions that arise for care workers making decisions in the absence of sufficient supports and resources to sustain individualized, "person-centred" approaches to care – particularly when care workers themselves are not supported in "person-centred" ways. Finally, I will discuss the implications that an increasing emphasis on accountability has for decision-making, reinforcing hierarchical arrangements of care work under new strategies for recording evidence of care.

Ultimately this chapter broadens the focus of my analysis of PSW decision-making in

order to examine how the decision-making process takes place within an LTRC context in which care and care needs are too narrowly defined, to the detriment of both workers' and residents' wellbeing.

### **The Increasingly Clinical and Market-Driven Meaning of “Care” in LTRC**

The purpose of my study of personal support workers at Riverside Home has been to understand PSWs' decision-making processes in their experiences of “making it work” – with “it” being the daily/nightly work of long-term residential care. However, examining the form of this care work reveals an important problem for these workers: the ways in which the “care” involved in LTRC work increasingly refers to a clinical, physiologically-focused understanding of care needs, to the exclusion of a social, relational model of care. This focus has numerous implications for PSWs in shaping work activities, work organization, and, subsequently, workers' decision-making throughout their daily/nightly experiences of caring for residents.

#### *A Medical Approach to Care: Too-Narrow Definitions of Need*

This clinical focus has been evident throughout my examination of PSWs' direct care work at Riverside Home. For instance, as explored in Chapter 5, PSWs make decisions about care amidst the need to track residents' liquid and food intake and whether/how a bath was given, and so on, exemplifying the “medical dominance” of direct care worker activities (Diamond, 1990: 175). Intended to enhance accountability, these records contain only physical indicators that “care” has been completed and that the PSW has done his or her job – rendering invisible the social processes involved in feeding, bathing, and so on. In Chapter 4, I explored the role descriptions of PSWs at Riverside Home, finding evidence that the direct care work of PSWs is understood

primarily as a task-oriented and medicalized process of bodily management and treatment (Cancian, 2000). The influence of a medical model approach to care is further evident in the reporting practices of Riverside Home. For instance, we observed each PSW shift beginning with a report between the on-coming RN and PSWs, and this report was entirely focused on residents' physical states: details on bowel movements, illness progression, complaints of pain, and so on [Field notes 9a: 15]. Indeed as the following field note excerpt illustrates, resident wellbeing has come to be defined as the absence of (or at least, stability in) a physiological problem. We observed an outgoing RN reporting to the oncoming RN, who then reported to the PSWs who were joining her on this oncoming shift:

It was a most cursory report – concentrating almost exclusively on clinical issues (e.g. bowels, fever, level of agitation). There was little to differentiate the report here – in a nursing home – from those given in an acute care hospital (on a medical floor). Not very much personal/historical information in context that would reflect that this is their home rather than a “hospital stay”. Following the RN to RN report, the incoming RN then “gives report” to the others [PSWs] – again, generally one-sided, brief ‘tour’ of any major clinical events. Mostly, residents were described as “fine”.

[Field notes 6b: 7]

As we observed in the shift change-over reports, a resident being “fine” refers to an absence of physical complaint or illness. Resident wellbeing holds a strictly medical meaning, with other dimensions (i.e. mental, emotional) going unrecorded and unreported – or, when they are mentioned, they are given clinical interpretations such as “level of agitation” noted above. This further means that PSWs are prepared for their shift only with knowledge about the physical wellbeing of the residents they care for, leaving the workers to discover for themselves *why* a resident may be angry, sad or confused – information that can be important to the job of approaching the resident for personal care, as well as for workers in protecting themselves against resident aggression.

As others have argued (Bowers et al., 2001; Diamond, 1986, 1992; Foner, 1994; Goodwin, 1996; Kontos et al., 2010a; McGilton, 2002; McGilton and Boscart, 2007; Weinberg, 2006), and as the analysis of workers' decision-making in Chapter 5 has suggested, direct care work requires a great deal of relational labour, and as such it is central to the wellbeing of residents. However, it is clear that this aspect of direct care work is not being captured in the medicalized notions of care underlying the recording, reporting and job descriptions of PSWs at Riverside Home – rendering the complexities of direct care work invisible. As Albert Banerjee (2010) has noted, a failure to capture the complexities of what is involved in “frontline” care work contributes to a failure to provide adequate resources and supports – a failure that PSWs at Riverside Home feel all-too keenly. For instance, when asked about how heavy the workload is, one PSW revealed to us particularly bluntly that he felt that his job was comparable to a battle ground, the enemy being *time*:

PSW10: That's your war. You are at war. You have to beat the time.  
[Interview 4: 6]

Another worker explained to us the impact that this “war” has on her physical wellbeing at the end of the day:

PSW3: You run all day. You're so damn... by the time you drove your car in the afternoon, you know, it take everything to go back home because you feel like you're going to fall asleep because you give everything. Everything. You need to be in shape to work here.  
[Interview 1: 9-10]

Furthermore, the medical model of care places emphasis on the physical wellbeing of residents as the primary goal of PSWs daily/nightly care work. For instance, PSWs' decisions to skip chatting with or grooming of residents take place amidst a context in which the physical task of merely “getting done” has been prioritized as the most important element in bathing care. There is no clinical measurement for the intangible

aspects of quality in one's bath experience; instead, "quality" bathing care takes on the meaning of a certain number of baths per resident, per week, delivered in the manner prescribed by a resident's care plan. These are decisions about bathing care requirements that PSWs have had no part in shaping, and yet in everyday experience they must make numerous decisions in time management, workload re-arranging and corner-cutting in order to carry out these requirements.

These findings are similar to those reported elsewhere in the literature on LTRC in Ontario. As Armstrong et al. (2009) found in their survey of all types of direct care workers (RNs, RPNs, and PSWs), a major concern reported was inadequate time to perform even essential care tasks, like feeding and bathing residents. The theme of insufficient time was also echoed in Banerjee et al.'s (2008) report on PSW-specific experiences across three Canadian provinces, including Ontario. Furthermore, the Armstrong et al. (2009) study found that the social and emotional care that is just as essential (albeit unrecognized) to the wellbeing of LTRC residents is the first thing that workers will decide to skip in order to get through their workload. In the absence of social and emotional care, LTRC work increasingly resembles what the authors call "assembly line care" (Armstrong et al., 2009: 109), such that care work increasingly resembles a task-oriented, physical processing of residents rather than a relationship. However, in invoking this "assembly line" imagery, it is further useful to consider the implications of a *market model* of care alongside the medical model: that is, the reorganization of LTRC according to market logic.

*The Market Model: Caring Amidst Cuts*

As Laniox (2011) has argued, “assembly line care” is only in part contextualized by the medical model. While the medical model limits the definition of care needs (and subsequently the understanding of what supports and resources workers need to adequately provide care), another context to consider is the way in which LTRC is shaped by the market model. Medicalized care is a series of physical tasks to be parceled out into discrete, quantifiable activities throughout the day, and market logic further deigns that these activities can be measured, monitored, and ultimately streamlined for maximum efficiency. Numerous others (Armstrong and Armstrong, 2010; Baines et al., 1992; Daly et al., 2000; Fuller, 1998; Williams et al., 2001) have noted that this market logic has increasingly been of influence in the restructuring of Canadian health care in general, and, as explored earlier in the provincial-level analysis of Chapter 3, has had numerous implications for Ontario LTRC specifically in the form of encroaching privatization, outsourcing, cost-cutting, and funding cuts.

The implications of an increasingly medical and market model in LTRC are quite serious for both worker and resident wellbeing. As explored in Chapter 5, workers frequently expressed the difficulties and frustrations that arise when there are insufficient resources and inadequate work organization to support the social, relational aspects of care. Yet getting to know residents by talking with them and spending time with them are crucial to being able to perform care appropriately – in other words, the relational aspects of care work are necessary in order to make decisions about how to care for residents. This disparity between the resources that workers had and the resources they felt they needed to adequately perform care highlights the specificity of care work. Care work is a

form of commodified labour that also involves intangible relational elements. As one PSW explained to us, the work of providing care is far more than the processing of bodies: it is relational care and as such it is also a type of work that requires sufficient resources to sustain as a social process:

PSW12: If I was the boss, I would start by adding someone else here, adding a PSW. Why? **Because we're working with human beings, people, not chairs or bags of potatoes. The more resources there are, the better the care.** When there are three of us doing the work, there is time to stop, to look, to put on some lotion, to talk, to leave. When there are just two of us doing the work, when you get someone who has wet everything, spread stool everywhere in a room, instead of 5 or 10 minutes, you spend 30 and there are other residents waiting for you and you know you finish at 7:30. Sometimes it's a rush. And when it's a rush, it's a real rush. But if there are three of you, it's less of a rush.  
[Interview 6: 6 – emphasis added]

As this PSW notes, direct care work is about people and not “bags of potatoes” – residents are not inanimate objects, and as such caring for them cannot be understood in purely physical terms. Care work requires more than just tending to a resident's body, it also requires observation, talking, and most of all, time. As this PSW notes, care work is thus also impossible to standardize, to measure out into preordained and finite units, and to distribute in a formulaic way. Instead, the time one needs to care for a resident will vary and will also impact the time that workers will have to care for other residents. Ultimately the worker's point that “the more resources there are, the better the care” highlights the need for sufficient *human* resources to provide care in ways that reflect the realities of what “care” actually entails: stopping, looking, talking, *and* tending to residents as human beings.

Riverside Home is not a for-profit care facility, and thus managerial decisions are not motivated by profit-seeking mandates. However, as it is embedded in the broader Ontario LTRC context, Riverside Home is nonetheless keen to maximize “efficiencies” due to the processes of provincial health care restructuring and funding cuts explored in

Chapter 3. As noted in Chapter 4, Riverside Continuing Care has recently undergone mass layoffs of direct care staff in response to funding constraints – including laying off PSWs. At the time of our research, workers were acutely aware that these cuts were imminent, and that the direct care of PSWs would likely be the area which would be targeted for cost-cutting. We also found that PSWs were concerned with the meaning of these cuts for the quality of resident care, as cuts would only further contribute to an already too-thinly stretched level of direct care. When we asked about what was happening at Riverside Home, workers told us about what these cuts meant for their work now, and the difficulties that would affect both workers *and* residents in the future:

PSW5: We're getting cut here, cut there, cut there and everybody is getting frustrated because we're having to pick up and we'll be the first ones to be booted out the door, the ones that are working and trying to pick up and trying to make things better for the residents because ultimately they're the ones that are going to suffer out of this. Like all the cuts and everything that's going on right now, they're the ones that's going to suffer because they're not going to get the care that they're supposed to. They're going to have bed sores. They're going to be wet in their diapers.

PSW6: They're going to get up late.

I: Because they're cutting the people that do that. [laughs]

PSW5: Exactly. They're saving money. So who is going to suffer? It's going to be the residents.

I: [Unheard] cut you because they're cutting these other people.

PSW7: Oh it'll affect the residents eventually.

I: You end up having to do the stuff that gets cut, right?

PSW6: Yeah.

PSW5: It's more of a rush. You're rushing and you can't take the time out that you need to take out. I mean we're busy now. Like it's hard to go in and even have a conversation with someone because you're so busy trying to get them up, get them their morning care and stuff done. With the cuts it's going to be... oh, I feel bad for them.

[Interview 7: 44-45]

Workers at Riverside Home are currently scrambling to meet residents' basic physical needs in feeding, continence care, bathing, and clothing – necessitating difficult decisions around prioritizing, saving time, cutting corners, and breaking rules, as Chapter 5 revealed. So what happens, as the workers above note, when the pace is further increased due to cuts, when there are fewer people to perform the care, and fewer resources

available to support the remaining care workers? Publications by unions that represent care workers have warned that LTRC workers in Canada are in dire need of better support for the sake of quality care and worker wellbeing (CUPE, 2009; NUPGE, 2007), and research has demonstrated that this is particularly the case in Ontario (Armstrong and Daly, 2004). In the wake of the removal of provincially-mandated minimum of 2.25 care hours per day, residents in Ontario now receive on average only 2.04 hours of nursing care per day (PriceWaterhouseCoopers, 2001). Driven by a market model approach to care, it is within this wider context of cuts (and the threat of yet more cuts in the future) that personal support workers' decision-making processes must be located.

### **The Ideal of “Person-Centred” Care: Tensions and Contradictions**

A second theme to consider in locating PSWs' decision-making processes is the influence of a “person-centred” approach to long-term residential care. Recall that in Chapter 3, I noted the ways in which Ontario PSWs have had their roles explicitly defined as being to support residents' “expression of preference” (OCSA, 2009a: 3) in daily care, while an emphasis on “client-centred and client-directed” care is evident in mandatory PSW training standards (MTCU, 2004: 2). Chapter 4's analysis of the concept of “good care” at Riverside Home revealed that person-centred care was of central importance in defining the facility's care philosophy. However the question these analyses raised was: how do PSWs put these ideals into practice in their decision-making processes? Where do these ideals fall short? Based on workers' experiences, it is clear that there are numerous problems with implementing a person-centred notion of care, for both residents *and* workers.

### Structural Barriers to Person-Centred Care

Workers' experiences with decision-making in Chapter 5 reveal that supporting residents' individual preferences can be extremely difficult. In some instances, workers struggle to meet residents' preferences, for instance by juggling simultaneous requests for help, or re-arranging work assignments when care is refused by a resident (or by a family member on the resident's behalf). Other times, workers simply cannot attend to residents' preferences, as regulations and work organization make it impossible to do so. These findings echo those of Argyle (2013), who noted that there are often "contextual barriers" to implementing the ideals of person-centred care in practice. However, it is important to realize that these barriers themselves arise within a particular context.

First of all, as discussed above, there are simply too few resources available to always support individual resident preferences. An interview with three PSWs illustrates the problems this can cause for workers when trying to juggle simultaneous requests for getting residents up at their desired times:

- I: So what happens if you know someone needs to get down to the meal helper but they're refusing to get up? What do you do?
- PSW4: Well if they really refuse we leave them.
- PSW1: We don't push them.
- PSW2: Sometimes maybe five minutes after it's going to be okay.
- PSW3: See with [the cognitive-impairment unit and the physical-impairment unit], like we work on [the physical-impairment unit], they work on [the cognitive-impairment unit]. Us we have a different clientele so us there's a lot of people that wants to get up early. It's not like them.
- PSW1: Yeah. Those will choose. The patient will choose. [laughs] They decide when they get up and we follow.
- PSW4: Sometimes they're ringing and they're very upset that you're not there to get them up. That's kind of daily for a few.
- PSW3: And say you don't have a meal helper so you have to start passing your trays so you're behind in your role so the bells just keep on. They get upset and the wheel go around and around.
- I: So what do you do when they're upset?
- PSW3: **Well what can you do, you know? Try to reassure them. 'I'm sorry but we're short and we do what we can, eh?'**

[Interview 1: 5-6; emphasis added]

Although PSWs try to support residents' individual preferences (indeed being told that they *should* do so in both training materials and Riverside Home's philosophy of care), these workers are left feeling helpless when there are simply too few PSWs available to meet simultaneous demands. As the PSWs above note, sometimes the only option workers have for dealing with the dilemma is to reassure upset residents as best they can. This is particularly the case for workers on the physical-impairment unit, where residents are less cognitively impaired and thus have the capacity to more clearly express their preferences (and displeasures when these preferences are not met). This excerpt also illustrates how workers' decision-making is located at the nexus of a particular work organization (i.e. insufficient staffing), regulations (i.e. required to get residents to the dining room for meals) and model of care (i.e. support for resident preferences), requiring the PSW to strategically maneuver in order to get even one aspect of their jobs done: rousing residents for breakfast.

Furthermore, the above-noted strategy of PSWs waiting and trying again in a few minutes to rouse a resistant resident also demonstrates how person-centred care as an ideal can in practice be hindered by rules and requirements, which pose an additional barrier for workers trying to implement person-centred care. For many workers, this was expressed in their difficulties with trying to implement a "home-like" approach to care, which is tied to the ideal of person-centred care and supporting resident preferences (Koren, 2010). For instance, one PSW noted that rules and regulations make this concept of "home" impossible for workers to implement in practice when we asked about whether residents could, say, have a glass of wine with their meals if they wanted to:

PSW5: But lots of times they say 'Well it's their home.' **Well there's a lot of things it's not their home because they're restricted because of Ministry standards or Ministry laws or whatever it is.** So how can you say that that's this

person's home when she's asking for a little glass of wine and the medication is okay so what's the problem?

[Interview 7: 40; emphasis added]

Despite training standards and facility care philosophies that repeatedly reinforce an approach to care that emphasizes residents' choices, the daily reality for PSWs is that some choices simply cannot be supported within the confines of existing rules and regulations. Unless prescribed by a doctor in a resident's care plan, PSWs cannot meet a resident's request for a glass of wine – rendering meaningless the ideal that the facility is the resident's "home".

Not only do rules and regulations present barriers to person-centred approaches to care, but so does restructuring – itself a product of the market model approach discussed above. As Chapter 5 revealed, Riverside Home's meals are now produced off-site, arriving to the residence dining rooms on prepackaged trays. PSWs felt that this change has had an enormous impact on their ability to meet residents' preferences, and that the previous system of having food made on-site and individually portioned out upon request was a more home-like approach:

I: It's interesting that we heard in another interview that it used to be that the food was cooked here and there was the smell of food and that made you more hungry.

PSW13: Yeah, they should do that like that again. Mmhmm.

I: It made a difference did it?

PSW13: Of course. It's their home, you know. It should be like home.

[Interview 8: 10]

Indeed PSWs felt that the tray system is "more like a hospital than a home" [Interview 1: 25] in restricting residents from having choices at meal times – more of something, less of something, or something other than what they ordered off the corporate menu in advance. This is to the detriment of residents, but also has implications for the care

workers whose job it is to get residents to eat (a particularly important concern given the intensive monitoring of food and drink consumed for each resident).

Finally, workers' decision-making in Chapter 5 also raised an important tension in person-centred care for PSWs in terms of what to do when residents (or their family members) refuse care from a worker, often on the basis of a workers' gender (male), race (non-white) or employment status (non-regular, i.e. part-time or casual). When this happens, PSWs rearrange care when they can, informally juggling assignments among workers on shifts – though sometimes there are simply no other PSWs to reassign the work to, particularly on night shifts. Similar to the findings of others (Berdes and Eckert, 2001), PSWs tended to minimize instances of refusal on the basis of race or gender as being a product of old age or illness, and understood honouring residents' refusals of care as an important element in showing “respect” for residents' preferences [Interview 4: 18]. However, there are numerous negative implications for workers in this process: first, care workers are rendered complicit in the reproduction of racist as well as sexist attitudes about who is more “fit” to perform care. Second, it is unclear how sustainable these practices of rearranging the care will be, given broader trends in the LTRC workforce. In the absence of “traditional” labour opportunities, more men are increasingly entering into LTRC work to earn a living (Bagilhole and Cross, 2006; Lupton, 2006). Furthermore, to fill the demand for cheap and flexible labour, Canada increasingly recruits migrant labour to fill shortages in the LTRC workforce (Bourgeault et al., 2009). While many migrant care workers are men from racialized groups (Hussein et al., 2014), the flow of care labour from the global South to the global North is primarily that of non-white migrant women (Eckenwiler, 2012). Finally, part-time, casual and “flexible” labour increasingly

represents a means of cost-saving for LTRC facilities amidst cuts to funding (Armstrong et al., 2008). Given these circumstances, it is likely the case that workers who are the most precariously positioned are under the greatest pressure to “respect” residents’ preferences in who cares for them. In this way, the notion of “person-centred” care may present an additional layer of risk in PSWs’ already risky job of direct care work.

*The Invisible Care Worker: PSWs Missing from Person-Centred Care*

Finally, the notion of person-centredness as an ideal approach to care stands in stark contrast with the reality that personal support workers themselves are not similarly supported in person-centred ways. As Chapter 5’s analysis reveals, PSWs’ capacity to make their own decisions about care is heavily restricted, often relegated solely to informal decisions (e.g. prioritizing, rearranging) or unsanctioned decisions (e.g. rule breaking). As others (Kontos et al., 2010a) have similarly found, the decisions of PSWs are often marginalized within a hierarchical work organization that devalues these care workers’ knowledge and experience. However, from a feminist political economy perspective, it is important to examine how the decisions that workers can and do make are located within a work environment that fails to support not only the job of “make it work”, but also what workers need for their wellbeing as *whole persons*.

One way to investigate how well workers are supported as whole persons is to examine how workers are treated when they are *not* working: i.e., when they are on break. Workers’ rights to breaks are protected by Ontario employment standards, and Riverside Home does provide some space for workers to take their breaks and lunch. However, just because workers are given breaks and space does not mean that either of these provisions is sufficient. For instance, we noticed in our observations at Riverside

Home that there is only one staff break room available between the two floors of the home for workers to use, and it is an extremely small, windowless room with space enough for only two armchairs for seating [Field notes 7d: 1]. There is a locker room for workers to use, but much of the already-small space has been taken up as an ad hoc storage space for wheelchairs, and without dividers there is no possibility for privacy if one is changing clothes [Field notes 7d: 2]. Furthermore, break times can themselves be extremely stressful when workers are in the middle of providing care – it is not work that can easily be dropped in order to take a break at a set time. Three PSWs illustrated how complicated this can be when describing what happens when the time comes for them to be on break:

- PSW5: And sometimes we get stress for our break.  
PSW6: Stuck in the elevator.  
PSW5: We are very busy and then we can't go out exactly on that time, like 11:30.  
I: You have to go at certain times?  
PSW7: We have to go at certain times.  
PSW5: Yeah, and we have to go at twelve o'clock so sometimes, you know, that's what I said, the toileting time. Like we don't have time, 15 minutes, we have to bring the person because she was screaming for toileting. So we don't have enough time to wait for her for 15 minutes because our break is there already.  
PSW6: So sometimes we do get our break and sometimes we don't but most people take their breaks for the most part.  
PSW5: But then it's added for the stress.  
I: It's time that can be a problem.  
PSW5: Well you can work around it. You can tell your partner 'I've got to go. I'm 10 minutes late. I'll be back 10 minutes later.' As long as you...  
PSW7: You communicate with your partner.

[Interview 7: 29-30]

PSW6's comment about being "stuck in the elevator" refers to a problem of both design and insufficient time: Riverside Home is located on two floors of a multi-story building, so leaving the residence itself to go outside for what is only a 15-minute break can be a challenge as workers lose time off their break in having to wait for the elevator.

Furthermore, having to take their breaks at a specific, scheduled time is a challenge given the unpredictable nature of care work: residents' needs do not similarly take a break! As

PSW7 above notes, it is important in these instances to “communicate with your partner”, but this of course requires workers to *have* a partner available to cover one’s break. We also found that lunch times are no better in terms of stress and time constraints. PSWs have 30 minutes for lunch, but many of them have to run to “check” on their car in that time: employee parking is not provided for PSWs at Riverside Home, so workers who drive to work have to move their car during lunch break in order to avoid a parking ticket [Interview 1: 10]. This sometimes requires workers to drive around the surrounding area looking for an open parking space on the street, which can take up nearly all of one’s lunch break [Interview 7: 32]. None of these experiences are the inevitable conditions of care work, but rather are the direct products of insufficient supports for staff, contributing to the stress of their jobs.

In keeping with a feminist political economy approach, we also asked care workers about their lives *outside* of paid care work – what happens when they go home, and how does their paid work life impact the rest of their lives and overall wellbeing? PSWs repeatedly told us that the job is both physically and emotionally draining, and requires them to maintain an artificial separation between work life and home life in order to cope with the stresses of their job. The following excerpt from an interview with two PSWs illustrates this separation starkly, while also exemplifying the sheer levels of exhaustion that workers feel at the end of the day:

- I: So this next question is trying to get at how you feel after work when you go home after a shift. How do you feel? Do you take the day with you?
- PSW8: No, I don’t. No, you have to leave it here. I’m so tired when I get home. I go to bed.
- PSW9: Me, I’m having a hard time. Like I’m driving with my husband at this time of the year and sometimes I say [unheard]. I arrive home. I undress. And he cook and I wake up when he’s calling me for supper. And I go deep sleep.
- I: So that’s pretty tiring.
- PSW8: Tiring!
- I: Yeah, that’s an impact.

- PSW8: On my life. **I've got no life. You got no life. Don't plan on going shopping or whatever. You don't have the strength.** Your legs don't want to go anymore. [laughter]
- PSW9: I go straight home. Me, I have a hard time to stop somewhere. I have to go home.
- I: Are you physically tired or emotionally tired or both?
- PSW8: It's both.
- PSW9: I think it's both will hit us like this. It has to be. I always compare my job to a man on the construction. You know, the man will go home, you know, work in the cold and how tiring it sounds, eh? [laughs] I feel the same. [laughter] But no, me at the beginning of my career I'd say you deal with death and it's such a funny way, world, because **it's not everybody who has to deal with death and you go home and the day continue but you got a young kid at home, you cannot bring the death or the sadness in your face. They don't deserve that.** Your family don't deserve that. So yeah, it seems like you have to change a mask.
- I: So that's what it feels like, a mask?
- PSW9: Mhmm.
- I: Put on a new mask.
- PSW9: For your family, you know.

[Interview 2: 8-9, emphasis added]

In noting that the end of the work day is not the end of her *whole* day, PSW9 describes having to put on a “mask” after work for the sake of her family: a performance of emotional labour to prevent the difficulties she experiences in her work life (i.e. in dealing with residents' death) from spilling over into her home. While this speaks to how deeply workers feel connected to the residents they care for, it also illustrates the difficulties associated with care work and how important it is for workers' wellbeing to feel supported. Additionally, PSW8's experience of having to “leave it here” (i.e. to not take her work home with her emotionally) is a way of coping with the strains and stresses of her job. However, in later saying that she “has no life” due to being too tired to do anything else after work, it is clear that this separation between work and home life is not necessarily successful. This point is further illustrated by PSW1 in the following discussion about how the organization of shift work has impacted her home life:

- I: Do you have a say about your shifts? Which shift you're on?
- PSW1: No.
- PSW2: Straight days.
- I: So it doesn't change really. You don't do weekends?
- PSW2: Oh yes. Every second weekend.

PSW1: We wish that they would take in consideration eventually after a certain time of experience in nursing that we would have an opportunity to Monday to Friday because like, you know, in 29 years of seniority you missed a lot of things, weddings, Christening, baptizing, Christmas, New Years, **you miss so much**. It's part of work but that would be something nice.

[Interview 1: 29, emphasis added]

Similar to PSW8 who felt she had “no life” after her daily shift, PSW1 feels that over her extensive employment as a PSW at Riverside Home she has missed “so much” in her non-work life due to the way shifts are organized. Although this experience is not as obviously stressful as physical exhaustion, it does illustrate the cumulative and emotional effects of restricting workers’ capacities to have input in their work organization – in this instance, how shifts are structured. The above experiences speak to Campbell’s (2013) argument that addressing problematic working conditions must go beyond an examination of staffing levels alone. There is far more to the strain of PSW’s direct care work than merely having too-few hands available to divide up the work: it also depends on how the work is organized.

PSWs’ experiences reveal that, despite a growing emphasis on a “person-centred” approach to care for residents, workers themselves are not similarly supported in person-centred ways. Even in a workplace specifically identified for inclusion in the *Re-Imagining Long-Term Residential Care* project for its commitment to quality care for residents, PSWs at Riverside Home similarly experience problematic working conditions echoed by care workers throughout the LTRC system. Large studies in Ontario (Armstrong and Daly, 2004; OHC, 2008) and across Canada (Armstrong et. al., 2009) have found similar issues with regard to insufficient supports for direct care workers, resulting in high levels of physical and emotional exhaustion. These outcomes are neither inevitable nor inherent to PSWs’ jobs, but rather are the product of the specific contexts in which their direct care work is located.

### **A Growing Emphasis on Accountability in LTRC**

A third and final context that is important to consider in locating personal support worker decision-making is the way in which LTRC work has been shaped by a growing emphasis on accountability. As examined in Chapter 3, this emphasis on accountability in the Ontario LTRC system has taken the form of expanded recording and reporting practices, resulting in expanded documentation tasks for workers to ensure compliance with financial and regulatory standards (Sharkey, 2008). Similar to the findings of others (Armstrong et al., 2009), Chapter 5 revealed that while some documentation is helpful to workers (e.g. in explaining why a resident was not changed, why there was leftover food, etc.), PSWs at Riverside Home are also required to perform a great deal of “meaningless paperwork” in the course of their care activities, presenting an additional time constraint. However, there are additional ways that the present approach to accountability has impacted PSWs’ direct care work: namely, in reinforcing the division of labour between different types of care staff and, as a result, reaffirming a hierarchy of care professions. This context is important to examine given the negative implications for PSWs, which include hindering teamwork and contributing to the devaluing and invisibility of PSWs’ direct care work in LTRC settings.

### **A Lack of Teamwork: Reinforcing the Division of Labour Between Staff**

As noted in Chapter 3, one of the ways that the Ontario Ministry of Long-Term Health and Care has expanded an emphasis on accountability has been to implement mandatory use of the RAI-MDS 2.0 instrument for receiving funding from the province. This assessment tool requires facilities to report to the province the average acuity of residents’ needs (primarily in terms of physical impairment and medical diagnoses),

which is then used to determine the level of funding that facilities should receive relative to a provincial case mix measure. Often abbreviated to simply “MDS” (minimum data set), this instrument requires an assessment of all residents’ conditions every 90 days, enormously increasing the amount of monitoring and recording work required to receive funding from the province. While Riverside Home has employed a designated “MDS Coordinator” to be in charge of scheduling, validating and submitting this information, it is the facility’s registered nursing staff (RNs and RPNs) that are responsible for actually coding and compiling resident assessments and inputting them into the computerized MDS system. PSWs also participate in the process of resident assessment by filling out tracking sheets on resident dependency levels (e.g. the amount of help required to transfer, to eat, and so on); however, it is only RNs and RPNs who have been instructed on how to code for MDS assessment.

As a result, registered nursing staff have increasingly been removed from the process of direct care, and now spend far more of their time inputting MDS data when they are not performing other tasks that only registered staff can perform (i.e. medication rounds). In speaking with PSWs about what this change has meant to them, it was clear that this change has had an impact on PSWs. Previously, RPNs would help PSWs with direct care activities when they could; however, with the expansion of the MDS workload, RPNs now spend this time performing MDS coding. As one group of PSWs told us, the way in which MDS has been implemented has reduced the feeling of teamwork among staff, and this was explicitly brought up in the context of having too few hands available to do the work:

I: So what parts of the job would you say you get to decide about?  
PSW2: Decide? Not much. [laughs]

PSW3: We do the work. Me, I will talk about me. I feel... I've been in nursing for 29 years. Nursing has changed. And I find with the MDS thing all the RPN they're doing the appeal and the MDS work and we don't have any help anymore on the floor.

I: You mean they're doing all the paperwork so they're not doing the care work.

PSW2: Yeah. It's more paper than anything now than patient care.

PSW3: But even sometimes you see they've got spare time but they're never going to offer us 'I'll do the bed for you' or 'Is it a complete bed change?' or 'I'll answer the bell.' There's no more of a teamwork. Teamwork is zero.

[Interview 1: 17-18]

PSW3's comment that "teamwork is zero" refers to teamwork *between* different types of staff, with PSWs having lost the additional helping hands of RPNs to the requirements of MDS data collection. This is also noted to be a change from how work used to be divided up: in another interview with a PSW, it clear that RPNs used to provide important additional help with direct care tasks:

PSW5: Because before the RPNs were to take, it used to be, three patients. Then it went down to two. They had to take two residents, you know, divide it up between whatever groups. Then when this MDS stuff came out which I realize it's important because it's for funding, whatever, so now the RPNs do not take anybody. They don't even take one patient.

[Interview 7: 13]

By shifting RPNs out of direct care, the requirements of MDS have meant that PSW workloads have increased, removing what was once an important source of extra support. If an RPN takes even one resident in the dividing up of the daily care assignments, this can be a substantial help for PSWs: as explored in Chapter 5, when even one additional resident is added to a PSW's workload it can have a chain effect of putting the worker behind on all other tasks. Now that RPNs are responsible for MDS input, the direct care workload has been shuffled primarily into the hands of PSWs. Two PSWs explained for us how this change has negatively impacted their workload, the pace of their work, and ultimately the ability of PSWs to provide quality resident care:

PSW9: Nursing has changed.

I: Nursing has changed?

PSW9: A lot.

I: Yeah.

- PSW9: Before it was more time with the clients. And over the years I realized there's too much paperwork. Too much information to get data, to get some funding for money. We kind of forget the real picture of nursing. The category of PSW get all doubled. So we're at the bedside, yeah, but it did increase our workload. And me, I feel in the morning every time we organize, we plan our day, and it's non-stop for more than three hours non-stop every day, every day. Non-stop. It's physical. And, you know, patients are human beings. I would not appreciate to be pushed like we push the clients.
- I: You feel you have to because of the non-stop.
- PSW9: It's non-stop. Everybody has to be up for breakfast.
- PSW8: It's lack of time. We have only so much time and that's it.
- PSW9: So yes, I do understand it's important the data, you know, and you have to prove whatever you do so yes, we'll have some money from the government and I do understand that but down the road there's an impact.
- I: Yeah.
- PSW9: **Eventually it seems like the more you got a title the less you have to deal with the clients so who is going to take care of the clients eventually?** So that's my real concern.

[Interview 2: 1-2, emphasis added]

While these workers clearly understand that RPNs have been reassigned to MDS tasks in order to obtain funding, they are critical of the failure to recognize what these changes would mean “down the road” in terms of increasing workloads and work pace for PSWs. Furthermore, as PSW9 notes, “the more you got a title” (i.e. as a registered care worker - an RPN or RN) the less direct care you are assigned, indicating how the division of LTRC labour occurs along divisions in education, registration and professionalization. Regulated workers are increasingly reassigned to administrative roles in order to meet the new demands associated with expanding measures of accountability. Amidst this reorganization, PSWs have emerged as the unregulated, “generic workers” onto whom responsibility for direct care can be systematically downloaded (Sky, 1995). Indeed, the above observations of Riverside Home's PSWs suggest that PSWs have become *the* direct care worker of LTRC settings.

### *Reinforcing a Care Work Hierarchy*

Furthermore, in removing registered staff from hands-on care and dividing care work according to training and registration, a vertical hierarchy between care workers is

maintained. This hierarchy sustains the devaluing of PSWs' direct care work, and contributes to the invisibility of PSWs' contributions to LTRC settings. As explored in Chapter 5, PSWs are the workers who are called upon to cover gaps in direct care work: as one PSW noted for us, "it's always a PSW picking up" [Interview 1: 23] when there are too few hands available to do the care. However, this "picking up" role also reflects the location of PSWs at the bottom of the workplace hierarchy, assigned the tasks deemed to be most menial. One PSW vividly described what this meant in terms of how different work is divided up among care workers at Riverside Home:

PSW13: It's supposed to be teamwork but it's not like that, you know. **'You're a PSW. You pick up the shit.'** You know.

I: It's really kind of divided?

PSW13: Oh my goodness, yeah.

[Interview 8: 7, emphasis added]

Although teamwork is supposed to be the ideal organization in the multi-disciplinary care team, PSW13 explains that in practice it is the personal support workers who deal with the "shit" of care work: the tasks that are seen as the least pleasant and least desirable. These tasks are crucial to the wellbeing of residents, but are accorded very little value.

However, PSWs are well aware of the fact that despite being at the bottom of the workplace hierarchy, they play an essential role in residents' wellbeing. For instance, three workers noted for us the importance of PSWs' close contact with residents for being able to accurately assess their bodily wellbeing:

PSW5: **Us, we're the bottom of the barrel which we shouldn't be because we know.**

PSW6: They wouldn't be able to do without us.

PSW5: No. We sometimes have more knowledge than some of the RPNs that come in here and it blows my mind.

PSW7: And RNs.

PSW6: They don't know what's going on without asking what's going on to the patient's body.

PSW7: We know. We're with them all the time.

PSW5: If we don't tell them nobody doesn't know.

[Interview 7: 13, emphasis added]

In being placed at the “bottom of the barrel” in the organization of care work, PSWs are responsible for residents’ daily bodily care of feeding, bathing, continence care, and clothing. However, it is only within this role that a care worker can really know “what’s going on” with those they care for – and as the PSWs in the above excerpt note, this knowledge is crucial for resident wellbeing. In the hierarchical organization of care work, the “bodywork” of direct care is accorded the lowest value and lowest status in being also the “dirty work” of care (Twigg, 2000; 2002). Differing from the professionalized (i.e. medicalized) aspects of physical care, bodywork has been devalued as unskilled and “auxiliary” care labour, and as such has been continually shuffled down the care work ladder into hands of those workers who are poorly remunerated, accorded lower professional status, and perceived as being less skilled relative to RPNs, RNs, and physicians: the personal support worker (Armstrong et al., 2008). It is in performing bodywork that PSWs gain important knowledge of residents; however, this knowledge and experience is similarly devalued. It is within this context that PSW decision-making is rendered invisible (Kontos et al., 2010a) – such that the struggles, strategies, and circumstances surrounding their decision-making processes are also neglected.

### **Concluding Thoughts**

This chapter has sought to further contextualize PSWs’ decision-making processes as explored in Chapter 5 by locating them within the broader approaches to care that shape LTRC work. The increasingly clinical emphasis in long-term residential care has resulted in the important relational aspects of PSWs’ direct care work being rendered invisible and insufficiently supported. At the same time, a market model approach to LTRC and LTRC work has resulted in a restructured, efficiency-driven

LTRC system in which the needs of both residents and the PSWs who care for them are too-narrowly defined. Within this context, a “person-centred” approach to care poses numerous tensions for PSWs, whose needs are not similarly considered in person-centred ways. Finally, amidst expanding accountability measures, LTRC work is increasingly reorganized in ways that sustain both a division of labour as well as a hierarchy in which PSWs’ labour is devalued.

By locating personal support worker decision-making within these contexts, I seek to add an additional layer of complexity to understanding these care workers’ decision-making processes. For instance, the analysis of Chapter 5 reveals how PSWs struggle to make decisions amidst insufficient staffing levels; however, as the analysis above reveals, this struggle has been partially the result of changes to the organization of care labour amidst new MDS requirements, and the outsourcing of food services. It is important to understand these complexities if we are to sufficiently address the challenges that an analysis of PSW decision-making raises.

## CONCLUSION

### Making it Work? Lessons Learned by Examining Personal Support Worker Decision-Making

My dissertation research has sought to understand personal support workers' decision-making in long-term residential care as a *complex social process* – that is, as both a product of and in response to the multi-layered (or “nested”) contexts in which long-term residential care work is situated. In using a feminist political economy framework, my project has examined PSW decision-making amidst five contextual layers:

- 1) The worker's immediate social location, as informed by the intersecting variables of gender, race, class, immigration status, etc.
- 2) Work organization and working conditions
- 3) Regulatory requirements
- 4) LTRC (re)structuring and global chains of care
- 5) Multiple (and/or conflicting) models of care and definitions of care needs

From the broadest “zoomed out” view, global neoliberal economic reforms have resulted in the movement of care labour across borders, entrenching global care inequalities as wealthier nations recruit migrant workers to meet their growing demand for (cheap, deskilled and devalued) LTRC labour. In the Canadian context, LTRC is situated within ongoing processes of downloading and privatization under slimmed-down, market model approaches to care. Furthermore, shifts in the provincial regulatory landscape have meant that LTRC work in Ontario has been shaped by new medically-defined measures of accountability, the deregulation of care standards, and a failure to develop regulation in ways that would benefit care workers. LTRC working conditions in Ontario are the result of these broader provincial, national and global processes, as care

workers commonly report difficulties in navigating time constraints, insufficient staffing levels, and risks to their personal health, safety and wellbeing.

These broader provincial, national and global trends in LTRC care work informed my analysis of the specific case site of Riverside Home. Organizationally this facility is characterized by vertically-oriented managerial oversight, while a concern for financial accountability has led to an increasing emphasis on fiscal constraint. The residents of Riverside Home have complex care needs; however, caring for these residents is characterized in role descriptions of PSWs as task-oriented, less complex, and less risky labour compared to that of other care workers. This notion of what is involved in PSWs' jobs also contrasts with Riverside Home's conceptualization of "good care" as being based on an individualized approach and an understanding of residents as whole persons.

Examining PSWs' experiences with four direct care activities – feeding, bathing/grooming, continence care, and clothing/laundry – reveals the ways in which the broader contextual layers shape workers' decision-making processes. My analysis of PSW experiences at Riverside Home suggests that these workers experience a narrowed *capacity* to make care decisions. Their workloads and working conditions are the products of broader structural, organizational and regulatory contexts and processes which workers do not have a hand in shaping. However, within these contexts, PSWs *do* make daily decisions in the ongoing daily/nightly struggle of trying to "make it work": they prioritize, speed up, slow down, cut corners, break rules, and find ways to protect themselves. These decisions are in response to specific workplace conditions shaped by restructuring, regulatory changes, work organization, and models of care. The ways in which PSWs make decisions about rearranging their work assignments in response to

refusal of care by residents/family members demonstrates that gender and race are also implicated in shaping their decision-making processes.

Finally, PSWs' experiences with decision-making can be located more broadly within three main trends in approaches to LTRC care, all of which were evidenced in data from the site visit to Riverside Home. The provision of LTRC is increasingly focused on clinical care, while reorganization and funding of care in accordance with market logic leads to the provision of "assembly line" care. Both of the medical and market models of care contribute to difficulties in the decision-making process, as PSWs' experiences reveal that relational care (an essential component in direct care work) is being neglected in too-narrow definitions of care need. Furthermore, while personal support workers at Riverside Home feel they are increasingly tasked with providing "person-centred" care, they simultaneously experience insufficient resources and supports to meet this ideal. Finally, the lack of teamwork and the feeling among PSWs that they are tasked with the most menial of jobs while registered care staff are increasingly pulled away from direct care work suggests there is an increasingly hierarchical division of labour in LTRC work. In this hierarchical arrangement, PSWs have been left at the bottom, becoming *the* direct care worker of LTRC.

Collectively, my findings demonstrate that PSW decision-making processes are shaped, in terms of both capacity and form, by the broader social, political, economic, and historical contexts within which LTRC work is situated. While I use data from a single facility to explore workers' decision-making, Riverside Home is itself situated within (and therefore shaped by) broader processes at the provincial, national, and global levels. These are conditions that are not of workers' own choosing, and yet are deeply

implicated in the processes of (re)structuring, regulation, work organization, and approaches to care that shape their daily/nightly experiences with decision-making. As such, my study demonstrates that an examination of personal support worker decision-making can be a useful “way in” to a broader, more complex understanding of LTRC working conditions – which are also, importantly, the conditions of care.

### **Addressing the Research Challenges: Strengths and Opportunities of the Study**

While there are a few challenges that should be noted with regard to my study, the strategies used to address and overcome them point to important strengths and opportunities in terms of the project design, the setting, and my research question. First of all, as discussed in Chapter 2, the site visit to Riverside Home (and the subsequent site visits comprising the ongoing fieldwork of the broader *Re-Imagining LTRC* project) was designed as a rapid ethnography. This is a method that involves many of the traditional features of ethnographic field work, however occurs over a much shorter timeframe and uses a team of researchers (in our case, multiple researchers from a wide variety of disciplinary backgrounds). This design allowed the site visit research team to obtain numerous interviews and rich observational data over a short period of time, as well as to benefit from having multiple international and interdisciplinary perspectives on our research team. However, one of the challenges that can arise with this method is building trust and establishing rapport with participants must also take place over a shorter period.

To address this concern, every effort was made to inform staff prior to our site visit as to the purpose of our research, and our team members were careful to make our daily observations and note-taking as unobtrusively as possible so that workers could feel comfortable with our presence. We also made use of our multiple identities in the setting

(Murray, 2003), drawing on our various positions in order to form connections with participants and find commonalities in our experiences (noting, for example, that one was previously a nurse/PSW, presently a student, etc.) Having an array of international researchers on our team also provided numerous opportunities to connect with participants, as residents and workers alike were curious to hear how LTRC worked in various team members' home countries. In this sense, our team members' wide array of standpoints (e.g. as an international researcher, as a student, as a former nurse, as a former PSW, etc.) was important for helping not only to enrich data collection, but also to build rapport and establish a comfortable research experience for our participants.

Our own comfort as researchers was challenged in this experience as well, for as other long-term care ethnographers have found (Higgins, 1998; Maas et al, 2002) it can be very stressful for researchers to see and hear some of the things they encounter in these settings of such "crying need" (Tinney, 2008: 203). However, one of the additional benefits of our research design was that, in being part of a team, we were able to lend each other immediate support in the field at times of distress. Furthermore, our team was committed to ensuring that team meetings throughout the duration of the site visit provided a safe space in which to debrief and discuss our experiences. These meetings also offered important points for encouragement and idea-sharing, which was particularly important and valuable for me as a novice researcher conducting LTRC fieldwork for the first time. In this sense, our fieldwork experiences validate the earlier assertion of Salzman (1986) that team-based ethnography presents a valuable and important opportunity for training the next generation of qualitative researchers. In turn, I was able

to enrich the team research process by contributing insights from my perspective as a novice researcher (Baumbusch, 2011)

A second challenge to address is the way in which entering the field openly as researchers may impact the site visit experience. Many LTRC ethnographies have been produced by researchers who actually take on jobs at the facility (Diamond, 1986, 1992; Gubrium, 1975; Henderson, 1995; Lopez, 2006a, 2006b, 2007; Powers, 1995), or unpaid volunteer work (Foner, 1994; Savishinsky, 1995). As such, one of the biggest methodological challenges raised in the literature has been that of conflict between one's role as a care worker and one's role as a researcher (Bland, 2002; Baumbusch, 2011; Tinney, 2008). In contrast, researchers on the Riverside Home site visit entered the field very differently: we were present at Riverside Home explicitly and openly as a team of researchers. Lacking another role on which to rely in order to "blend into" the settings, it is possible that the conspicuousness of our research team had an impact on what we saw and heard at Riverside Home. This may be especially the case since in the weeks prior to our site visit Riverside had been under inspection. As Vesperi (1995) notes, a common challenge with conducting ethnographic observations in LTRC settings is being interpreted by staff as a "potential spy", or as challenging the authority of staff.

However, the fact that we repeatedly heard from PSWs, at length and in detail, about stress, frustrations, violence, and racism, suggests that these workers felt comfortable enough with our research team to discuss at least some of the difficulties and negative experiences associated with their work and working conditions. As Fine (1993) has noted, the idea that we can get at the "truth" of a setting is one of the "lies" of ethnography. Our observations and note-taking are always interpretive processes, and as

Emerson et al. (2011) argue, ethnographic field work is itself an interpretive process. In this sense, one of the most important benefits of rapid ethnography is that in being conducted as a team, interpretation of what we see and hear in the field is a *collective process* – one that does not necessarily result in consensus, but rather takes advantage of differing perspectives and possible interpretations. Throughout our site visit to Riverside Home, regular meetings with our team of researchers allowed us to brainstorm on “next steps” in our site visit (i.e. leads for interviews, key areas to investigate in the daily/nightly routine, questions about how a particular process unfolds, etc.) Furthermore, researchers were paired together in the daily fieldwork of both observations and interviews, allowing for immediate confirmation, clarification, and/or reflection. In these ways, our project design produced multiple “safe spaces” in which to collaborate and generate diverse interpretations of what was seen and heard in our fieldwork experiences (Gerstl-Pepin and Gunzenhauser, 2002).

A third challenge to address is that the interview data for my analysis of personal support workers’ experiences with decision-making is drawn from a small sample size: 16 PSWs spoke with us in 10 semi-structured interview sessions, ranging from one to 4 participants in each interview. However, this small sample size does not represent the full extent of the data used for my analysis, as team members’ field observations as well as extensive documentation from Riverside Home have also formed the basis of my analysis. It is important to recall as well that in addition to interviewing PSWs, the Riverside Home site visit involved interviewing the full range of staff and management at Riverside Home, and the facility’s residents, volunteers and family members. Although I do not use them in my analysis, these interviews were important for helping to situate

many of the structural topics that the members of our research team would asked PSWs about throughout the process of interviewing and observing during our site visit to Riverside Home. For instance, details provided by early interviews with upper management led to our team members asking about how changes to Riverside Home (i.e. RAI-MDS, restructuring meal services, etc.) had impacted PSW work.

There are of course some challenges with obtaining participants in any LTRC setting. Personal support workers do not always have the ability to take time off from their shift to conduct an interview, and after-hours interviews are harder still when workers leave their shifts exhausted. Workers may also be unwilling to talk in a formal interview setting given the precariousness of their positions, particularly given that at the time of our site visit, the union had been warning workers of imminent job cuts.

However, I should note that many of the interviews conducted with PSWs at Riverside Home were obtained during working hours, arranged by our research team members in advance for a time when staff would be able to leave the floor (i.e. at night when there was less of a rush) or when additional staff had been obtained to cover the shortage. This experience likely speaks to the level of managerial support and enthusiasm for our Riverside Home site visit. Furthermore, the fact that PSWs did reveal more sensitive information to our research team (i.e. violence, stress, racism, experiences with rule breaking, etc.) suggests that their level of comfort with our team and desire to share their experiences outweighed potential risks associated with disclosing the information.

Finally, I should emphasize that while my research draws on ethnographic data from a single LTRC facility, it is meant to provide some initial answers to a previously unexplored research question. As earlier ethnographic studies have shown, much can be

learned about LTRC work by looking closely within a single LTRC facility (Diamond, 1992; Gubrium, 1975; Lopez, 2006a, 2006b, 2007). Furthermore, the goal of my analysis was to situate PSW decision-making within specific social, economic, political and historical contexts, and as such I do not seek to generalize my findings from this single facility in Ontario, Canada to all persons occupying this job category elsewhere.

However, my situated analysis raises the important question for future research: do my findings resonate with PSWs elsewhere in Ontario? Thus despite its various challenges, my study offers some initial, detailed and important insights into the decision-making processes of PSWs working in LTRC, which have to date been lacking in the literature.

### **Significance and Contributions of my Research Findings**

My research provides a number of important contributions to the existing literature on care work in LTRC settings. First and foremost, my findings both confirm and build upon prior work that has used a feminist political economy lens to understand frontline LTRC workers, their working conditions, and the importance of these workers to the daily/nightly operations of LTRC facilities (Armstrong and Daly, 2004; Armstrong and Jansen, 2006; Armstrong et al., 2008; Armstrong et al., 2009; Banerjee, 2010; Daly and Sebezeley, 2012). Many of these researchers were involved in the Riverside Home site visit, and continue to be involved in the ongoing larger international project, *Re-Imagining Long-Term Residential Care*. Collectively their prior and ongoing work seeks to understand, from various disciplinary perspectives, how PSWs' care work in LTRC is situated within broader historical, social, political, and economic processes. Their work also situates social actors in relation to multiple and intersecting inequalities on the basis of gender, race and class. I offer my own findings as a contribution to these ongoing

research efforts in demonstrating how personal support workers' decision-making is situated within conditions that are neither natural nor inevitable – and as such are open to the possibility of transformation (Armstrong, 2001).

Secondly, my analysis helps to extend the ethnographic literature on PSW's care work in LTRC in general, and in Ontario specifically. In this dissertation I have used a layered analysis in order to understand PSW's work in LTRC as situated within multiple "nested" contexts. To date only a handful of ethnographic studies have offered an analysis of LTRC work that extends beyond the facility that serves as the study site (Diamond, 1992; Foner, 1994; Gass, 2004; Lee-Treweek, 1997; Lopez, 2006a, 2006b, 2007), and fewer still have done so from a Canadian perspective (DeForge et al., 2011; Kontos et al., 2010a). My dissertation thus offers an important extension to the limited ethnographic literature on PSW's LTRC work from an Ontarian perspective. This contribution is particularly significant given Lilly's (2008) assertion that little is known about PSWs in *any* care setting, and that this category of care worker is poorly understood. To this end, my dissertation provides rich ethnographic data on the every day/night experiences of PSWs in LTRC, providing to a better understanding of not only what is involved in their work, but also the contexts, consequences, and contributions of their work.

Thirdly, my dissertation also makes an important contribution to the as-yet limited methodological literature on rapid ethnography. Rapid ethnography is a relatively new method that has yet to be widely applied in social sciences research. To the best of my knowledge, this dissertation is the first to make use of data from a rapid ethnographic study, and demonstrates that rapid ethnography is a viable – and indeed valuable –

method for studying of work experiences in LTRC settings. My dissertation also demonstrates that inclusion of doctoral students in rapid ethnography teams can be an enormously useful opportunity. This method makes it possible for the next generation of sociological researchers to participate in a research experience that would otherwise require more resources (in terms of time, funding, access, etc.) than an individual student could feasibly hope to obtain.

Fourthly, my findings help to extend the literature on care worker decision-making in LTRC and other health care settings. To date the vast majority of research on care decision-making has focused on the clinical decisions of physicians and registered nursing staff – those professions that are higher in the health care hierarchy and whose decisions are formally recorded in residents’ care plans (Dellefield, 2006). While some organizational analyses have examined the decision-making of personal support workers (Campbell, 2002; Kruzich, 1995), this literature fails to consider their decision-making processes beyond input into the assigned tasks of caring for residents. As Kontos et al. (2010a) have argued, most of the decision-making of PSWs is neglected if we consider only the formal, medicalized accounts of residents’ care needs – and it is only through an understanding of workers’ daily/nightly experiences with care work that these decision-making processes can be understood.

While some research has attempted to go beyond formal care planning decisions (Anderson et al., 2005; Berdes and Eckert, 2007; Janes et al., 2008), the explanations are unfortunately grounded in individualistic models rather than situating decision-making processes within the broader contexts surrounding PSWs’ LTRC work. It is this limitation that my research addresses: by extending our understanding of decision-

making beyond both the formal care planning process *and* individualistic explanations, PSWs' decision-making can be viewed as a complex social process. In this sense my research extends previous work on LTRC care worker strategies, such as rule breaking (Bowers and Becker, 1992; Jervis, 2002; Lopez, 2006a, 2006b, 2007), resistance (Lee-Treweek, 1997) and “work-arounds” (DeForge et al., 2011), by situating PSWs' decisions within broader organizational, provincial, national, and global contexts. By examining these contexts, we might consider the possibilities for improving LTRC working conditions, for the sake of those workers struggling to “make it work” for the residents they care for.

Furthermore, my research helps to fill in gaps in our existing knowledge about where workers have more versus less capacity to shape their daily/nightly experiences of LTRC work – and not only where this capacity exists, but also the factors that shape this capacity and how workers work within these conditions. Some initial explorations of PSW working conditions have attempted to estimate how much say these workers have in the daily experiences of care work (Banerjee et al., 2008). However, quantifying workers' capacity to make decisions gives us only a partial understanding of PSW work experiences, and raises the numerous questions that my study has sought to address: where can workers *not* decide? What are the factors that shape these conditions? When workers *can* decide, what are the decisions they make, and why? In answering these questions, my study helps to extend and contextualize prior research findings on workers' capacities to shape their daily work experiences. For instance: while a PSW may report being able to prioritize the order of residents to wake and ready for breakfast, this decision is based on how much available help there is in terms of other PSWs working on

the same floor, the number of meal helpers available to feed residents as they are brought to the dining room, meal scheduling time restrictions, regulations on where residents can eat, and resident preferences, capacities, and (potentially) resistance. This is but one example of my findings that illustrate the importance of situating PSW decision-making as a complex social process.

Finally, and most importantly, my analysis of PSW decision-making as a complex social process helps to emphasize the skills, strategies and labour involved in the jobs of these care workers, which are essential to the running of long-term residential care facilities. My research thus contributes to broader critiques of the ways in which personal support work is a category of care work that is often neglected in both the structural and ideological processes informing long-term residential care (Konrad, 2011; Armstrong et al., 2008). In this sense, my research presents a challenge to the notion that direct care workers are “unskilled” or “ancillary” to care, and contributes to the broader political efforts to have this crucial labour recognized, valued and supported.

### **Future Directions: Caring for LTRC Care Workers**

My findings suggest some important directions for future research and activism in LTRC and LTRC labour. First of all, it is painfully clear that personal support workers simply do not have sufficient time to care in ways that meet residents’ needs. The relational elements of care work are most likely to be cut – despite being an important facilitator for care worker decision-making, as workers require sufficient time to get to know resident preferences, moods, etc. in order to meet their needs. Furthermore, these workers are rushed to meet even basic *physical* care needs of residents, raising risks to the wellbeing of both worker and resident alike. These conditions are both deplorable and

unsustainable – but they are also fixable. It is possible to address the dangers of insufficient time by examining the working conditions that lead to this experience: namely, overwhelming workloads and insufficient staffing levels. As my analysis has suggested, future research and activism should consider the role that not only funding levels play in working conditions, but also the ways in which changes to the regulation and restructuring of LTRC services (e.g. expanding mandatory bathing requirements without similarly expanding staffing levels; outsourcing of dietary and laundry services) can impact workloads and work organization. In other words, we need to assess how changes to funding, regulation, and the restructuring of LTRC translate into daily/nightly realities for personal support workers and those they care for. To this end, it is essential that future research on PSWs and their working conditions begin with workers' own experiences, in order to render visible the important, complex, and yet often invisible and devalued work of these direct care workers in LTRC (Armstrong et al., 2008).

Secondly, future research should focus on the consequences of a narrowed capacity to make decisions. It is known that PSW decision-making has an important impact on the wellbeing of residents, as these workers make innumerable adjustments to daily care in order to address residents' care needs (Kontos et al., 2010a). However, my findings also give some initial indications that the wellbeing of these workers themselves is at risk when their capacity to make care decisions is restricted. For instance, by restricting PSWs' capacity to decide certain aspects of direct care (e.g. giving a bed bath rather than a tub bath when a resident is agitated), regulations can expose workers to the risk of violence. Having decision-making control is known to be important to workers' wellbeing (Karasek, 1990; Kompier, 2006; Stansfeld and Candy, 2006), however with

one notable exception (Hsu et al., 2007) there has been a complete neglect of the importance of decision-making capacity for the wellbeing of PSWs as a specific and uniquely-situated category of direct care worker in LTRC. My research suggests that expanding the decision-making capacities of PSWs would be one way of caring for both residents *and* care workers themselves.

Finally, it is clear that future policy, planning and multidisciplinary research in LTRC must consider the ways in which existing contradictions in approaches to care make it highly unlikely that personal support workers will be able to “make it work” for much longer. Culture change approaches to improve the lives of LTRC residents – such as individualized or “person-centred” care – are extremely difficult (if not impossible) to implement if care workers themselves are not similarly supported in person-centred ways. Furthermore, the encroachment of both medical and market models into LTRC has led to an overly-narrow definition of resident care needs, as well as insufficient resources available for workers to actually provide care. These workers are precariously positioned at the disjuncture between idealized notions of care on the one hand and slimmed-down models of LTRC under neoliberal market logic on the other. This disjuncture is unsustainable, and is dangerous for all. So I would like to end this investigation with a call to action, as provided by two care workers we spoke with. At the close of one interview, two PSWs questioned the length of time that they assumed our research would take to enact real change in their working conditions:

I: So anything else you want to add to what we’ve been talking about because we’re here with our tape recorders on? Anything you want to say?

PSW9: But is it going to make things change only in 10 years down the road?

I: Oh we hope not. We hope it’s not that long.

PSW8: I only have four years to go so you have to be quick! [laughs]

[Interview 2: 23]

Although PSW8 was joking in reference to her own upcoming retirement, these workers were nonetheless concerned that change would be too slow to come – that they would only see the results of our research “10 years down the road”. My analysis of the struggles and stresses involved in decision-making has revealed that change cannot come soon enough for personal support workers in long-term care. As Irene Jensen (2011) has urged, there is a dire need for “bold actions” to support and protect long-term residential care in ways that recognize inseparability of working conditions from the conditions of care. It is my hope that this dissertation will serve as a catalyst towards such bold actions – both for me and my fellow care researchers.

**APPENDIX A: Ethics Approval Forms**



UNIVERSITÉ  
UNIVERSITY  
**OFFICE OF  
RESEARCH  
ETHICS (ORE)**

5<sup>th</sup> Floor,  
York Research Tower,  
4700 Keele St.  
Toronto ON  
Canada M3J 1P3  
Tel 416 736 5201  
Fax 416 650 8197  
[www.research.yorku.ca](http://www.research.yorku.ca)

**Memo**

**Certificate #:** STU 2012 - 116

**Approval Period:** 07/04/12-07/04/13

To: Suzanne Day, Department of Sociology, [suzday@yorku.ca](mailto:suzday@yorku.ca)

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics  
(*on behalf of Wade Cook, Chair, Human Participants Review Committee*)

Date: **Wednesday 4<sup>th</sup> July, 2012**

Re: Ethics Approval

Making it work: A Study of the Decision-Making Processes of Direct Care  
Workers in Long-Term Residential Care

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I am writing to inform you that the Human Participants Review Sub-Committee has reviewed and approved the above project.

Should you have any questions, please feel free to contact me at: 416-736-5914 or via email at: [acollins@yorku.ca](mailto:acollins@yorku.ca).

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM  
Sr. Manager and Policy Advisor,  
Office of Research Ethics

## RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE

Upon receipt of an ethics approval certificate, researchers are reminded that they are required to ensure that the following measures are undertaken so as to ensure on-going compliance with Senate and TCPS ethics guidelines:

1. **RENEWALS:** Research Ethics Approval certificates are subject to annual renewal.
  - a. Researchers are required to submit a request for renewal to the Office of Research Ethics (ORE) for review and approval.
  - b. **Failure to renew an ethics approval certificate or** (to notify ORE that no further research involving human participants will be undertaken) **may result in suspension of research cost fund and access to research funds may be suspended/withheld ;**
2. **AMENDMENTS:** Amendments must be reviewed and approved **PRIOR** to undertaking/making the proposed amendments to an approved ethics protocol;
3. **END OF PROJECT:** ORE must be notified when a project is complete;
4. **ADVERSE EVENTS:** Adverse events must be reported to ORE as soon as possible;
5. **AUDIT:**
  - a. More than minimal risk research may be subject to an audit as per TCPS guidelines;
  - b. A spot sample of minimal risk research may be subject to an audit as per TCPS guidelines.

**FORMS:** As per the above, the following forms relating to on-going research ethics compliance are available on the Research website:

- a. Renewal
- b. Amendment
- c. End of Project
- d. Adverse Event

## **APPENDIX B: Interview Guide for the Riverside Home Site Visit**

### **Key Areas in Interviewing PSWs at Riverside Home<sup>18</sup>:**

1. How do you experience your work each day? Are you treated well, valued? Do you have flexibility in terms of your schedule, in terms of what you do when? What about your relationship with others – other providers, residents, families, administrators? Optional: If you would describe your job to someone who has no idea what it is like to work in an LTC facility, what would you say?
2. When you go home after your shift, what makes you feel good? What, if anything, makes you feel bad?
3. What do you think about the tasks you do? What tasks are you more/less happy doing? What about reporting and record keeping?
4. If you were in charge, what would you change?
5. What does good care mean for you? For residents? What would you look for in a facility for you to live in?
6. What do you need in your job as you get older?
7. What is your view of women and men as care providers? As residents?
8. What would you have asked in this interview? What did we miss? What did we get right?

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<sup>18</sup> Note that our research team used this schedule as a topic guide *only*: questions were not necessarily phrased as above in the actual interviews.

## **APPENDIX C: Site Visit Schedule**

### **RIVERSIDE HOME** **SITE VISIT SCHEDULE**

	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>	<u>Saturday</u>
<b>Unit 1</b>						
7AM - 1PM	PhD student (Canada) Post-doctoral fellow (Canada)	Sr. academic: work organization (Canada) Sr. academic: approaches to care (Canada)	Team meeting  Interviews	Interviews	PhD student (Canada) Sr. academic: accountability (Canada)	Sr. academic: work organization (Sweden) Post-doctoral fellow (Canada)
1PM - 7PM	Sr. academic: accountability (Canada)  Sr. academic: work organization (Canada)	Senior academic: work organization (Sweden)  PhD student (Canada)			Post-doctoral fellow (Canada) Sr. academic: approaches to care (Canada)	Sr. academic: accountability (Canada) Sr. academic: work organization (Canada)
7PM - 12AM	Sr. academic: approaches to care (Canada) Sr. academic: work organization (Sweden)	Post-doctoral fellow (Canada) Sr. academic: accountability (Canada)			Sr. academic: work organization (Canada) Sr. academic: work organization (Sweden)	Sr. academic: approaches to care (Canada) PhD student (Canada)
<b>Unit 2</b>						
7AM - 1PM	Social worker (Sweden) Sr. academic: accountability (UK)	Sr. academic: financing (Canada) PhD student (Canada)			Sr. academic: approaches to care (Canada)  PhD student (Canada)	Sr. academic: accountability (UK)  PhD student (Canada)
1PM - 7PM	PhD student (Canada) Sr. academic: financing (Canada)	Social worker (Sweden) Sr. academic: approaches to care (Canada)			Sr. academic: accountability (UK)  PhD student (Canada)	Sr. academic: approaches to care (Canada)  Social worker (Sweden)
7PM - 12AM	Sr. academic: approaches to care (Canada)  PhD student (Canada)	PhD student (Canada) Sr. academic: accountability (UK)			Sr. academic: financing (Canada)  Social worker (Sweden)	PhD student (Canada) Sr. academic: financing (Canada)

## **APPENDIX D: Observation Guide**

Produced for Site Visit Observations, *Healthy Aging in Residential Places*  
By Mia Väbo (December 2012)

### **OUR FOCI: ACTIVE, HEALTHY AGING, DIGNITY AND RESPECT FOR RESIDENTS AND STAFF PROCESSES, PRACTICES AND CONDITIONS RATHER THAN INDIVIDUALS**

Remember that observation is not just watching. Use all senses! Smell, noise, screaming, music, small talk, etc.

- Is the ward calm or chaotic? Are staff rushed? Rushing?
- Describe the physical space. How is it furnished and decorated? Are semipublic spaces decorated by staff? How do they interpret the taste of older people? (bric-a-brac?)
- Describe the spaces for social gatherings, physical layout, accessibility.
- Describe “viewpoints” for people who are too tired to participate (outlook, in busy spaces).
- Think mental, social and physical stimulation. What works? Does not?
- How are out-door spaces? How are they used?
- How are residents dressed, based on what? Do they have diapers?

Try to capture the rules, routines and rhythm of the place.

Do residents have a common daily rhythm or do they have their own – for instance do they eat breakfast alone or with other residents, do they decide themselves when to get up in the morning and go to bed in the evening? Can they walk at night? Toileting?

- Is the activity of the place isolated from the community outside (people coming in/people going out)?
- How clear are the borders between different spaces? How are residents greeted by staff, in what spaces? Do the nurses knock before entering the residents’ rooms?
- How many staff, of what kinds, doing what? Volunteers? Family?

Try to capture different kinds of events/episodes – staff meetings, lunch breaks, meals for residents, waking up time, newspaper reading, physical training, special arrangements (movies, concerts, picnics, etc.)

Talk to different categories of people and observe how they interact.

- What are the relations between different categories of people, e.g. between newcomers and oldtimers, leaders and staff, staff, family, volunteers, residents?
- How do leaders provide inspiration, intellectual stimulation, etc.?
- Do family members and guests move freely about the place?
- What kinds of interactions are there between staff members – gossip, humour, collegiality, etc.?
- Who is asked and how are they asked to go to social arrangements?

Be aware of your own role and how you are welcomed, how different people react to you and treat you, and on what basis they treat you the way they do. Some can see you as outsiders who are there to judge them or who might have the rhetorical power to voice their concerns to other outsiders; others may mistake you for a family member or staff. Take notes discretely, or remove yourself to a private space to write them. Do not enter private spaces without specific consent. Record as much as possible in your notes. No detail is too small.

**ASK YOURSELF WHAT IS MISSING**

**APPENDIX E: Consent Form used for the Riverside Home Site Visit**

**Re-imagining Long-term Residential Care:  
Healthy Active Ageing in Residential Places**

**Information and Consent for Interviews**

**Principal Investigator:** Dr. Pat Armstrong, Distinguished Research Professor, Dept. of Sociology, York University, Toronto, Canada, who can be reached at 416-736-2100 ext. 22550 or at patarmst@yorku.ca.

**Sponsor:** This study is paid for by the Social Sciences and Humanities Research Council of Canada, the Canadian Institutes of Health Research, and Riverside Continuing Care.

You are being invited to participate in a research study that seeks to find out what works in long term care homes to make sure that people who live and work in these homes are healthy and active, and get respect.

**YOUR PARTICIPATION IS VOLUNTARY.** It is up to you to decide if you want to take part in this study. Before you decide, you should learn what the research involves. This consent form will tell you about the study, why the research is being done, and what will happen to you during the study and the possible risks or discomforts.

If you do not participate, you do not have to provide a reason and your care, work and relationships will not be affected. You can withdraw from the study at any time and will destroy any information we have collected about you immediately.

Please take the time to listen to or read the following, ask questions and think it over before you decide.

**Who is conducting this Study?**

An international team of researchers, including professors and graduate students. It includes researchers from the United Kingdom, Sweden, and Canada. This research at Riverside Home will be on-going from Dec. 3 to Dec. 8, 2012.

The results of this research will not be used for profit in any way.

**What is the purpose of the Study?**

We want to know how people can get the care they need and want. How can people who live and work here stay healthy and active?

We want to know who does what for whom, with what kind of training. Who decides about care? What are the rights of people who live here, staff who work here and families?

We want to know what kind of rules and standards help make sure that long term care homes are good places to live, to work and to have loved ones live, while also not wasting money.

We want to know who pays for care, who gets what kind of care and who owns the home? Do these things change the care given to people who live in long term care or what it is like to work there?

**Who Can Participate in the Study?** All residents who live here, the people who work here and the family and friends of residents may participate.

**Who Should Not Participate in the Study?** Residents who cannot decide to participate on their own or whose legal guardian decides that this is not a good idea.

**What Does the Study Involve?**

The study asks participants to provide information about living or working at Riverside Home in a 60-90 minute interview with one of our researchers. This interview will be recorded. It may take one or several sessions to complete, depending on what you and the researcher decide together. You will not be identified in the transcripts produced or in our research results.

**Will Taking Part in this Study be Confidential?**

Your privacy will be respected. Your name or any information that could identify you will never be revealed in any way, including to people here at Riverside Home. Your information will be given a unique study number. Only this number will be used on any information collected about you so that your identity will be kept confidential. Information about your identity will only remain with the Principal Investigator, who will have a list that matches your name to your study number.

**Are There Risks? What are the Benefits?**

There are no risks to this study but if you feel any discomfort you may withdraw at any time. By participating in the research, you will help us identify practices and conditions that allow residents and care providers to be treated with dignity and respect. This will help us advise those who make policy and manage residential care.

If you have any questions or want more information about this study before or after you participate, you can contact Dr. Pat Armstrong at 416-736-2100 ext. 22550.

**Who do I contact if I have questions or concerns about my rights as a participant in the study?**

If you have concerns or complaints about your rights as a research participant and/or your experiences while participating in the study, you may contact the Riverside Ethics Office and speak to [personal information removed].

**How do I find out about the Research Results?**

The researchers will present the results starting in the spring of 2013. They present at conferences and meetings with senior's groups, workers' groups, employer groups, funders and advocacy groups. They write papers and books for university people and the general public and we post information on a public website, [www.yorku.ca/reitc](http://www.yorku.ca/reitc).

**Thank you for thinking about participating in our study.**

**Re-imagining Long-term Residential Care:  
An International Study of Promising Practices**

**Consent to Participate (Interviews)**

I \_\_\_\_\_ (*print name*) have reviewed, understand and appreciate the information about this study.

- I have had enough time to think about the information and to ask for advice if I think it is necessary.
- I have had a chance to ask questions and was satisfied with the answers I received.
- I understand that all information collected is confidential and the results will be used for scientific objectives.
- I understand that my participation is voluntary and I can refuse to participate or answer a question, or can withdraw at any time without a reason without affecting: (check all that apply)  my care  my work  my relationships at Riverside Home.
- I understand I am not waiving any rights by signing this form.
- I understand there is no direct benefit to me from this study.
- I have reviewed this form and freely consent to participate in this study.
- I have been told that I will receive a signed and dated copy of this form.

\_\_\_\_\_  
Participants Name (*print*)                      Signature                      Date

\_\_\_\_\_  
Substitute Decision Maker                      Signature                      Date  
(*if applicable*)

\_\_\_\_\_  
Witness                      Signature                      Date

\_\_\_\_\_  
Principal Investigator                      Signature                      Date

## **APPENDIX F: Coding List**

- 1) Demographics
  - a. Gender
  - b. Race
  - c. Class
  - d. Age
  - e. Migrant
  - f. Prior occupations
- 2) Regulation
  - a. Rules of Riverside
  - b. Managerial oversight
  - c. Legislation
- 3) Financial/Resources
  - a. Riverside's resources
  - b. Residents' resources
  - c. Workers' resources
- 4) Restructuring
  - a. Changes to Riverside
  - b. Changes to LTRC system
- 5) Work Organization
  - a. Teamwork
  - b. Staffing
  - c. Workload
  - d. Division of labour
- 6) Time
  - a. Insufficient time
  - b. Shift schedules
  - c. Timing
  - d. Tempo
- 7) Care
  - a. "Good care"
  - b. "Bad care"
  - c. Care needs of residents
  - d. Care needs of workers
- 8) Decision-making
  - a. Barriers to decision-making
  - b. Facilitating decision-making
  - c. Rule breaking
  - d. Using knowledge/experience
  - e. Cutting corners
  - f. Rearranging
  - g. Prioritizing
- 9) Wellbeing
  - a. Emotional wellbeing
  - b. Physical wellbeing
  - c. Life outside of work

## **APPENDIX G: Excerpt from the Ontario Long Term Care Homes Act, 2007**

### **Ontario Long-Term Care Homes Act, 2007**

#### **Qualifications of personal support workers**

**47.**

(1) Every licensee of a long-term care home shall ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2).

(2) The personal support worker program,

(a) must meet,

(i) the vocational standards established by the Ministry of Training, Colleges and Universities,

(ii) the standards established by the National Association of Career Colleges, or

(iii) the standards established by the Ontario Community Support Association; and

(b) must be a minimum of 600 hours in duration, counting both class time and practical experience time.

(3) Despite subsection (1), a licensee may hire as a personal support worker or to provide personal support services,

(a) a registered nurse or registered practical nurse who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker;

(b) a person who was working or employed at a long-term care home at any time in the 12-month period preceding the first anniversary of the coming into force of this section as a personal support worker and who has at least three years of full-time experience, or the equivalent considering part-time experience, as a personal support worker;

(c) a student who is enrolled in an educational program for registered nurses or registered practical nurses and who, in the opinion of the Director of Nursing and Personal Care, has adequate skills and knowledge to perform the duties of a personal support worker; or

(d) a person who is enrolled in a program described in subsection (2) and who is completing the practical experience requirements of the program, but such a person must work under the supervision of a member of the registered nursing staff and an instructor from the program.

(4) The licensee shall cease to employ as a personal support worker, or as someone who provides personal support services, regardless of title, a person who was required to be enrolled in a program described in clause (3) (c) or (d) if the person ceases to be enrolled in the program or fails to successfully complete the program within five years of being hired.

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<sup>19</sup> Note that the pseudonym used for my site, "Riverside Home", applies to references as well. This includes materials provided by the facility itself (such as reports, brochures, training manuals, etc.) The titles and URLs of some references have also been altered to protect anonymity.

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