Abstract

Home support workers (HSWs) encounter unique safety issues in their provision of home care. These issues raise ethical concerns, affecting the care workers provide to seniors and other recipients. This paper is derived from a subproject of a larger Canada-wide study, Safety at Home: A Pan-Canadian Home Care Safety Study, released in June 2013 by the Canadian Patient Safety Institute. Semi-structured, face-to-face, audiotaped interviews were conducted with providers, clients and informal caregivers in British Columbia, Manitoba and New Brunswick to better understand their perceptions of patient safety in home care. Using the BC data only, we then compared our findings to findings of other BC studies focusing on safety in home care that were conducted over the past decade. Through our interviews and
comparative analyses it became clear that HSWs experienced significant inequities in providing home care. Utilizing a model depicting concerns of and for HSWs developed by Craven and colleagues (2012), we were able to illustrate the physical, spatial, interpersonal and temporal concerns set in the context of system design that emphasized the ethical dilemmas of HSWs in home care. Our data suggested the necessity of adding a fifth domain, organizational (system design). In this paper, we issue a call for stronger advocacy for home care and improved collaboration and resource equity between institutional care and community care.

Introduction

“Safe, compassionate, competent and ethical care” is a central tenet of the Canadian Nurses Association’s Code of Ethics (CNA 2008: 8). This standard of safe care is not new, either to Canada’s recent codes of ethics or to the profession of nursing (Kangasniemi et al. 2013). One of the early dictums for physicians and for hospitals was “Above all [or first], do no harm” (Beauchamp and Childress 2001), meaning that in trying to help the sick, physicians were to avoid causing injury or wrong. Thus, it is not surprising that when the downsizing and re-engineering of healthcare took hold in Canada (Shannon and French 2005) in the late 1980s and early 1990s, serious concerns about safety were raised by many healthcare workers. In most Canadian provinces, the downsizing was accomplished by a number of ways, for example, moving to regional authorities, closing facilities, restricting programs and other means to decrease administrative costs. Among the measures taken was the dismissal of managers and front-line staff, resulting in a “shrinkage” in the amount of time available to provide appropriate care and support. This measure had the effect of what many considered an obvious ethical outcome, namely, compromising the safety of patients and clients (Shannon and French 2005; Storch 2005).

Towards the end of the 1990s, attention began to focus on the safety of patients in hospitals, and in 2005 the Canadian Patient Safety Institute was established. Based upon the findings of seminal research on safety in hospitals in Canada, Baker and colleagues (2004) determined that 7.5% of medical–surgical patients experienced adverse events in Canadian hospitals and that 37% of these events were highly preventable. Initially, the focus on research and practice remained on safety in hospitals only, pinpointing isolated practices with serious negative patient outcomes. Gradually that focus broadened to include routine nursing care and preventive practices, such as hand-washing. It was several years later that the spotlight on patient and client safety widened to include concern about safety in home care. In 2013 the first Canada-wide study was released titled Safety at Home: A Pan-Canadian Home Care Study (Doran et al. 2013: 5). Among their many
significant findings, the researchers in this study determined that 10.1% of home care clients experienced adverse events annually, and that 56% of these events were highly predictable.

The Pan-Canadian Study used mixed methods to meet a broad range of objectives to better understand home care in Canada. These included subprojects for “a) a scoping review of literature; b) a quantitative analysis of Canada’s comprehensive secondary health databases; c) a review of health care clients’ chart and incident reports; d) incident analysis; and e) interviews of client, family members, informal and formal providers” (Doran et al. 2013: 8). The fifth subproject involved interviews with clients, informal caregivers and health providers in New Brunswick, Manitoba and British Columbia. It is this subset of findings, with a focus on the BC data, that we have utilized in our analysis in this paper. The purpose of this paper is to explore safety concerns related to home support workers (HSWs) in the provision of home care in British Columbia.

In considering safety concerns in home care, it soon became clear to researchers and caregivers that clients were not the only group affected by poor safety practices in home care, and that healthcare workers of all types, family caregivers and friends were also involved. In short, safety in home care is seen “to include all those involved” in any way. Another difference between home care and hospitals is that in hospitals there is some degree of national standardization flowing from the Canada Health Act, whereas home care has no such legislation. As Lynam and colleagues (2003: 113) noted, although Canada has a national system, the “provinces are responsible for the delivery of care; therefore, approaches to service delivery and models of governance vary from province to province.” Lynam and colleagues also recognized differences in the provision of home care as “unintended consequences” of restructuring, particularly efficiency and inequity in British Columbia. These consequences have much to do with politics and ethics, as evidenced in the allocation of scarce resources, time available for vulnerable clients and respectful work experiences for health providers as well as clients.

A number of studies on safety in home care in British Columbia have been conducted in the past decade, all including HSWs and some specifically focusing on these workers. In this paper, we will focus on the multiple safety concerns and ethical challenges of HSWs (who are variously called community health workers, personal support workers, home health aides, community health aides and homemakers) as they work to support clients. Their role includes providing domestic and personal care services so that clients may remain in their homes as long as possible. We will first provide a brief review of these BC studies, followed by a rationale for our choice of model for analysis. We will then use this model to draw
comparisons between our study findings and those of other researchers, after which we discuss organizational concerns as they affect ethical practice and safety. We then discuss the context of home care and provide concluding comments and recommendations about the interface of client safety and ethics.

**Brief Review of BC Studies on Client Safety**

Lynam and colleagues (2003: 116) conducted a study involving 60 patients while they were hospitalized and after their discharge home, as well as 56 healthcare professionals (mainly nurses) caring for these patients. A central tenet taken in this research was “that individuals’ experiences are mediated by institutional processes and associated with social structures.” Thus, these researchers began with individual perspectives of clients and care providers before proceeding to gather information about the context of policy and practice. Among other findings, they heard from healthcare professionals and HSWs that the acuity of illness and the shortage of staff threatened their capacity to provide adequate care, and that it was difficult to meet the changing needs of their patients/clients. Gaps included deficiencies in communication; that “previous commitments to ongoing staff development and education have been eroded as consequences of working in an environment with fewer resources” (Lynam et al. 2003: 128); and that some patients/clients were more vulnerable (e.g., at risk of falling) because of lack of resources for continuity of care. As will be clear in the discussion to follow, we found the situation for HSWs some 10 years later is virtually identical to that described by Lynam and colleagues in 2003. Deficiencies in communication and shortage of resources, including time, are significant ethical problems because of the potentially negative impact on client care and support.

Another BC study by Stevenson and colleagues (2008: 21) focused on exploring “safety practices in community home health care including both client and provider safety.” Participatory action research (PAR) was utilized in this study, which included three phases, with each phase informing the development of a subsequent phase. The first phase comprised three types of interactions (focus groups, interviews and staff meetings) with 129 staff and managers in home care. A second phase focused on Friday discharges from hospitals highlighting problems of communication of essential information from hospital to home care staff. This failure to relay information caused HSWs to be put at risk when entering a client’s home. The third phase involved a trial of a risk identification tool (Stevenson et al. 2008).

In 2009, a pilot study (Lang et al. 2009) consisting of interviews with clients, family members, informal caregivers and healthcare providers (mainly HSWs) was conducted in a rural area of British Columbia as preparation for the
Pan-Canadian Study noted above. Findings of this pilot provided a range of safety concerns not as common in urban areas. These concerns included issues related to vermin infestation, structural instability of homes and other safety issues that HSWs confronted.

Choice of the model for comparison and analysis
Based upon a series of previous studies outside British Columbia, Mahmood and Martin (2008) developed, and Sims-Gould and Martin-Matthews (2010) enhanced, a framework of actions and interactions central to home care work involving specific domains of practice. These were labelled organizational, social, spatial and temporal domains. To develop their model categorizing HSW safety concerns, these researchers conducted face-to-face, in-depth interviews with 118 HSWs in British Columbia. They found that HSWs faced numerous safety issues. Based on findings from interviews with 115 of the 118 HSWs, Craven and colleagues (2012) further analyzed HSW perspectives to identify types and patterns of safety concerns in home care. This analysis allowed them to refine the Sims-Gould and Martin-Matthews (2010) model. Each set of findings led to changes in the previous models. Because the model of Craven and colleagues (2012) resonated with our perceptions of HSW safety concerns, we have used it as a tool, a framework, to compare our BC data on HSWs with their findings, as well as with those of other researchers noted above.

Data Collection and Analysis
Subproject 5 of the Pan-Canadian Study was designed to include six households in each of three provinces. A household was defined as inclusive of the client, a family member or friend and a home care provider or providers. In 2011 and 2012, semi-structured, face-to-face, audiotaped interviews were conducted with providers, clients and informal caregivers in British Columbia, Manitoba and New Brunswick. The study utilized interpretive description as a methodology and social ecology as a framework to capture the scope of social, emotional, functional, physical and contextual factors that influence safety in home care. Interviews were conducted in homes of participants, or at a location of their choice, for both convenience and confidentiality. In addition, two focus groups were conducted in each province, one with HSWs and one with professional healthcare providers (Lang et al. 2009). Following ethics approval from the joint university and agency research ethics board, eligible client participants were contacted by their healthcare agencies to determine whether they were interested in participating in the study. Eligibility criteria included ability to speak and understand English, to have received home care services in their own home for a chronic condition and the willingness of their informal caregivers and their healthcare providers to participate. Consent was obtained prior to proceeding with interviews and focus groups. A total of 14 HSWs in an urban BC setting participated in the study. The participants were 24 to 63 years old, with three males and 11 females. Because our
interest was in exploring the providers’ safety experience and because the majority of providers we interviewed were HSWs, we chose HSWs as our focus. Furthermore, HSWs provide the majority of care and support hours, are the least educated and are unregulated.

We audiotaped interviews and transcribed them. In addition to reporting demographic data, we asked 10 probing questions that included the HSWs’ background in home care, a description of their work with a particular client, and questions about their own physical and emotional safety. Focus group questions were targeted to safety in home care in general, and to specific precautions and concerns about workers’ personal safety.

To analyze our data, we initially read all transcripts independently, then met consistently to compare the themes we found in them. Once analysis of all transcripts was complete, we re-read and evaluated our themes. Following this step a meeting was held with the researchers from New Brunswick, Manitoba, British Columbia and other members of the Subproject 5 team to compare findings. At this point, we realized the value of preparing this paper focused on HSWs in British Columbia.

Our focus on HSWs resonated well with the model presented in the research of Craven and colleagues (2012: 4) on HSW safety concerns. Their model features physical, spatial, interpersonal and temporal safety concerns. As we analyzed our findings and compared them with those of others, we found it necessary to make modest adaptations to their model descriptors and by adding a fifth domain (organizational/system design). Our model positioned these domains differently (see Figure 1 later in this paper). The definitions of five areas of safety concerns in our model are described below.

**Description of Our Model’s Components**

In this section we provide descriptors of our model, illustrating the modifications we have made from the model of Craven and colleagues (2012). These changes are identified in italics in the descriptors below.

**Spatial concerns**: Concerns based on features of the home space, inside and outside areas of the client’s home, the spatial layout of the home, the geographic location (e.g., dangerous neighbourhoods), the adequacy of the set-up of the home (e.g., limited space for hospital equipment), the presence of hazards or threats (e.g., clients’ pets), as well as advance notice of safety-related issues (such as guns in the home). Our adaptations depicted spatial as separate from the other domains as it encompasses inherent features of care at home, only some of which can be changed by organizational policies and planning.
Physical safety concerns: Concerns of a physical or medical nature, including musculo-skeletal injuries, trips, falls, adequacy of equipment and supplies, and communicable diseases, related both to the experience of and the potential risk for physical harm, as well as the preparation of the HSW for mitigating these concerns.

Interpersonal concerns: Concerns arising from interactions between HSWs, other home care workers and the client’s family members that affect the HSW psychologically, socially or emotionally, as well as the HSW’s ability to address interpersonal issues and concerns.

Temporal safety concerns: Concerns related to the timing of the service and the workers’ schedule, including time of day, week or year, rushing with clients and time pressures related to travelling to clients’ homes, as well as “timely practice” and sequencing of events in care (e.g., timely assessments and update of care plans).

Organizational (system design) concerns: Concerns about the structure and organization of home care, including policies, procedures and practices that hinder the provision of high-quality and safe home care. This domain overlaps with many concerns from the other domains. (See Figure 1.)

We move now to discuss our BC findings and to draw comparisons to other BC study findings, showing similarities and differences of HSW concerns. We begin with spatial concerns because these are inherent features of care at home, only some of which can be changed by organizational policies and planning.

Spatial safety for HSWs
“The client’s home is also a workplace, and should not become a limiting factor in receiving services” (Lang et al. 2009: 99). However, in interviews with clients and HSWs it became clear that they perceived home as a space where clients should feel comfortable and in control of their lives. Clients should be able to expect that they have input into who enters their space and how their space is altered. To respect these perceptions, it is necessary to recognize that a client’s home will never be a public and regulated space. Thus, a unique balance has to be reached to ensure not only the physical safety of all those involved, but also their emotional and mental safety. HSWs voiced their recognition of this relationship: “You know, it’s just a thing where it’s their house, their space. I’m a guest but I have a job to do.”

The layout of clients’ homes presents distinct challenges for healthcare providers. Whereas hospitals are standardized in ways that meet provisions for care, the majority of homes are not designed to be places for physical care. This means that the layout of the client’s home may include hallways too narrow for easy
mobility with wheelchairs or walkers, bathrooms that are too small or poorly designed and beds that may be too high or too wide. Furniture badly positioned, carpets that make navigating wheelchairs difficult and scatter rugs can present problems for HSWs who must assist clients through these obstacles. In “hoarder” or messy homes, healthcare providers worry about tripping and falling. Risky buildings that have broken steps, poor handrails and other unsafe features are also problematic.

Other internal features of clients’ homes that presented challenges for HSWs were pets, specifically dogs or cats. Clients frequently needed a HSW to assist with care of the pet, particularly cleaning out the litter box or taking the pet outside.

Another spatial safety concern is the neighbourhood in which the client resides. In two cases the clients and healthcare providers considered the neighbourhood unsafe due, in one case, to the proximity of a needle exchange program, and in a second instance to a public park occupied by “undesirable people posing a risk for robbery of the client’s drugs.”

One HSW in our study stated:

I had a friend who works in the [urban centre] towers, … and apparently she had called the office and said, “Oh, we need a home care nurse.” And [the response was] “Oh yeah, the home care nurses don’t go there because it’s unsafe for them but they’re sending us [home support workers] there.”

This perceived disparity between risks considered acceptable for HSWs but not for professional healthcare providers illuminates the potential for serious ethical problems of inequity in the workforce. Exposed most clearly in this instance seems to be the value placed upon worker safety, which is different for non-professional and professional staff. Such differentiation could have no ethical justification.

Central spatial concerns in the study by Sims-Gould and Martin-Matthews (2010: 102) related to client habits that conflicted with HSW safety, the presence of pets and general cleanliness. Extra tasks, such as taking out garbage and recycling involving stairs and icy surfaces, were often unsafe. Comments from HSWs in the study by Craven and colleagues (2012: 4) illustrated these spatial safety concerns when they spoke of worries about barking dogs and clutter in the home.

Spatial risk factors were also reported in the study by Stevenson and colleagues (2008: 22), who found that concerns were expressed about “neighbourhoods where staff felt uneasy due to high crime rates, drug trafficking, etc.,” posing risks to staff and clients. These researchers probed different types of risk-taking to
determine whether staff felt that they were expected to put themselves at risk: staff stated they were not expected to do so, but in describing the persistence of risks they indicated that things have always been this way. The drive to and from homes in winter was noted as a safety factor, as were unsafe neighbourhoods (specifically those considered to be populated by drug dealers). The researchers drew attention to the “high tolerance of risk” that HSWs held. In comparison, they noted that quality of practice environments and safe workplaces are entrenched issues in acute care (Stevenson et al. 2008: 22).

Being in the client’s home necessarily requires that HSWs respect clients’ choices about how they live, to some degree. Dogs and cats may be a given, unless these pets become safety hazards for HSWs. But cluttered space, scatter rugs and client habits that create poor environments for all, as well as pet care, need to be negotiated. While it may be impossible to remove all risks, the matter of health providers’ “working at risk” constitutes a delicate balancing of harms and benefits for all concerned.

Physical safety for HSWs
One outstanding physical safety concern in our study related to lifting clients and the use of lifts. HSWs seemed prepared to do their best to get clients into bathtubs and onto commodes without assistance from another person and, if needed, without a lift designed for that purpose.

R: The first time I was there … because of the issue of them getting her into the tub actually or getting her up on the toilet seat, because of the unsafe condition, I wasn’t sure exactly how to handle her.

I: And so there wasn’t proper equipment to get her in and out of the tub and toilet?

R: There was some equipment, but she couldn’t use it because of the arthritis in her hands … so she couldn’t get the safety rail. … I am not even sure she was to have a bath, actually.

In other cases we learned of HSWs rescuing clients who fell, and they did so by taking risks themselves in lifting these clients rather than calling 911 for help, as instructed. Because a second HSW or someone else was rarely on hand to assist, the HSW chose to take this risk to help the client. Sometimes even clients who had properly installed lifts refused to use them, counting on the HSW to assist them without a lift to help them get up. HSWs seemed to feel an ethical commitment to help clients even when it involved personal risks in providing such assistance.
An added danger to clients and HSWs was the use of improperly installed lifts; the use of lifts with inadequate training for their safe and proper use; and working with lifts and other equipment that did not meet standards of safety. In one case an improperly installed lift had fallen from the ceiling. The HSW expressed her fear about using the lift “because we don’t know if that tracking is stable.” She confirmed that the lift had fallen on the client, then onto her own head and arm, injuring her arm.

Many HSWs stated that they had absolutely no training in the use of lifts; others indicated that their training was inadequate. One or two HSWs who had previously worked in residential long-term care had good training and experience in the use of lifts, but the community-based HSWs, who comprised the majority of HSWs in our study, did not have such training.

Another safety concern arose with regard to clients who were mentally ill or violent. HSWs noted that they had no advance warning of this potential danger, normally because it was not communicated to them, or their supervisor had not yet visited to assess the home, or the supervisor had not updated the care plan to indicate this risk. More than one HSW stated that she was struck by a client:

I bent down to get face to face with the guy, a gentleman who is 99, and got clocked in the face, right hook. It was wow! I wasn’t expecting it. I always been told to get to eye level and be respectful. And bang! Like wow!

Another HSW also experienced violence.

She told me I could leave. And I said to her, “But how?” She clobbered me. … That was my first experience. And after that I learned to just duck and get out.

In some cases guns were present in the home and handled by a client. In one situation we were told that a client was waiting with two guns for a HSW. A fairly consistent safety concern was the HSW’s indicating that he or she had no warning about these dangers. In caring for clients with infections, or if the HSW wanted to avoid spreading a “bug,” only a few HSWs knew about the location of masks, gloves or gowns for their use – and many did not seem to know they could ask for these supplies.

Another major difference between safety in home care, as opposed to safety in hospital, is that the HSW typically works alone. This means that when there is a fall there is no one immediately available to help lift the client or to remind the HSW of the dangers of lifting without a lift; and when a spatial location feels
dangerous or is potentially dangerous, there is no one there to help mitigate the risks. We also learned that often when workers called the help line to report a major concern, there was only an answering machine and call-backs were unreliable, sparse or not timely.

In studying Friday discharges from hospital to home care, Stevenson and colleagues (2008: 22) found that HSWs “were often responsible for doing the first assessment.” These HSWs indicated that they found Friday discharges particularly challenging because equipment suppliers and support services were closed. They also found that HSWs “appeared to have accepted a high degree of risk, and had done so for a long time,” including working at risk of musculo-skeletal injury. Craven and colleagues (2012: 4) found the absence of functional lifts in the face of “inappropriate beds (e.g., need for hospital style bed)” to be a serious safety issue in bedrooms and in bathrooms in many homes. To make matters worse, when an injury was reported initial questions tended to blame the victim, that is, questioning the worker’s knowledge of body mechanics and types of shoes worn, rather than assessing the physical challenges of the home.

In summary, physical harms affect all those involved in home care – the client, the family, healthcare providers and HSWs – as they are all intertwined in this healthcare relationship.

Interpersonal safety concerns
A major safety concern with implications for interpersonal safety was the lack of consistency in HSWs’ assignment to regular clients. Almost uniformly, both HSWs and clients stated this as a serious problem, noting that developing trust is very important for the HSW–client/family relationship. One HSW stressed how important it was to ensure the initial visit to the client went well:

You try to do the things the right way the first time and make the person feel totally comfortable.

Making “the person feel totally comfortable” has a great deal to do with relational ethics (Bergum 2013: 127). Comfort levels between clients and care providers improve with each subsequent home visit as they strengthen that relationship.

Understandably, clients registered their frustration when a different HSW arrived, after getting used to and establishing a relationship with a particular HSW, because the connection that had been made was broken. Clients and family members indicated that it is frustrating to have to orient new HSWs to their home, and to care needs and particular practices, over and over again. Sometimes the lack of continuity in home support can lead to upset or angry clients:
You walk into a client’s place, and you know it has nothing to do with you, it has to do with the fact that you’re not the regular worker, and they take it out on you.

HSWs expressed their own concern about the paucity of information they receive about new clients, making it more difficult to establish a positive relationship with them and their families:

HSWs do not receive enough information about new clients, sometimes don’t even know their age, and when care plans are out of date, this creates tensions between client and HSW – just told person is in a wheelchair but is found walking and not using a wheelchair; don’t know if person is just out of hospital.

HSWs noted that this makes being sensitive to family members and their needs doubly difficult. One family friend who assisted a client indicated how important it is that HSWs listen to clients well. Concerns were expressed by HSWs, clients and family/friends that HSWs needed better training in interpersonal communication to better support clients and their families, as well as more knowledge of calming techniques for confused, mentally ill or violent clients. At the same time, HSWs spoke of ways they had developed to calm clients (e.g., change the TV channel) and to de-escalate potentially violent behaviour by distraction.

We found that HSWs had a strong desire to be part of the home care team, wishing they could work with one another more closely:

We’re not getting enough where we can work together as a team because we’re all kind of separated and we’re not able to assist in a better fashion. … There’s no continuity of a system between workers and clients.

Whether there was a misunderstanding among HSWs or whether they were actually given an order, they stated that it was part of their contract “to keep quiet and not say anything,” including not sharing helpful information about what worked well for a particular client whom two HSWs might be visiting independently. This widely held belief would seem to work against enhanced support for HSWs or clients. Several HSWs commented on their desire to meet with other HSWs through inservice education or even staff meetings, but these gatherings were no longer available to them.

Stevenson and colleagues (2008: 22–23) also discovered that workers were concerned about the lack of information they received. For example, workers were often not given a completed risk assessment prior to their initial visit. This
led to concerns about what they would encounter in the home, a relevant concern because older people with dementia were a majority of their clients. Additionally, there was often inconsistency in the information given. In the study by Sims-Gould and Martin-Matthews (2010: 104), building rapport to provide more meaningful care was found to be an important way to obtain client approval as well as worker satisfaction.

Craven and colleagues (2012: 4) found several safety concerns that HSWs encountered in work with persons with dementia or mental illness. Many concerns focused on “perceived physical risk for workers,” including aggression, injury and fire hazards. Interpersonal concerns with family members were also highlighted, particularly “when family members were unwilling or unable to purchase appropriate equipment for the home.”

A relational ethic pays attention to individuals (clients, family members and healthcare providers). This means that at the individual level trust is built by good communication and investing time by health providers, clients and families to promote ethical care and support (Rodney 2013).

Temporal concerns for safety
A consistent message from almost all HSWs and clients related to concerns about time and timing. During our data collection, recent reductions in funding to home support services required HSWs to factor their travel time into the client assignment time, thus reducing the amount of time for each client. HSWs spoke about the set amount of time allowed per client, stating that it was difficult to provide adequate care and support within such limited time. “Not enough time” was a steady theme that included the need to rush clients, to end up doing things quickly and sometimes even harshly, in order to provide their care in the allotted time. One HSW noted that “if you rush clients, then falls happen.” Another HSW stated:

I need 1.5 hours of morning care for [client], and that includes getting to the next place. HSWs need to multi-task in too short a time, and often need to use their own half-hour to help the client.

Two of the clients in our study found their ability to do limited part-time work, despite their major limitations in mobility, was sustaining. But a temporal concern for HSWs was the matter of timing their visit to align with the client’s work schedule or other responsibilities.

One of my clients works, and on her workdays if we are running late, she gets stressed out – having her hair done is not part of the plan. If another
worker goes in to provide for her complex needs, the hour of time is not enough.

This remark also points to the efficiencies of use of time when a consistent HSW is assigned care for a client. Another HSW observed that shortage of time also limits attention to the client’s emotional needs because physical tasks have to take priority.

An equally important safety concern about timing is the common concern that client assessments by health professionals were often not done or communicated to HSWs in a timely manner. This meant that a HSW was often going blindly into his or her first visit to a client. When a client cannot communicate his or her needs well, some serious safety concerns may go unaddressed owing to lack of supervisor–HSW communication. Moreover, the communication book is located inside the home, and thus, HSWs can be in a dangerous position even while reading “the book,” without any knowledge of their danger until it is too late. They may also fail to notice serious mental or physical health concerns that the client may present. Other temporal safety concerns were delays in obtaining equipment for a client, and delays in an order’s being written for delegation of tasks. Without this latter order, HSWs could continue to visit their client but were unable to provide needed medications or perform other necessary procedures without authorization through the delegation of tasks.

In comparing our findings to those of other BC studies, we found several similarities. One of the main foci of the study by Stevenson and colleagues (2008) was the timing of discharge from hospital, especially Friday discharges, and how that timing affects safety. This timing created several safety concerns for all healthcare providers, including lack of sufficient information received and the challenges of getting services, as noted earlier. When only a diagnosis or dressing-change orders were provided, the providers had no information to know the client’s domestic arrangements or other information necessary for a safety-conscious visit.

The HSWs in the Sims-Gould and Martin-Matthews (2010: 102) study discussed “the compression of time to provide care, the reallocation of tasks when you have little extra time, and the time required for travelling between clients’ homes.” This concern was reported many times by HSWs who struggled to finish their assignments before getting to the next home. HSWs found that they were often several minutes late coming from the previous client, and felt pressured to leave the current client 10 minutes early to get to the next client.

In the study by Craven and colleagues (2012: 5), the temporal safety focus also included travel and travelling time. It seemed apparent in all the BC studies that
travel time was an issue. This often had a domino effect on HSWs’ workload and their ability to meet clients’ need for a clear estimated time of HSW arrival.

In our interviews, HSWs reported consistent concerns about insufficient time in the home and travel time, particularly with respect to arriving late for the home support visit, and being rushed to provide the care needed before having to leave.

Organizational factors and system design that affect safety
To better convey the way in which we modified the model of Craven and colleagues (2012), we chose to develop a schematic. Similar to Craven’s model, our physical, temporal and interpersonal domains overlap. But in our study, we perceived the spatial domain as separate because when one is considering how to minimize harm, little can be done to change the space in which HSWs practise. The concerns indicated as physical, interpersonal and temporal concerns have a great deal to do with the structure and organization of home care, because system design affects these concerns. Taking into account the context of home care and home support in Canada, as Lynam and colleagues (2003) suggest, can provide a better sense of how many of these types of concerns might be addressed. Our model is depicted in Figure 1.

Figure 1. Domains of home support worker safety

Source: Adapted from Craven et al. (2012).

Concerns about the organization and structure of home care, including policies, procedures and practices that hinder the provision of high-quality and safe home care, are “organizational concerns.” Many of these concerns were identified and analyzed by Lynam and colleagues (2003) and by Ceci (2006). Among these concerns were shortages caused by placing efficiency as the highest priority in the provision of care and support. In the name of efficiency, corporate streamlining of processes included displacing and decreasing front-line staff needed for
high-quality care. The effect created by these actions deeply affected the care provided, the processes for managing shortages, time for clients and the morale of the healthcare providers.

In our research, we found the impact of the shortage of staff, including professional staff (assessors and supervisors) and HSWs, was a serious challenge as home support administrators attempted to do more with less. A critical shortfall noted by HSWs was the lack of proper preparation for home support work, either through inappropriate hiring or the misalignment of the work they are required to do with their educational preparation. Schedulers were described as extraordinarily busy, causing them to make mistakes in assignments of HSWs to clients, and often leading to delays in provision of care or to inefficiencies. For example, HSWs spoke of being able to meet the needs of clients who were assigned to them on a steady basis, while a new worker might need twice the amount of time to accomplish morning care or mobility tasks.

The many concerns raised about delayed assessments or delays in delegating tasks were explained as a function of the shortage of supervisors (assessors and others). HSWs spoke often of having no one who could answer a call about a problem in a timely manner, and about arriving to provide home support without a care plan updated or authorization to perform a required procedure. One unintended outcome of this shortfall was that without sufficient communication, it was difficult to establish good rapport with clients at the outset owing to lack of information. As Lynam and colleagues (2003: 120) found in their study:

… the processes of tracking patients and mechanisms for maintaining an awareness of background information related to a patient’s condition and treatment often do not work effectively in [a] streamlined clinical environment.

Whether in a hospital acute care environment or in home care, knowing the person for whom one is caring is critical to building a trusting relationship. The restricted information that HSWs might have about a client they visit was a function of many missing links in home care – in our study, the lack of teamwork with other health providers, the sense of being forbidden to speak to one another about best care practices for a client, and no time for a scheduler or supervisor to give HSWs information that promoted client safety and support.

The Context of Home Care and HSWs’ Role

In May 2012, the Conference Board of Canada issued a report titled *Home and Community Care in Canada: An Economic Footprint* (Hermus et al. 2012). In this report, both public and private home healthcare and home support spending are estimated by province from 1999 through 2010. As a share of total spending on
home care, New Brunswick leads the way at 8.78%, with Manitoba and British Columbia at 5.2% and 5.6%, respectively, of the total of healthcare spending. The Conference Board noted that Canadian research points to benefits of more optimal investments in home and community care services, with the frail elderly as their focus. In particular, they suggest that “lower-level support services (assistance with shopping or transportation, for example) would help some people to keep living in their own home” (Hermus et al. 2012: 22). The Conference Board also noted, with some concern, that there has been an upward substitution of home care to more costly hospital and residential long-term care with a trend “away from the provision of longer-term support services to short-term care” (p. 23), which “can be enough to help some people who have a decline in function stay in their home and out of institutions” (p. 24).

That perspective represents part of the picture at the provincial level, but perhaps the most significant decisions about home care occur at the regional level, at least in British Columbia. Ceci (2006) studied the economic discourses of case managers (and their managers) in home care as they responded to client situations. She found a growing distance between professional discussions that focused on the best interests of the clients, and organizational discourses, largely economic discussions that shift the way in which home care clients are viewed to accord with the budget. One issue that Ceci (2006: 60) probed was the allocation of home support hours. She discovered that in order for case managers to allocate resources in what seemed to them a rational approach – a better control of resources – they determined that resources should first be allocated to the “most complex clients,” that is, using a medical model to determine allocations. This meant a reduction in home support services – justified by classifying clients as more independent than they actually were. This being the case, lack of adequate preparation for some of HSWs’ duties, exacerbated by limited supervision, poor communication and shortage of staff, could explain the difficult situation in which these workers have found themselves.

**The Interface of Ethics, HSWs and Safety**

A common moral obligation of those who care for and support others is that they are to do their work for their clients’ benefit. In doing so, they are expected to be capable of performing their assigned tasks in ways that remove or minimize harmful practices or situations. Unsafe use of lifts to mobilize clients is but one example of a potentially harmful practice if the technique of managing the lifts is not understood. In order for HSWs to practise safely, they need to know about various equipment and have an opportunity to develop skills in using it.

In addition to the knowledge and skills required for physical aspects of care, HSWs also need to know how to develop caring and supportive relationships with
clients. This requires both a basic educational focus on such relationship building as well as ongoing inservice education for both physical skills and relational skills. Knowledge of ethics in practice would be an important addition to their basic and continuing educational programs so that they might develop the skill to engage with clients through a relational ethic.

Relational ethics is built on the premise that all relationships are experienced as moral. In each connection one enacts the question of what is the “right thing to do” both for oneself and with and for others. (Bergum 2013: 127)

But unless HSWs receive greater support from supervisors who understand the importance of embedding ethics into practice and practice environments, their ability to provide good, ethical home support may not be possible. Rushing through every home visit does not lend itself to making strong connections with clients or providing safe care. HSWs need a team leader who can oversee all aspects of home support, that is, the overall care plan, the work involved in implementing the care plan, and the suitability of assignments. This is challenging work given the high volume of clients needing home support and the rapid changes in level of client need, particularly with elderly and frail clients. But moral support and guidance need to be available to HSWs. Clear and manageable assignments and appropriately delegated tasks are critical.

The benefit of having a team leader to oversee and support their work would be the opportunity to establish HSWs as a visible part of the home care team. In our study, HSWs expressed a longing to be recognized as part of the team to affirm the value of their work, to provide opportunities for them to contribute their insights about client needs to other team members and to learn from others. Such teamwork could invest the HSW–client relationship with a sense of dignity, and thus could enhance their contributions overall. Another benefit of being part of the home care team would be to enable HSWs to practise within the limits of their competence by better understanding the work of others, allowing them to feel safe to speak up about their limits of practice (a key ethical matter of accountability) and giving them a sense of belonging.

A major ethical reality surrounding and permeating home care is the matter of equity within healthcare – essentially, equitable allocation of resources within society – and within home care and home support programs. In spite of the growing movement from public health officials, administrators and the public to embrace home care as a more efficient and effective way to provide care, a disproportionate amount of funding continues to flow to acute care in hospitals. An unknowing public lauds the virtues of being at home for care, even dying at home; that is, until faced with the actual hands-on challenges of providing care they
assumed home care would and should provide. The inequities must be corrected if the goal of high-quality and safe home care services is to be realized.

Conclusions

We have focused on one province in Canada (British Columbia), and on home support workers in British Columbia in particular, to draw attention to the importance of home care, the key role that HSWs play in home care, the breadth of safety issues they encounter, the ethics of home support and home care practices, and the difficulties that HSWs experience in providing care. At a minimum we have been able to reinforce the study findings of other researchers and draw attention to the ongoing nature of the inequities involved in the provision of home care. But in addition, we have provided more specific details about safety risks for health providers, particularly HSWs. Examples and quotations included in this paper offer some depth of understanding in unpacking the meaning of the list of safety concerns for home care providers, specifically HSWs.

We conclude with some speculations about why such difficulties continue. As noted in the introduction to this paper, the challenges and safety issues for HSWs and other home care workers are not new. They have existed for over a decade.

One of the difficulties with home care as a field of practice is that it is dispersed, fragmented and invisible except to those already working or living to capacity. It is also a field of healthcare shaped by a fairly narrow circle of decision-makers. (Ceci 2006: 66)

That small and somewhat isolated circle of decision-makers are disadvantaged in all sorts of ways, including by health legislation and health policy that circumvents a freer flow of funding similar to that enjoyed by hospitals and acute care providers. At a national level, our major policies in healthcare do not attend to the field of home care in the same manner that hospitals enjoy. Based upon historic legislation, the Hospital Insurance and Diagnostic Services Act of 1958, hospital funding and support was shifted to the replacement legislation, the Canada Health Act of 1984. By this move, hospitals secured a similar approach to funding, that is, cost sharing between the federal government and the provinces, gradually modified over the years to a transfer of tax points from the federal government to the provinces and a lower percentage of funding. However, home care has had no such history and stands outside this Act, creating both a vulnerability and an uncertainty about how it will be offered in each province. In effect, this is a legislated inequity.

Such inequity needs to be viewed through an ethics lens at the societal level, the health administrative level and the level of the case manager and front-line health-care professional. As Lynam and colleagues (2003: 137) have observed:
Enacting a commitment to equity, then, means demonstrating that mechanisms are in place to provide necessary care. … this could mean physically assisting a patient who is unable to meet his hygienic needs; ensuring that a woman who cannot communicate her diabetic status is fed when she needs to eat; ensuring that a patient who is in pain … receives appropriate treatment; or ascertaining that someone undergoing diagnostic procedures or being discharged home understands the possible consequences.

Urgently needed are “champions” for the essential role that home care plays in Canada. Such leadership also means advocating for adequate funding and coordinated home care across regions and across Canada (Ganann et al. 2010: 66).

The release of the first Pan-Canadian Study on safety in home care (Doran et al. 2013) provides a rich opportunity for every advocate to be vocal about the recommendations from this report. Among them is a call for cross-sectorial case managers of home care; for integrated interdisciplinary teams to be established; for incentives to be sought to build collaboration between home care and institutional care; for standardization of home care; and for standardized competencies for HSWs to be developed. Implementing these and other changes would go a long way towards creating a more ethical and equitable healthcare and home care system.

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