

## "Out of Control": Violence against Personal Support Workers in Long-Term Care

Albert Banerjee <sup>1</sup>  
Tamara Daly <sup>2</sup>  
Hugh Armstrong <sup>3</sup>  
Pat Armstrong <sup>4</sup>  
Stirling Lafrance <sup>5</sup> and  
Marta Szebehely <sup>6</sup>

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<sup>1</sup> Doctoral candidate, York University Department of Sociology

<sup>2</sup> Assistant Professor, York University, School of Health Policy & Management

<sup>3</sup> Professor, Carleton University, School of Social Work

<sup>4</sup> Professor, York University, Department of Sociology and Women's Studies and CHSRF/CIHR Chair in Health Services and Nursing Research

<sup>5</sup> Master's Candidate, York University, Department of Sociology

<sup>6</sup> Professor, Stockholm University, Department of Social Work

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# “Out of Control”: Violence against Personal Support Workers in Long-Term Care

## 1. Executive Summary

Working in Canadian long-term care is dangerous. But it need not be. This study shows that, while Canadians working in long-term facility care experience violence virtually every day, this is not the case in Nordic countries. Clearly, the high level of violence in Canadian facilities is not a necessary feature of work in long-term care and can be reduced.

This report on the violence experienced by personal support workers draws on an international study comparing long-term, facility-based care across three Canadian provinces (Manitoba, Nova Scotia, and Ontario) and four Nordic European countries (Denmark, Finland, Norway and Sweden). It is supported by focused discussions and offers insight into long-term care from the perspective of workers.

Our findings are deeply troubling. Personal support workers tell us that violence is a *constant and ongoing* part of working in Canadian facilities. The violence they experience is physical, verbal and sexual. Racism is also common. Almost all personal support workers have experienced some form of violence. And nearly half experience physical violence on a *daily* basis.

Most incidents of violence go unreported. Violence remains invisible and unaddressed. Workers tell us that they don't report violence because they don't have the time to complete the paperwork, they don't believe anything will be done, or they are afraid of being blamed. Most disconcerting, workers tell us they are expected to tolerate this abuse as part of the job.

Our international comparisons show that the level of violence in Canadian long-term care facilities is extraordinary. Canadian personal support workers are almost *seven* times more likely to experience violence on a daily basis than workers in Nordic countries. *Clearly, the high level of violence in Canadian facilities is not necessary and can be reduced.*

Long-term care workers link violence with working conditions. Having too much to do, working with too little time and too few resources places workers in dangerous situations. *Working short-staffed is a major contributor.* Canadian personal support workers tell us they routinely work short-staffed. Almost half say they do so on a daily basis. And over one third felt they are too often left alone to care for residents. Working short-staffed is much less common in Nordic countries. Nordic long-term care workers also experience greater flexibility on the job and greater communication among colleagues – both factors that mitigate workplace violence.

Canadian personal support workers express serious concerns about the increasing care needs of residents and their lack of adequate training. Moreover, the training that is provided is not supported with adequate resources, requiring workers to attend on their own time or during breaks.

Working under extreme conditions constitutes a form of violence in itself – a structural violence that originates in large measure in the way long-term care work is organized and funded. Such conditions can be changed. But at present, working in long-term care takes a severe toll on Canadian caregivers. Canadian personal support workers are *twice* as likely to end the day feeling physically exhausted, *three times* as likely to experience back pain, and *four times* as likely to be mentally exhausted as Nordic workers.

The dramatic difference in rates of violence and conditions of work between Canadian long-term care facilities and those in Nordic countries makes it clear that these problems can be addressed. A number of recommendations are apparent:

- Governments must recognize chronic short-staffing as a key contributor to workplace violence. Governments need to address short-staffing by legislating adequate care standards and by providing the funding to meet these standards.
- An empowering work environment needs to be fostered; one that gives personal support workers a true voice in how their work is designed, organized, and scheduled.
- Documentation of violence is necessary. Our study shows this will not be successful until the culture of blame is addressed.
- Appropriate training that recognizes the complete medical, mental, emotional and social needs of residents is essential. Workers must be supported so that they have the time and resources to attend training sessions. Training must be accessible (on paid time, with absent staff replaced), designed with worker input, credentialized, and comprehensive.
- More broadly, the difference between Canada and Nordic countries evidences a history of neglect. Long-term care must be recognized as an essential health service and become a national priority.

## 2. Introduction

Canadian long-term care facilities are violent and dangerous workplaces. Workers experience violence virtually every day. They are often pushed, shoved, hit, yelled at, and bitten. This study shows that violence is a constant and ongoing part of their job. But it need not be. Our study finds levels of violence are much lower in Nordic countries. The high level of violence in Canadian facilities is exceptional and *not* a necessary feature of work in long-term care. Violence can be reduced.

This study is based on a survey of workers in long-term care facilities in Manitoba, Ontario, and Nova Scotia. It also draws on front line accounts obtained through focused discussions with long-term care workers. It is part of a larger project comparing Canadian long-term care facilities with those of Nordic European countries. We draw on these international comparisons to highlight some of the stark realities of working in Canadian long-term care facilities.

What we found is disturbing. Our study shows that workplace violence is an *everyday* occurrence for many long-term care workers. Violence is physical, verbal, and sexual. We also find racism and structural<sup>[1]</sup> violence – stemming from severe working conditions – inflicted on caregivers who are committed to caring but robbed of the resources to do so. Because this study is based on workers’ perspectives, we find that long-term caregivers work under conditions that not only foster violence but also render it invisible. Most violent incidents go unreported. Workers are afraid to report violent incidents, fearing that they will be blamed. Or they simply don’t have the time to do so. Alarming, workers inform us that they are expected to take such abuse. They are told to “lighten up.” The situation, as one worker put it, is “out of control.”

Yet our research shows that violence does not need to be part of long-term care work. Comparisons with Nordic countries demonstrate that the levels of violence there are far lower than they are in Canada. The prevalence of violence in Canadian long-term care facilities reflects a history of neglect.<sup>[2,3]</sup> This neglect has resulted in an under-resourced and understaffed work environment. Our study finds current working conditions require long-term care workers *to do too much, in too little time, with not enough resources*. Rushing care tasks, working understaffed, not having time to develop relationships with residents, and caring for cognitively impaired elderly – too often without the appropriate training – all contribute to the violence experienced by care workers.

While our study examines the experience of long-term care work for the full range of employees in such facilities, this report focuses on violence against *personal support workers (PSWs)*. The choice to concentrate on personal support workers is due to the fact that much, but certainly not all, of the violence occurs during direct care activities.<sup>[4]</sup> And because personal support workers provide the bulk of direct care, they are most frequently exposed to violence.

Our focus on personal support workers should not be taken to imply violence does not impact other workers. In fact, we find that 16.8% of registered nurses and one quarter

(24.6%) of licensed practical nurses, registered practical nurses, and registered nursing assistants experience violence on a daily basis. These numbers are shocking. Clearly they are far too high. But they do not come close to the prevalence of violence for personal support workers. Our data show that nearly half (43.0%) of personal support workers are subject to violence every day. For this reason we focus on their experience in this report. Indeed, reflecting on the situation of personal support workers in British Columbia's long-term care facilities, Neil Boyd observes that they face a greater risk of injury from violence than do local police officers.<sup>[4, 5]</sup>

One final note. Violence in long-term care is not just a workers' issue. It is a women's issue. The vast majority of caregiving staff are women. In our study, almost all (95.1%) of the personal support workers are women. When we speak of violence against personal support workers, we are in effect speaking of violence against women. And it is important to note that many of these women are from immigrant and/or racialized groups.

Yet, despite the fact that most workers and residents in long-term care are women, gendered analyses are usually absent in the research on long-term care. In this report, we understand gender as a *context* shaping the lives of caregivers. In the case of long-term care, gendered assumptions – particularly the devaluation of caring labour and the privileging of instrumental tasks over relational care work – have greatly contributed to the levels of workplace violence that we observe. These assumptions should be kept in mind when interpreting this research and working towards change.

### 3. Method

This report draws on three sources of data to illuminate the violence experienced by personal support workers. First, it draws on a survey of workers in unionized long-term care workplaces in Manitoba, Ontario and Nova Scotia. The Institute for Social Research (ISR) at York University was responsible for the sample design and distribution. The sample was based at the level of the organization, and designed to be proportional by provincial population and by nursing home ownership type.

Eighty-one unionized long-term care facilities were selected. Five major health care unions (CAW, CFNU, CUPE, NUPGE, SEIU) provided contacts at each facility to aid the ISR in the distribution of the survey. A union representative at each workplace was asked to distribute the survey to the staff at the facility. The survey was conducted between January and August 2006. Workers from 71 (87.6%) of the workplaces participated. A total of 948 surveys were returned. Of these, 415 were from personal support workers, the vast majority (95.1%) of whom were women.

Second, nine focus groups were conducted in order to validate the survey results and provide workers with an opportunity to discuss our findings and offer additional comments, insights and elaborations. These discussions were conducted between December 2006 and May 2007 in each of the three provinces surveyed (Manitoba, Ontario, and Nova Scotia).

Third, this research forms part of a larger comparative project investigating working conditions in long-term care facilities across Canada and the Nordic countries of Denmark, Finland, Norway, and Sweden. To facilitate comparisons between countries, the survey was designed in coordination with our Nordic partners to ensure that largely identical questions were asked in both the Nordic and Canadian context.

The Nordic data was collected as part of a larger study, *NORDCARE: The everyday realities of care workers in the Nordic welfare states*.<sup>1</sup> In 2005, surveys were mailed out to a random sample of 5000 unionized care workers in both home-based as well as residential-based care for older or disabled persons in Denmark, Finland, Norway and Sweden. The response rate varied between 67 and 75 per cent. In total, 1574 surveys were completed by Nordic care workers in residential care for older people (391 in Denmark; 432 in Finland; 435 in Norway; 316 in Sweden).

For ease of reference, in this report we refer to Nordic countries and Nordic Europeans in lieu of listing the countries each time. Similarly, we refer to Canada and Canadians, rather than listing the three provinces. Further, when interpreting our findings, one should bear in mind that in the Canadian context surveys were sent only to *unionized* facilities. These results are therefore not representative of non-unionized facilities.

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<sup>1</sup>The study was financed by the Swedish Council for Working Life and Social Research, and led by Marta Szebehely (Professor, Stockholm University, Department of Social Work).

#### 4. Frequency of violence

While researchers have only recently begun to attend to violence against long-term care workers, the studies that have been done show that it is a common occurrence.<sup>[6]</sup> It is most frequently verbal and physical.<sup>[7]</sup> The verbal violence experienced by care workers often includes threats, screaming, cursing, racial insults, and demeaning remarks. It can also include excessive demands and complaints. The physical violence experienced by care workers typically includes being slapped or hit with an object. It frequently involves being pinched, bitten, having one’s hair pulled, being poked or spit on. Having one’s wrists painfully twisted is also very common. Sexual harassment and violence has been noted, though far less studied.<sup>[8]</sup>

Our study found remarkably high rates of violence. Almost all (89.7%) of the personal support workers in our survey indicated that they had experienced some form of physical violence from residents and their family members while at work (Table 1).

**Table 1: Frequency of violence experienced by personal support workers in Canadian provinces**

Frequency Type of Violence	More or less every day	Every Week	Monthly	Less often	Never
Physical violence	43.0%	23.1%	7.8%	15.8%	10.3%
Unwanted sexual attention	14.3%	15.8%	7.5%	31.8%	30.6%
Racist comments	6.1%	5.6%	3.8%	23.0%	61.5%

Nearly half (43.0%) reported that physical violence occurred more or less *every day*. Another 23.1% said that they experienced violence on a weekly basis. The focus group participants made it abundantly clear that violence is a *constant and ongoing* part of the job. One spoke for many when saying:

*I’ve been punched in the face several times. I’ve been punched in the jaw several times. Getting hit. Having your wrists twisted....Pulling and shoving at you. I mean that’s a day-to-day thing....Violence is an everyday occurrence.*

Unwanted sexual attention was also commonly experienced by the personal support workers in our survey (see Table 1). Approximately one third (30.1%) said they experienced unwanted sexual attention on a daily or weekly basis. Another 39.3% said they experienced unwanted sexual attention on a monthly basis or less often. Just under

one third (30.6%) of personal support workers said they had never experienced unwanted sexual attention.

Describing a “typical” incident of sexual violence, one care worker noted: “Doing a bath on a male resident he tries to push your head down to his penis.” Or, as another care worker put it: “you tell them to wash their private parts and they say ‘No, you wash it. You’re paid to do that’.”

Staff also faced racist comments (see Table 1). On the whole, 11.7% said they encounter racist comments on a daily or weekly basis. This figure likely underestimates the level of workplace racism for a number of reasons. First, we looked at responses as a whole and did not compare rural and urban facilities. It is likely that visible minorities, who comprise a higher proportion of the personal support staff in large urban centers, experience higher incidents of racism than those reported in this study. Second, the questionnaire was available only in English and workers were required to fill them out alone. This prevented the aid of interpreters, so workers with language barriers are likely to be underrepresented. Nonetheless, in our focused discussions, some care workers commented that they personally experienced or overheard racism “all the time” at work.

Overall, our results about the frequency of violence against workers support the findings of other researchers and suggest the problem may be even more widespread. Examining one 320-bed long-term care facility in Winnipeg, for instance, Donna Goodridge and her colleagues concluded that personal support workers can expect to be physically assaulted by residents 9.3 times per month on average and verbally abused 11.3 times per month.<sup>191</sup>

Few personal support workers remain untouched by violence. As one respondent told us: “Somebody has always got a bruise or a bump.” Or in the words of another:

*It’s physical. It’s moral. It’s sexual. It’s verbal.... I’ve had broken ribs. I’ve been sexually assaulted in a shower room. Had my clothes torn off.*

## 5. Official reporting of violence

Research suggests that the vast majority of violence in long-term care goes unreported.<sup>[4, 10]</sup> Studies indicate that official reports are generally completed only if medical attention is required.<sup>[7]</sup> For the most part, either nothing is said, or a comment might be made to a nurse. Such comments, however, are unlikely to result in a formal, written report. Donna Goodridge and her colleagues, for instance, estimated that of the 15,000 incidents of violence experienced over a six-month period, less than one per cent (0.27%) had been reported.<sup>[9]</sup>

A number of explanations have been suggested for the lack of documentation, including the creation of additional paperwork, the lack of management follow-up, a culture of blame, fear of confrontation with management, the desire to avoid conflict with residents, and the myth that violence is just part of the job.<sup>[7, 11, 12]</sup> It may also relate to sexism – specifically the invisibility and normalization of violence against women.

Participants in our focus groups cited paperwork and fear of being blamed by their superiors as reasons for their silence around workplace violence. “When you are injured on the job to do WCB forms there’s what?, eight pages?” Another said it somewhat differently:

*... there’s so much paperwork involved in filling out an occurrence report or an incident report and when you do that then the nurse looks at you ‘Explain the situation’. She looks at you as if to say ‘Well that’s your fault.’*

Being blamed for incidents of violence was not only common, but evidenced a demoralizing and unsupportive work environment. The sense of futility is palpable in the following remark: “If you get hit it’s ‘What did you do?’ It’s always your fault.” This experience was voiced by yet another: “Yeah, it’s your approach. But slap a manager, boy you’re out within the hour.” Workers report being blamed even for sexual violence: “We had one [care worker] and when they went to management to complain, management told her that perhaps she shouldn’t be so friendly with the male residents.”

Most disconcerting was our finding that violence has become routine and that caregivers are expected to tolerate it: “...we’ve been told it’s part of our job,” said one care worker. Another observed, “We try not to [accept it], but management ‘Well you’re a big girl. You can’t be... Nobody can bother you. Lighten up’.”

What our findings make clear is that though there is a definite need to improve the documentation of violent incidents, we cannot expect staff to participate in reporting procedures until the culture of blame is addressed. Indeed, our study finds trust between management and staff lacking throughout. For instance, over half (60.7%) of all the personal support workers we surveyed told us their supervisors don’t trust the staff and that there was too much monitoring and control. And over one third (35.1%) told us that they “rarely or never” got support from their closest supervisor. Under these conditions, it

is understandable why violence is unreported. Violence remains invisible to the public. And for care workers, it goes unaddressed.

## 6. Variations in Violence

Workplace violence in long-term care is frequent. But it is preventable. Our international comparisons clearly demonstrate that such violence need not be part of the job. When comparing the levels of violence experienced by Canadian long-term workers with those experienced by workers in the Nordic European countries of Denmark, Finland, Norway and Sweden, some startling differences emerge (see Table 2).

**Table 2: Workplace violence in Nordic and Canadian long-term care facilities**

Country	Staff subjected to violence by a resident or family member*				
	more or less every day	Weekly	Monthly	Less often	Never
Denmark	5.0%	10.3%	7.0%	43.0%	34.7%
Finland	8.1%	11.6%	10.5%	46.5%	23.3%
Norway	6.8%	10.7%	7.5%	45.2%	29.7%
Sweden	6.2%	13.3%	10.5%	43.0%	26.9%
Nordic Europe	6.6%	11.4%	8.8%	44.6%	28.6%
<b>Canada</b>	<b>43.0%</b>	<b>23.1%</b>	<b>7.8%</b>	<b>15.8%</b>	<b>10.3%</b>

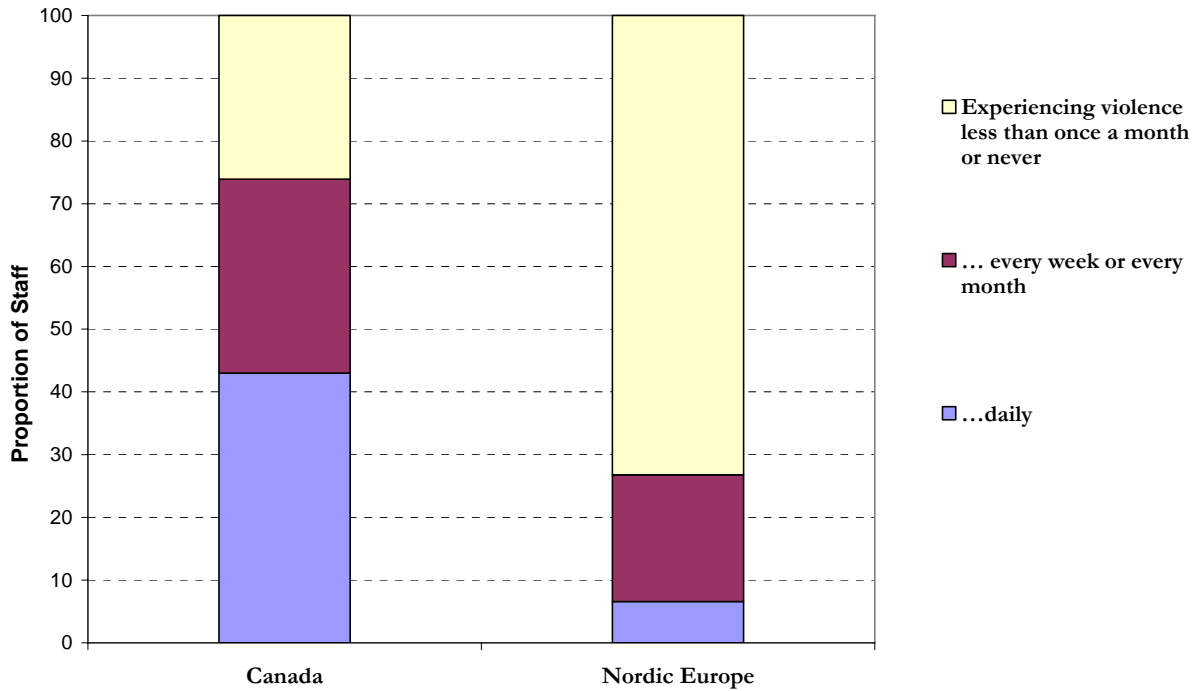
\*Note that the Nordic questionnaire likely over estimates the level of violence as it asks about violence *and* threats of violence. The Canadian questionnaire asks only about actual violence.

Levels of violence in Canadian long-term care workplaces are extreme when compared with the situation in the Nordic countries. For instance, **Canadian long-term care workers are nearly seven times more likely to experience daily violence than workers in Nordic countries.**<sup>2</sup> To put it another way, in Canada, nearly half (43.0%) of personal support workers experience violence on a daily basis. The average amongst the Nordic countries is 6.6 per cent. Similarly, while nearly three-quarters (73.2%) of Nordic workers say they experience violence less than once a month, only one quarter (26.1%) of Canadian long-term care workers can say this.

The differences are even more striking when represented visually. Violence in Canadian long-term care facilities dwarfs our Nordic comparators (see Figure 1).

<sup>2</sup> Due to different job descriptions across countries, in this report the Nordic figures refer to residential care workers in general. However, due to the way residential care work is organized in the Nordic countries, it makes most sense to compare the entire group of Nordic care workers to Canadian personal support workers. Nordic care workers, whatever their job title, usually do the same work as personal support workers, in addition to several other tasks which, in the Canadian context, are carried out by registered practical nurses. There is some variation in exposure to violence in Nordic residential care – the proportion experiencing daily violence in different occupational groups varies between 3.8% - 7.7% in Denmark; 2.8% - 12.5% in Finland; 0% - 8.1% in Norway and between 5.7% - 5.9% in Sweden. The higher figures usually refer to more specialised workers, for instance those who work only with elderly people with a psychiatric illness or with people with learning disabilities. But in all cases, the numbers are much lower than in Canada.

**Figure 1: Frequency of violence experienced by long-term care staff in Nordic countries and Canadian provinces**



And we have reason to believe the differences may be even higher. The Canadian questionnaire asked only about violence. The Nordic questionnaire was worded to ask about violence *and* threats of violence. This means that the actual violence experienced by Canadian staff far outstrips both the actual and threatened violence in Nordic countries. And, our focussed discussions revealed nuances to the problem of violence in the three Canadian provinces not revealed in the survey responses. For instance, workers not only talked about the lack of reporting indicated above, but also directly linked violence to their working conditions.

## 7. Violence and working conditions

Studies have shown that poor working conditions are key contributors to the violence experienced by caregivers.<sup>[13-15]</sup> In particular, having too much to do, too little time, and limited autonomy, places personal support workers in a bind: they must enter into a situation they know is potentially dangerous, rush a daily care activity, or suffer the consequences of not completing their work.

Daily care activities – where most of the violence occurs – often involve intimate acts and the sharing of personal space. If such care is rushed or worse if it is forced – for instance, when residents are required to get up, get dressed, or bathe before they are ready – this may leave residents feeling threatened, fearful or overwhelmed and prone to retaliate violently.<sup>[12]</sup> Furthermore, lack of autonomy disables workers from adapting to residents’ care needs.<sup>[14]</sup>

Policies in relation to incontinence pads provide a telling example. In our focus groups, workers reported that they are restricted in the number of diapers they can use per patient and are told they cannot change a diaper until it reaches the saturation point as indicated by a blue line. This is the case even if the worker judges the diaper needs changing and the resident is demanding that change. Workers are faced with an ethical quandary. On the one hand, they wish to respect patient autonomy. On the other hand, policies necessitated by under-funding jeopardize the residents’ wellbeing and their own safety.

It is for these reasons we asked employees about their workloads. The results of our survey show that personal support workers do not have nearly enough time to complete required tasks, let alone provide emotional care or socialize with residents. The majority of personal support staff (60.3%) reported that there was almost always too much to do (Table 3). They report being continually rushed, “on a treadmill,” “almost like Speedy Gonzales shooting all over the place” and “running around like a chicken with their head cut off.”

**Table 3: Long-term care workers in the Canadian sample reporting overwork and sense of inadequacy**

Frequency	All or most of the time	Sometimes	Rarely	Never
There is too much to do	60.3%	36.0%	2.9%	0.7%
Feeling inadequate as a result	40.6%	46.8%	8.2%	4.5%

Working short-staffed is a key contributor to excessive workloads and the feeling that there is never enough time. Indeed, working short-staffed appears to be the norm in Canadian long-term care. Almost half (43.8%) of the personal support workers we surveyed said they worked short-staffed on a *daily* basis. Another third (34.4%) reported that they worked short-staffed on a weekly basis. Only ten per cent said their workplace was short-staffed less than once a month. These numbers likely underestimate the

problem of understaffing because we inquired about facilities that operated short-staffed due to illness or vacation only. Focus group participants noted that they were also short-staffed because many vacancies were left unfilled. However, the problem is clear: “Never mind being sick or on vacation. Period. We’re short-staffed.” Indeed, some suggested this was a management strategy: “It’s a cost saving measure for them if they don’t replace the person.”

Once again our comparisons with Nordic countries show that these working conditions are not inevitable (see Table 4). Differences are particularly stark around levels of staffing. **Working short-staffed is the norm in Canada and experienced more or less every day by nearly half (43.8%) of Canadian personal support workers. In contrast, only 15.4 per cent of Nordic workers reported being short-staffed on a daily basis.** While Nordic workers will understandably see this as being too high, what our findings show is that working short-staffed is not inherent to the long-term care setting. It is a historical legacy – in large measure a product of policy and hiring decisions.

**Table 4: Working short-staffed, comparing Canada and Nordic Europe**

Country	How often do you work short-staffed?				
	More or less every day	Weekly	Monthly	Less often	Never
Denmark	23.1%	31.1%	21.9%	18.2%	5.7%
Finland	12.4%	26.9%	31.4%	26.2%	2.9%
Norway	13.6%	32.4%	18.5%	31.2%	4.2%
Sweden	12.0%	29.7%	22.8%	32.3%	3.2%
Nordic Europe	15.4%	30.0%	23.8%	26.7%	4.0%
<b>Canada</b>	<b>43.8%</b>	<b>34.4%</b>	<b>8.7%</b>	<b>10.6%</b>	<b>2.5%</b>

Working short-staffed and without adequate time or resources can also be understood as a form of “structural violence”<sup>[1]</sup> perpetrated against caregivers. It understandably leaves workers feeling insufficient and demoralized. For instance, workers were asked how often they felt “inadequate” because residents were not receiving the care they should (see Table 3). A full 40.6 per cent of personal support workers said they felt inadequate “all or most of the time” while another 46.5 per cent said they “sometimes” felt inadequate. Only 12.7 per cent reported rarely or never feeling inadequate. In the focus groups, workers provided examples, like not being able to take time to explain to residents why they have to go back to their room, not being able to sit with residents when they are crying, or not allowing residents to chew their food. Speaking of having to feed three or four residents at a time, one care worker remarked that “It’s horrible when you’re shoving [food] in there.” Such structural violence impacts personal support workers who are deeply committed to caring well. And they suffer additionally:

*It’s heartbreaking when you leave and you know that say a resident has been upset and you haven’t had the time to sit and talk to that resident....it hurts... You leave the building. And that goes home with you, you know.*

*It really makes me feel personally bad when I know in my heart how somebody should be cared for, how you know that you would like to receive care yourself, how you believe that your family members should receive care. And when you are in that situation giving care to the residents and you know there's no way you can approach what you feel you should be doing, that is a very disappointing thing. You know you're letting the residents down and yourself down.*

## 8. Socializing and relational caring

A further consequence of the under-resourced and understaffed long-term care environment is that many opportunities for building relationships with residents are lost. Spending time with residents – e.g., chatting, sharing coffee, watching TV, eating, running errands together – is essential to building relationships. These relationships help prevent violence and also define good care.<sup>[13]</sup>

We therefore asked care workers about the time spent socializing with residents. On the whole, caregivers reported that they spent far less time than they would like. Over half (53.9) of the personal support workers said they “rarely or never” get to chat or have coffee with residents (Table 5). Even fewer participate in recreational activities with residents or accompany them on errands.

**Table 5: Frequency and type of socializing engaged in by long-term care workers in Canadian sample**

Frequency Type of Socializing	Several times a day	Once every day	Every week	Every month	Less often or never
Having coffee or chatting with resident	16.2%	16.7%	8.2%	5.6%	53.3%
Participate in a recreational activity with resident	5.0%	5.5%	6.6%	7.6%	75.3%
Accompanying residents on an errand	0.8%	0.3%	2.1%	5.8%	91.1%

In contrast to the situation in Canada, sitting down for coffee is part of every day work for most caregivers in the Nordic countries. Half (49.7%) of the caregivers in Nordic countries told us they sit for coffee with residents at least once a day, whereas in Canada the mere suggestion of sitting and having coffee with residents provoked laughter. Though some recalled a time when socializing and emotional care was a reality: “...it’s not like years ago where you had that time to sit with a person if they were crying and, you know, it’s just a lot less time and more work to do.”

The lack of opportunity for socializing with residents is not surprising given the highly stressful working conditions and the under-funding of long-term care. Relational caring requires time and flexibility. Such human care requires, most importantly, institutional support – both in the form of a facility culture that encourages relating as well as provides the material resources to enable workers to provide such care.<sup>[3]</sup>

But poor working conditions are only part of the picture. We would do well to understand the dismal working conditions in long-term care as a legacy of sexism. As Nordic scholar Kari Waerness reminds us, one of the effects of sexism has been the undervaluing of caring labour.<sup>[16]</sup> Sexism, more specifically, has led to a profound ignorance of the forms of rationality and judgement, the types of communication, the capacities and know-how required to perform quality care work. To put it simply, gendered assumptions have obscured the *complexity* of care work.<sup>[17, 18]</sup>

Caring, as a result, has come to be seen as something that women do naturally rather than a skill that people learn and hone. This myth underlies the poor training personal support workers receive, the lack of resources that are placed at their disposal, the lack of autonomy and flexibility they are given, as well as the privileging of instrumental tasks when accounting for their labour. The lack of support and task-oriented focus, in particular, misunderstands caring work, submitting it to an industrial, instrumental logic. It dehumanizes both workers and residents:

*...it gives me the feeling that they're on an assembly line.....You've only got a very limited time to do 'x' number of residents and therefore you're getting them in, getting them dressed, getting them back out. There's no time... There's no time to give that personal touch. And it makes me feel like they're in an assembly line.*

## 9. Autonomy and communication among co-workers

Flexibility in being able to organize one’s work is a defining characteristic of an empowering work environment.<sup>[13]</sup> Flexibility has also been shown to prevent violence as it allows workers to accommodate residents’ needs, moods, and desires.<sup>[12]</sup>

Communication amongst co-workers is important as well in preventing violence, because it enables caregivers to discuss the changing needs of particular residents, to be warned of bad moods, and to share successful behavioural management strategies.<sup>[19]</sup>

For these reasons, we asked personal support workers about the amount of autonomy they had to affect the planning of their daily work and whether or not they had enough time to discuss difficulties with their colleagues.

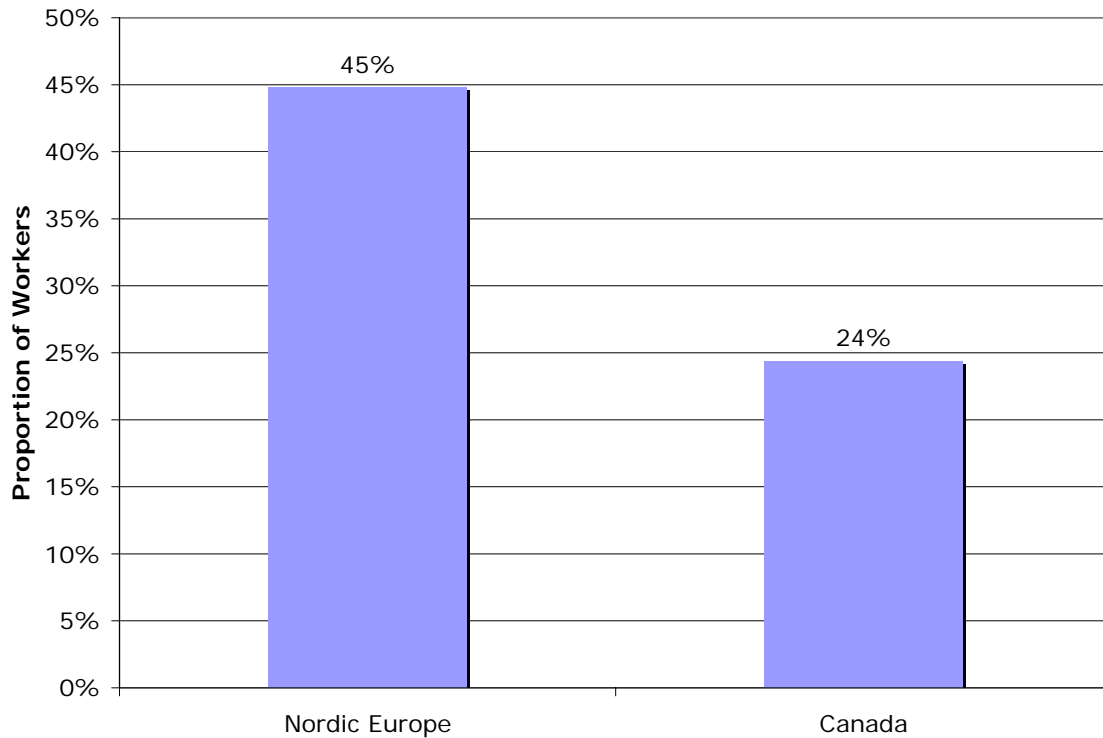
We found that levels of autonomy and communication were low. Only 23.8 per cent of personal support workers said they could affect the planning of each day’s work. Similarly, only 21.5 per cent said they could engage with colleagues about workplace difficulties “all or most of the time” (Table 6). Approximately half of the personal care workers we surveyed said they “sometimes” could affect the planning of their day. However, this flexibility might be more apparent than real. In our focused discussions, caregivers cautioned that flexibility often means continually re-prioritizing in the context of not having enough time.

**Table 6: Autonomy and communication among personal support workers in Canadian sample**

Frequency	All or most of the time	Sometimes	Rarely	Never
Power to affect daily planning	23.8%	49.7%	22.5%	4.0%
Enough time to discuss difficulties with colleagues	21.5%	55.0%	21.8%	1.7%

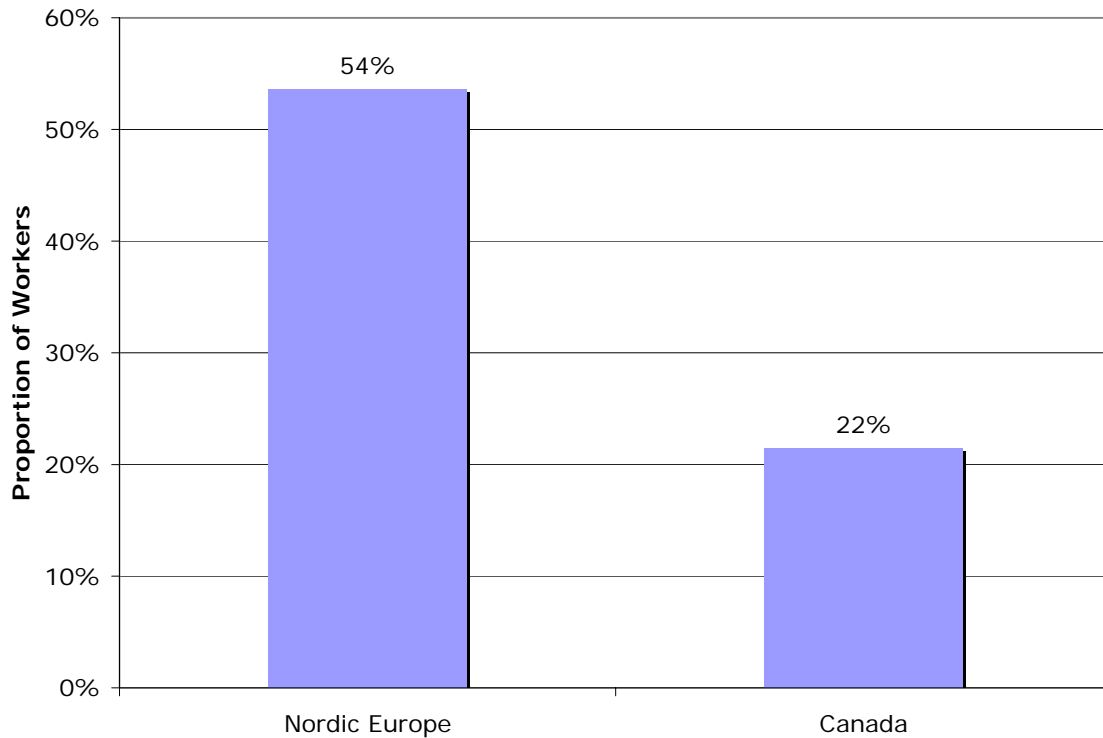
When we compare the situation in the Canadian provinces surveyed to that of Nordic countries, we find that the Canadian situation stands out as unique. In the Nordic countries we surveyed, workers report a greater degree of flexibility than they do in Canada (see Figure 2). In particular, almost half (45%) of all Nordic workers said they could affect the planning of each day’s work “all or most of the time.” In Canada, only one quarter (23.8%) of personal support workers had such flexibility. The greater flexibility experienced by long-term care workers in Nordic Europe may play an important role in explaining the lower levels of violence there. More research is needed, however, to explore these relations.

**Figure 2: Proportion of workers who can affect the planning of each day’s work “all or most of the time” in Nordic countries and Canadian provinces**



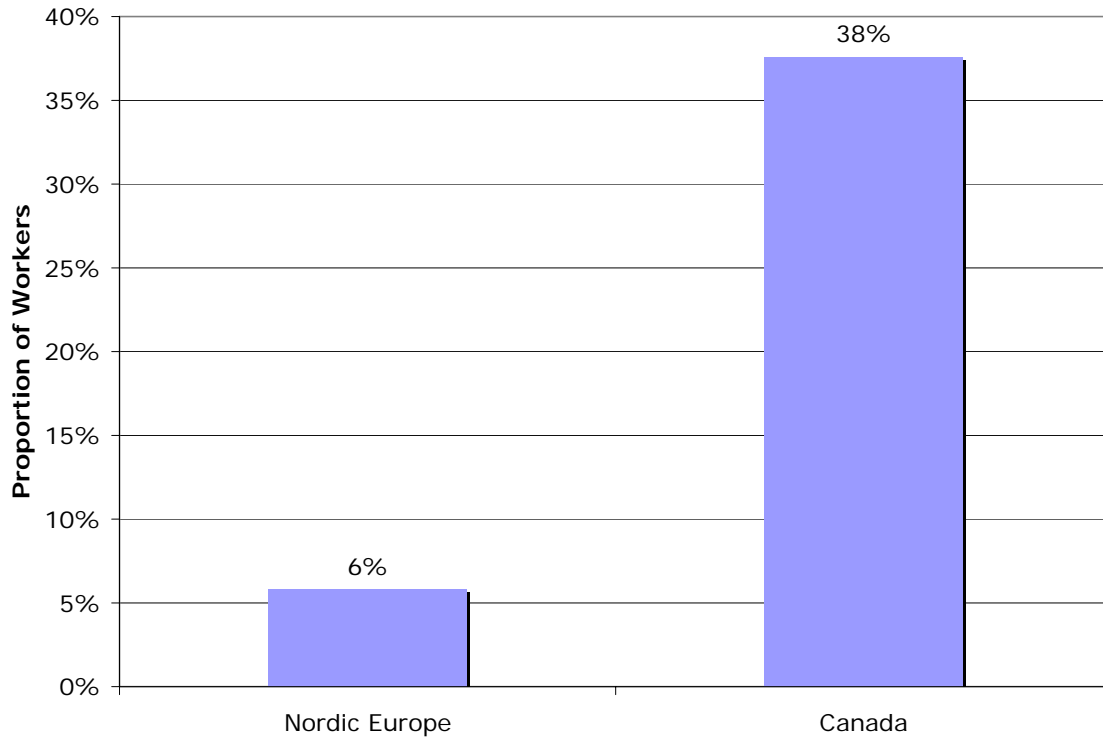
Important to understanding the different levels of violence between Nordic countries and Canada is the level of communication amongst colleagues (see Figure 3). *Half* (54%) of all Nordic workers tell us they are able to discuss difficulties with their colleagues most of the time. In Canada, only *one fifth* (21.5%) are able to share knowledge in this way.

**Figure 3: Proportion of workers who have enough time to discuss difficulties with colleagues “all or most of the time” in Nordic countries and Canadian provinces**



Given these large differences in levels of communication and flexibility – combined with routine short-staffing– it is perhaps not surprising to learn that Canadian personal support workers feel that they work alone. Indeed, more than a third (37.6%) of Canadian personal support workers “strongly agreed” with the statement that they are they are too often left alone to care for residents. Only six per cent of Nordic workers felt this way (see Figure 4).

**Figure 4: Proportion of workers who “strongly agree” that they are too often left alone to care for residents in Nordic countries and Canadian provinces**



Feeling alone or being left to solely care for a resident, in an environment that requires teamwork, presents significant health and safety dangers for both workers and residents.

## 10. Dementia

Residents are entering long-term care older and sicker than they were in the past.<sup>[20]</sup> It is not unusual to find a long-term care facility with 60 to 70 per cent of its residents suffering from Alzheimer's disease or other forms of dementia.<sup>[21]</sup> Many, if not most residents, also suffer from the burden of multiple diagnoses and impairments. This places additional stress on caregivers who lack sufficient time and resources to properly care for people with these needs.

That some residents may be particularly aggressive has also received some consideration in the research. Boyd's examination of WCB incident reports, for instance, found that 10 per cent of residents were responsible for all the violent incidents reported. Not surprisingly, gender is relevant here. Men were found to be three times more likely to be aggressive than women. That particular residents are prone to violence has encouraged the development of special care units (SCUs) for severely cognitively impaired or challenging residents, as well as training interventions to enable care workers to develop specialized skills in both mitigating and managing violent situations. Studies have shown that such interventions decrease violence against caregivers, though they do not eliminate it.<sup>[19, 22, 23]</sup>

Personal support workers in our study expressed serious concerns about the care needs of residents and the lack of time and resources to meet those needs. As one respondent described the situation:

*They're coming in 90-plus years old and total care... So even though you may have a ratio of eight residents to one, you're still in actual fact probably doing 12 to one 'cause of the amount of care that you've got to do.*

Younger residents are also coming with serious and complex needs:

*...we work in...long-term care which includes people that have had spinal injuries and car accidents and ALS and MS and mental illness as well as physical illness so it's not just the elderly that we're looking after. We've gotten a lot more complex care residents into our facility. And some of us don't necessarily have the training to deal with someone who is physically and mentally ill...and that in itself can be a stressor to the one who hasn't had proper training to deal with this person.*

Lack of resources is also evidenced by the failure to provide adequate training. As one caregiver put it:

*We have all these other mental disorders. None of us have training for it. None of us. None of us had psych courses. I don't care if it's an LPN, a housekeeper. The only ones that **may** have some training are the RNs. .... We're not safe. The residents aren't safe... it's out of control. It's really **out of control**. (our emphasis)*

As noted above, research indicates that training interventions can help prevent violence and provide a safer environment for staff and residents. However, our study suggests that training in itself is *not* enough. Training programs must be supported with adequate resources. Current training programs provided directly in the facilities – i.e. “in-services” – often require workers to attend on their own time or during much needed breaks. Not surprisingly, this fosters resentment and results in low participation. As one care worker put it: “We have in-services but they call them lunch-and-learn and they do them on our break time. And they provide us a sandwich and they think this is a great time.”

Focus group discussions also revealed that care workers do not have the time to attend training sessions: “...you go in for like 10 minutes and you leave. Like you don't have time for the full half hour.” In order to meet management and Ministry of Health requirements, some employees may simply attend for the first few minutes, sign in and leave. Participation rates are inflated as a result: “They just don't care really if you go in for two minutes. Just sign that piece of paper...” Requiring training, without actually ensuring that the training is effective and adequately resourced, is, as our research shows, at best counterproductive and at worst dangerous.

## 11. Effects of violence

Given the lack of official reporting and the laxity with which facilities track violent incidents, as well as limited research on workplace violence, it is difficult to determine the effects of workplace violence on staff. What is clear however is that workers tell us that violence is “terrible,” “degrading” and creates an intensely “stressful” workplace.

The high levels of physical, verbal and sexual violence combined with the structural violence of caring in an under-staffed and under-resourced environment stretches workers to the limit. Personal support workers leave physically and mentally exhausted. They finish work *almost always* physically tired (62.9%), mentally exhausted (39.6%), and suffering from back pain (36.3%). These are stark indicators of the effects of caring under current conditions. As one worker put it: “by the time my day ends I’m like ‘Oh my god let me out!’”

As in other areas, the Canadian situation is extreme. By looking at most of the Nordic European countries, we see that the situation can be improved (Table 7). Nordic rates of exhaustion are far lower. **Canadian personal support workers are twice as likely to end the day feeling physically exhausted, three times as likely to experience back pain, and four times as likely to be mentally exhausted as Nordic workers.**

**Table 7: Effects of working in long-term care, comparing Nordic European countries with Canadian provinces**

Country	When I finish work I almost always experience:		
	Physical exhaustion	Mental exhaustion	Back Pain
Denmark	26.0%	8.3%	11.5%
Finland	32.8%	11.6%	9.8%
Norway	29.5%	8.0%	12.1%
Sweden	28.7%	15.5%	15.2%
Nordic Europe	29.4%	10.6%	11.9%
<b>Canada</b>	<b>62.9%</b>	<b>43.5%</b>	<b>36.3%</b>

Violent working conditions have material effects as well, including increased financial costs (such as costs for medical and psychological care, when these are offered), property damage, decreased productivity, and increased security.<sup>[4]</sup> In particular, a number of studies suggest that violence against staff might play an important role in precipitating the costly turnover that plagues the long-term care work environment.<sup>[24]</sup> Indeed, turnover rates among personal support workers are astoundingly high, ranging from 40 per cent to 70 per cent, though in some institutions turnover is as high as 500 per cent.<sup>[13]</sup> Such high turnover exacerbates heavy workloads in an already short-staffed work environment – conditions that staff talked about in the focussed discussions as precipitating workplace violence and the very high reported illness and injury rates. Both the high turnover and the injury rates in turn contribute to costs for workers, employers, and the state.

## 12. Conclusion

Working in long-term care is dangerous. Personal support workers experience violence with alarming regularity. They can expect to be physically and verbally assaulted on a daily basis. Sexual violence is also prevalent. Violence has become normalized as “just part of the job.”

Yet violence is not inherent to long-term care work. Comparisons with Nordic countries clearly show that long-term care can be provided under far safer conditions. We need to have a better understanding of how Nordic countries are preventing the violence that is so prevalent in Canadian facilities. Our study suggests the answers can be found in the working conditions and working relations of Nordic facilities. This is an area where more research is needed.

What we do know is that the high levels of violence experienced by Canadian long-term workers are consequences of *current working conditions that force caregivers to do too much, too fast, with too few resources, and with limited autonomy*. What we also know is that good working conditions are linked to good living conditions for residents.

*Strategies can be developed to improve working conditions for workers and living conditions for residents at the same time.* The chronic short-staffing offers an excellent place to start. Providing more autonomy and resources for workers would be another. Real change would involve recognition of the skills involved in this highly gendered care work. Documentation of violent incidents is also necessary, for most go unreported. Of course, as our study shows, the reporting of violence can be expected to occur *only* if the culture of blame and fear is addressed and forms of violence such as racism and sexual violence are recognized. Fostering a truly empowering work environment should therefore be a key policy direction. This will require giving personal support workers a true voice in how their work is designed and organized. It will also mean adequately supporting and rewarding *care* in the fullest sense of the word – not simply privileging tasks.

Demographic changes – such as the greater needs of older and sicker residents, the burden of dementia and the tensions created by mixing residents of different ages and different needs – are placing greater strain on personal support workers. This needs to be recognized and adequately supported. Certainly, better training in these areas is required, but as our study shows training alone will not be enough. Workers do not have the time and resources to participate in training sessions let alone care for these residents.

Finally, the levels of violence encountered are astounding. They raise some fundamental questions about the place of long-term care in Canadian society. How is it possible for such violence to go unnoticed and unaddressed? Where does the care for the elderly sit in the minds of Canadians? And what do such levels of violence say about our care for those workers to whom we entrust our loved ones? These are troubling questions that should give us pause. If we take the long-term care of citizens who have contributed a lifetime to be a barometer of our society, what does it reveal?<sup>[2]</sup>

### 13. References

1. Farmer, P., *On suffering and structural violence: A view from below*. Daedalus, 1996. **125**(1): p. 261-283.
2. Armstrong, P. with A. Banerjee, *Challenging Questions: Designing Long-Term Facility Care with Women in Mind*. 2007, Women and Health Care Reform: Toronto.
3. Vladeck, B.C., *Unloving Care Revisited: The Persistence of Culture*, in *Culture Change in Long Term Care*, A.S. Weiner and J.L. Ronch, Editors. 2003, Haworth Social Work Practice Press: Binghamton, NY. p. 1-9.
4. Boyd, N., *Gently into the Night: Aggression in Long-term Care*. 1998, Worker's Compensation Board of British Columbia: Victoria.
5. Boyd, N., *Violence in the workplace in British Columbia: A preliminary investigation*. Canadian Journal of Criminology, 1995. **37**: p. 491-519.
6. Lusk, S.L., *Violence experienced by nurses' aides in nursing homes: an exploratory study*. AAOHN Journal, 1992. **40**(5): p. 237-241.
7. Gates, D., E. Fitzwater, and U. Meyer, *Violence against caregivers in nursing homes: expected, tolerated, and accepted*. Journal of Gerontological Nursing, 1999. **25**(4): p. 12-22.
8. Hellzen, O., et al., *The meaning of caring as described by nursing caring for a person who acts provokingly: an interview study*. Scandinavian Journal of Caring Science, 2004. **18**: p. 3-11.
9. Goodridge, D.M., P. Johnston, and M. Thomson, *Conflict and Aggression as Stressors in the Work Environment of Nursing Assistants: Implications for Institutional Elder Abuse*. Journal of Elder Abuse & Neglect, 1996. **8**(1): p. 49-67.
10. Gates, D., E. Fitzwater, and P. Succop, *Reducing assaults against nursing home caregivers*. Nursing research, 2005. **54**(2): p. 119-127.
11. Levin, P.F., et al., *Assault of Long-Term Care Personnel*. Journal of Gerontological Nursing, 2003. **March**: p. 28-35.
12. Shaw, M.M., *Aggression Toward Staff by Nursing Home Residents: Findings from a Grounded Theory Study*. Journal of Gerontological Nursing, 2004. **October**: p. 43-54.
13. Gruss, V., et al., *Job Stress Among Nursing Home Certified Nursing Assistants: Comparisons of Empowered and Nonempowered Work Environments*. Alzheimer's Care Quarterly, 2004. **5**(3): p. 207-216.
14. Chappell, N.L. and M. Novak, *The Role of Support in Alleviating Stress Among Nursing Assistants*. The Gerontologist, 1992. **32**(3): p. 351-359.
15. Novak, M. and N.L. Chappell, *Nursing assistant burnout and the cognitively impaired elder*. International Journal of Aging and Human Development, 1994. **39**(2): p. 105-120.
16. Waerness, K., *The Rationality of Caring*. Economic and Industrial Democracy, 1984. **5**(2): p. 185-211.

17. Armstrong, P., H. Armstrong, and K. Scott-Dixon, *Critical to Care: Women and Ancillary Work in Health Care*. 2006, The National Coordinating Group on Health Care Reform and Women; <http://www.cewh-cesf.ca/healthreform/>.
18. Armstrong, P. and T. Daly, *There are Not Enough Hands: Conditions in Ontario's Long-Term Care Facilities*. 2004, CUPE: Toronto.
19. Morgan, D.G., et al., *Work stress and physical assault of nursing aides in rural nursing homes with and without dementia special care units*. Journal of psychiatric and mental health nursing, 2005. **12**(3): p. 347-358.
20. Stephenson, M. and E. Sawyer, eds. *Continuing the Care: The Issues and Challenges for Long-Term Care*. 2002, CHA Press: Ottawa.
21. PwC, *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators*. 2001, PricewaterhouseCoopers, LLP.
22. Morgan, D.G., et al., *Evaluating rural nursing home environments: dementia special care units versus integrated facilities*. Aging and Mental Health, 2004. **8**(3): p. 256-265.
23. Gates, D., et al., *Preventing Assaults by Nursing Home Residents: Nursing Assistants' Knowledge and Confidence - A Pilot Study*. Journal of American Medical Directors Association, 2002. **3**: p. 366-70.
24. Kozak, J. and T. Lukawiecki, *Abuse and Neglect in Long-Term Care: A Resident's Perspective*. 2001, Family Violence Prevention Unit, Health Canada: Ottawa.