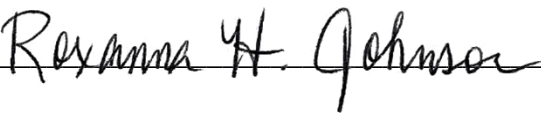# Experiences of Dementia Care Workers in Nursing Homes:
An Exploratory Study Comparing Canada, Scotland, and the United States

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Declaration

I declare that none of the work contained within this thesis has been submitted for any other degree at any other university. The contents found herein have been composed by the candidate, Roxanna H. Johnson.

Abstract

This comparative research explores the work experiences of dementia care workers in nursing homes. The aim of this study is to understand concepts central to care and to gain insights from the care workers' perspectives. A comparative framework and symbolic interactionist approach is used to analyse data collected using ethnographic methods from 59 dementia care workers in Canada, Scotland, and the United States. The fieldwork settings are institutionalised; dominated by for-profit ownership; and provide care for a resident population with high cognitive and physical needs.

The comparative findings underscore the importance of work conditions that provide care workers with sufficient resources to do their job and enough time to complete their work. The absence of these critical components creates stressful work conditions for the care workers. The lack of time, staff and supplies such as towels, wash cloths, and continence products do not allow the residents' choices in their care and disregard their dignity and rights.

The inability to deliver care for the residents according to the guaranteed government care standards often result in the violation of human rights for the care workers and residents. The care workers are unable to supply the quality of care they know the residents need and are capable of providing given better circumstances. There are frequently not enough care workers, resources, or time to meet the level of care that relevant standards mandate or the care workers know is possible. The analysis reveals that care workers struggle to provide more than basic physical care and are seldom able to meet essential social care needs for the residents.

Unwritten rules are implemented in each setting that include separating people with dementia, placing these residents out of view of the public, not allowing the residents access to go outside, and not providing them with engaging and meaningful interactions. While policies are frequently developed with good intentions, many are counter-productive without dementia knowledge. This comparative research reveals care practices and routines share strong similarities across the fieldwork sites while the care worker characteristics as a workforce vary the most between countries. Some differences involve the training required, average age, pay and mode of dress or appearances.

Too often researchers frame stress issues for care workers as problems with attitudes, motivation, training and incentives. Yet, the broader social structures and conditions that set the context in which these problems have their origins are commonly ignored. Good working conditions for care workers are precursors to good care for the residents. This thesis concludes with recommendations for practice, research and policy development.

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I will be forever thankful to my Dad for his dedication to education and improving the lives of so many people through education. Somewhere along way I acquired a true love for learning but never realised where it would take me. Scotland was a long way from home, and I am grateful for all of my incredible Baha'i friends who always made me feel welcomed and to all the wonderful friends I made along the way. I would like to acknowledge my original supervisors Anthea Innes and Ian McIntosh. I graciously thank Louise McCabe for believing in me and seeing this thesis through.

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Glossary of terms and synonyms

This comparative research covers three countries all with unique terminology, concepts and locations. For signposting, a paragraph or statement that identifies the topic, the country of location and the name of the nursing home or care worker term will be presented first and then the relevant information will follow. However, when a general discussion or statement is presented and then followed by three citations at the end that is representative of all three countries when available, unless otherwise noted.

Care worker(s)	the general term used for dementia care workers, direct care workers, front line workers, and workers in general
CA	Scotland: Care Assistant(s)
CNA	The United States of America: Certified Nurse's Aide(s)
PSW	Canada: Personal Support Worker(s)
C	Canada
S	Scotland
USA	United States of America
Management	Administrative/management Assistant
Matron	Nurse Manager or Administrator
Managers	Matron and Administrators
RS	Registered Staff (nurse)
SN	Sister Nurse (head nurse)
RN	Registered Nurse
LVN/LPN	Licensed Vocational Nurse/Licensed Practical Nurse (USA)
24/7	Twenty-four hours a day, seven days a week
ADL	Activities of Daily Living

CMS	Centers for Medicare and Medicaid Services (USA)
DWE	Double Weekend (shift consisting of 16 hours on Saturday and Sunday in the USA)
NHS	National Health Scotland
LTC	Long-term care
LTC Continuum	Care services ranging along a continuum from light support to residential housing to nursing homes
the ACT	Canadian Ministry of Health and Long-Term Care Act will be representative for all of Canada unless otherwise noted for anonymity
Nursing Home(s)	Intensive Personal Care and Residential Care with Nursing; Residential Homes and Care Homes; Intermediate Care Facilities (ICF), Skilled Nursing Facilities (SNF)

Nursing Home Ownership Status:

Canada	Proprietary
Scotland	Private
USA	**For-profit** - will be the general term used
WHO	World Health Organisation

Chapter 1: Experiences of Dementia Care Workers in Nursing Homes

Introduction

This comparative thesis explores questions central to care for dementia care workers in nursing homes in Canada, Scotland and the United States of America (USA). The aim is to reveal through multiple methods understanding of the work experiences, concepts of care, training required and the use of reflexive practices to gain insight from the care worker perspective across the fieldwork sites. This research explores various aspects of nursing homes and reveals common characteristics fundamental to work for the care workers within the nursing homes across these three nations. This thesis is critically concerned with how dementia care workers in nursing homes experience and perceives their work, how it is delivered, organised, and informed for those providing care. When possible, this research will consider how larger social structures are linked to the nursing home as an institution and how this influences the care workers experiences. In order to achieve these goals, cross-national macro comparisons are utilised, then ethnographic research is used for fieldwork, and micro comparisons are employed for the final analysis. Symbolic interactionism offers a framework to organise descriptions and explore how care workers create, negotiate and derive definitions through interactions that exist between people and their social worlds. The interpretations of meaning constantly change as meanings are created through interactions. A comparative approach is applied along with symbolic interaction as complementary theoretical perspectives. The dual approaches helped to identify comparable components within each country to gather data for comparisons and a deeper understanding of the dementia care workers' experiences.

I have been asked why I chose care workers and the nursing home setting for my research and respond by comparing standard training requirements across different occupations. In the USA, it takes 1,500 hours of training, a proficiency and written exam to be a licensed barber or beautician (hair dresser); 400 hours of training, a proficiency and written exam to be a licensed dog groomer; but only 75 hours of training, a proficiency and written exam to be a certified nurse's aide in a nursing home (Cain and Wesselhoft, 2005). Senate Bill 950 was introduced and approved in the State of Oklahoma to require just 10 hours out of the 75 hours of training for care workers to be mandatory dementia-specific training (Cain and Wesselhoft, 2005). With the projected population trends and no cure for dementia in sight the need for dementia care will only increase.

Care Workers

Until recently, there was no universally agreed-upon definition of health care worker either in the literature or practice (International Longevity Center – Schmieding Center for Senior Health and Education-USA [ILC-SCSHE-USA], 2006:5)[1]. The term 'health care support' generally refers to specific services provided to people who cannot care for themselves (ILC-SCSHE-USA, 2006). The Organisation for Economic Co-operation and Development (OECD) recently defined universal personal health care workers as:

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[1] The International Longevity Centre is a global alliance with multi-national consortiums consisting of 14 partner countries. The mission is to address longevity and population ageing in positive ways. The Alliance partners carry out the mission through developing ideas, undertaking research and creating forums for debate and action (www.ilc-alliance.org, 2013). The ILC-UK is a registered charity incorporated with limited liability in England and Wales. Various key partner organisations such as Joseph Rowntree Foundation link Scotland with the ILC-UK. The ILC-SCSHE-USA represents all of the United States of America. The ILC-UK and ILC-SCSHE-USA are both members of the www.ilc.alliance.org.

.. people providing routine personal care, such as bathing, dressing,

or grooming, to elderly, convalescent, or disabled persons in their

own homes or in institutions (OECD Health Data, 2013:1-2).

These workers perform basic self-care functions that under other circumstances the individual would perform independently. Care workers provide intimate personal care that is both physically and emotionally demanding (Henderson, 2001; Secrest et al. 2005; Innes et al. 2006). They assist people with basic care, referred to as activities of daily living (ADL). These ADLs include tasks such as eating, dressing, bathing, toileting and transferring or moving the person (OECD Health Data, 2013).

Over time, these workers have been given a variety of job titles according to their location in relation to their country, provinces and territories. Canadian care workers are referred to as: health care aides; health care assistants; nursing aides; nursing assistants; direct care staff; personal care workers; personal support workers and unregulated care providers (Berta et al. 2006; Health Canada, 2012). In Scotland and the rest of the UK the primary designations for care workers are: care assistants; care workers; generic support workers; health care assistants and ward assistants (McKenna et al. 2004; Scottish Social Service Council [SSSC], 2010). In the USA, titles include: certified nurse's aides; certified nursing assistants; direct care workers; geriatric aides; nurse aides; nursing assistants; health care assistants; orderlies; patient care assistants; personal care aides; resident assistants; and simply caregivers (ILC-SCSHE-USA, 2006; Paraprofessional Health Institute [PHI], 2011). For this comparative research the following terms or acronyms are used: Canada:

personal support workers (PSW); Scotland: care assistants (CA); for the USA: certified nurse's aides (CNA). The term 'care worker' is the universal term used to discuss care workers in general and to preserve anonymity.

The Nursing Home

The nursing home setting is only one part of the long-term care (LTC) continuum that includes a variety of health and social care services available in a given area. The continuum ranges from light support in housing needs extending through a range of services across a spectrum to intensive, high dependency nursing in acute hospital settings (Bland, 1999; Joy and Fong, 2000; Berta et al. 2006). The most common terms for nursing homes across the countries in this comparative research include: intensive personal care and residential care with nursing; residential homes and care homes; intermediate care facilities (ICF), skilled nursing facilities (SNF), and nursing homes. The term *nursing home(s)* is used interchangeably throughout the research literature across the three countries and will be used to identify the setting and level of care services described and analysed in this thesis. Nursing homes provide 24 hour care. The care services include nursing care, supervision, and ADL support (American Health Care Association, 2006; Government of Canada, 2006; The Scottish Government, 2007a). Nursing home services are provided to an unrelated group (legally necessary) of people. In the literature, regulations and assorted government documents the terms used to identify this group of people varies from client, to patient, to service user, and to resident. For this research the term to identify this group of people will be *resident(s).*

The growing ageing population trend will radically change the characteristics and dramatically impact the need for care workers as the population ages globally (Suzman and Beard, 2011). The demographic changes raise considerable concerns in respect of establishing a well-trained, and in career terms, a stable health care workforce (Innes et al. 2006; Armstrong et al. 2009; Dill et al. 2013). Across the nations in this study the percentages of older populations are expected to increase over the next decade, escalating the need for health care workers throughout the LTC continuum. Therefore, the resource of qualified care workers for quality care in nursing homes will be of greater significance in the future (Suzman and Beard, 2011).

Research Aims and Questions

This study seeks to explore and understand the work experiences of dementia care workers in nursing homes in Canada, Scotland and the USA. To achieve these aims my research questions are:

- What are the care workers' experiences and perceptions of care?
- What are the care workers' training requirements in each country?
- How do organisational characteristics influence the delivery of care in the settings?
- How do care workers define the concept of care and make distinctions of care?
- How are reflexive (insightful; perceptive; instinctual) practices used by care workers in each country?

Structure of Thesis

This research is framed from the bottom up reflecting the position of care workers who are at the lowest level in terms of wages and training. Therefore the analysis is presented in a like manner. As Brooker et al. (2011:19) reminds us, everyday routines and actions of care practices are established and passed along like 'folding sheets'. Routines are established by the rule-setting of the institutions but the care actions are embodied in the everyday experiences of the care workers. The perspectives of the care workers are at the core of interest but are created through the interactions. Therefore selecting symbolic interaction as an appropriate theoretical stance for the organisation of descriptions and interactions together with a comparative framework accentuate the complementary qualities of these two theoretical perspectives.

There were three phases to this research that incorporated a mixed method approach. First, was a review of documents and research literature across the three countries to conduct cross-national comparisons at the macro level utilising secondary data. This information was then scrutinised to identify comparable characteristics developed into 6 Tables in chapters 3 and 4. The demographic and organisational information allowed me to identify the average nursing home in each country on Table 1 according to size and ownership. Table 2 provides an index for contextualisation of a countries health and social problems in relation to income by Wilkinson and Pickett (2009). Tables 3 to 6 present life expectancies by country; the continuum of LTC services by country; and the percentage of residents in age categories over 65 living in nursing homes. This knowledge along with the literature review on care workers, their work setting, challenges, issues and topics researched

provided a solid knowledge base to develop Table 7 on the care worker's training requirements. This foundation was used for the development of my ethnographic research tools and comparative methods discussed in chapter 5. The information combined provided parameters to select a nursing home in each country using purposive sampling to conduct fieldwork.

The second stage of my research was to gain access to a nursing home identified by comparative methods at the macro level to collect data at three fieldwork sites, one in each country. Then, the qualitative ethnographic research tools were utilised to gather data in the field for micro level comparisons. My ethnographic research tools (for care workers) consisted of a short structured interview followed by a long-open-ended interview and then observations. Each care worker was observed while they assisted residents with meals in common spaces throughout each nursing home. The observations of interactions are placed on a continuum developed as Table 8.

The third stage of this research process was to apply the rich data gathered from the research methods using cross-national comparative and ethnographic methods of inquiry. A symbolic interaction perspective was then utilised to identify significant themes for and a comparative analysis at the micro level. Theoretical perspectives or frameworks provide insight to research activity. Symbolic interaction offered the organisation of descriptions required for the write-up of each fieldwork experience descriptively for an analysis using a comparative framework. This process incorporated cross-national comparisons at the micro level using the findings from each country for the thematic write-up. Making use of

information from the first two stages, insights, and experiences from the field provided me with information to compare, look for similarities, differences, and patterns among and between countries. This also allowed me to identify unique features for care workers and care practices within the nursing home settings. Thus far, this chapter has presented background information on the rationale for this thesis and will now outline the chapters.

In chapter 2, I explore the role of care work in nursing homes. The workers provide care under difficult conditions while offering care for people with high levels of cognitive and physical needs. The similarities and differences are highlighted to offer a well-rounded comparative view of the requirements and job expectations. The historical perspective provides a summary of how care work has evolved to its current role and moves on to explore various causes commonly attributed to work place stress. An overview of relationships and care are presented to emphasise the importance of the role of care workers within body work. Last, gaps in the literature are pointed out to highlight a need for this research.

Chapter 3 examines the work setting of the nursing home as a service in the long-term care continuum. The concept of institutionalisation by Goffman (1961) is introduced. The 4 primary characteristics of total institutions are explained (batch living, binary management, the inmate role, and institutional perspective) to demonstrate the influence these have on nursing homes. The nursing home is often viewed negatively as a stigmatised place to work, live, the services provided and as an institution. The organisational characteristics are outlined to underscore the similarities in nursing homes across these three countries.

Chapter 4 summarises the historical developments of the nursing homes in each country beginning with the World Health Organisation's (WHO's) (1947) new definition for health framed from a preventative perspective. The order in which each country adopted and embraced this definition had an impact on the development of their health and social care policies and the nursing home. Wilkinson and Pickett (2009) demonstrate this notion on Table 2 from a different approach. The demographic trends are outlined on Tables 3 to 6 from various perspectives for critical comparisons of the populations in each country. Table 7 examines the training required for care workers in each country emphasising the various paths, locations and hours required for care workers in each country.

Chapter 5 provides an overview of the mechanics of this research. The selection of my research aims, questions, methods and theoretical perspectives are outlined to offer contextualisation for my research study design. The choices made before fieldwork influenced many features of the research process, such as the number of fieldwork sites, location, design of the research tools, sample size, data collected and the analysis process. The justification, process and development of the observation check list is outlined and continuum designed in the field as an analysis tool is presented as Table 8.

In chapter 6, I offer context setting for each fieldwork site for my findings presented in chapters 7, 8, 9, and 10. A comparative framework is utilised to focus on various aspects central to the care workers. Descriptions of the care workers, residents, and the building characteristics are presented along with the shifts and staffing ratios. Various aspects of appearances are highlighted to accentuate the commonalities and inconsistencies among

these assorted features. The aim of this chapter is to set the scene for the three research sites to allow for more accurate comparisons in the following analysis chapters.

Chapter 7 outlines the delivery and negotiation of care. This chapter is based on three assumptions identified in the literature review. The nursing homes are: institutionalised; operate in an industry dominated by for-profit ownership; and provide care for a similar resident population. The daily struggles of the care workers are explored in themes that are developed from the care worker quotes from the interviews. In the absence of dementia knowledge, time and resources, the residents with dementia are separated at each setting and work by a comparable set of unwritten rules.

In Chapter 8, I explore the symbolic self of a person transitioning from life at home to living in a nursing home. Then the demands and descriptions of care are scrutinised to showcase the differences in the care workers' perspectives across the countries. The care workers' descriptions focus on the positive aspects of care until they are asked to make distinctions between different types of care. The care practices by country are examined and discussed by themes. This is followed by an overview of human rights from the WHO (2002) on ethical choices in long-term care. The violation of human rights is then explored for care workers and residents in nursing homes based on the care workers' quotes.

Chapter 9 highlights the feature that varies the most throughout this research, the care workers as a work force by country. The goal of this chapter is to systematically outline the differences identified in the literature review, fieldwork, and data reported by the

participants. Then I demonstrate how the care workers as a workforce in each country vary and link that information with the findings of Wilkinson and Pickett (2009). In the absence of resident knowledge and preferences, the care workers use reflexive practices based on their personal experiences underscoring the importance of exploring care worker characteristics as a workforce.

In chapter 10 new understandings of the work experiences for dementia care workers are presented. The key findings and contributions to knowledge are outlined. I then return to my research questions to discuss each and the insights gained from this explanatory comparative research. This research identifies key features that significantly impede the care workers ability to provide care for residents according to the country specific care standards. Although the care workers responsibilities centre around a whole person they are only delegated enough time and resources to care for part of the person. This leaves many resident care needs that are guaranteed within the care standards, ignored or only partially met. The results from this thesis have implications for practice, research and policy. The comparative findings highlight the importance of work conditions that provide care workers with sufficient resources to do their job and enough time to complete their work.

Chapter 2: The Working World of Dementia Care Workers

- I'm here because my heart's here (anonymous care worker).

This research is concerned with care workers that provide care in the nursing home setting. This chapter will present findings from the research literature on care workers in Canada, Scotland, and the USA to describe the work they do and to emphasise the importance of their role. Within this chapter, I will identify key concepts and themes relevant to my research and highlight gaps in the literature.

Care Workers

In chapter one, a definition from the OECD (health data, 2013) provides a universal definition for personal care workers. The Bureau of Labor Statistics in the USA under Standard Occupation Classifications defines personal care workers or professional caregivers as those who provide basic patient/resident care under the direction of nursing staff (US Bureau of Labor Statistics, 2012). This description extends the OECD (health data, 2013) definition to include providing patient care under the direction of nursing staff. These care workers perform ADL duties that include: feeding, bathing, dressing, grooming, and transferring or moving the patients (US Bureau of Labor Statistics, 2012).

Szebehely and Daly (2009:1) argue that the rich literature on care work stresses how care is much more than practical work and includes multiple forms of care on the body. Lee-Treweek, (1996) underscores that care work is primarily provided by women, considered

an extension of women's traditional roles and viewed as a labour of love. Yet, care work is physically and emotionally demanding (Lee-Treweek, 1996; Gubrium, 1997; Casper and O'Rourke, 2008). Across the countries in this study the division of work responsibilities other than ADL are conducted by people in more specialised positions (Daly and Szebehely, 2012:143). Care workers are frequently referred to as the 'eyes and the ears' of the health care system, specifically within nursing homes (Office of Inspector General [OIG], 2002; Stone and Harahan, 2010:110). These workers have considerable responsibilities but lack the time, support, authority and autonomy to adequately provide care to meet the residents' needs (Innes et al, 2006; Armstrong et al. 2009).

From an economic perspective, care workers are recognised as a substantial proportion of health care worker force (McKenna et al. 2004; Health Professions Regulatory Advisory Council [HPRAC], 2006; Innes, 2009). Care workers perform approximately 90 percent of the hands-on care for the residents in nursing homes, and yet, are the least trained (Peterson et al. 2002; Innes et al. 2006; Casper and O'Rourke, 2008). These workers are characterised by working under poor conditions with high turnover, and all too often with capricious and arbitrary supervision (Henderson, 2001; Zimmerman et al. 2005; Brooker et al. 2011). Care workers form the backbone of the organisation providing the majority of care and make or break the reputation for most nursing homes (Edwards, 1997; Noelker, 2001; Pietro, 2002).

Historically, the personal hands-on care provided for older people in nursing homes is frequently considered as repetitive and something just about any 'warm body' can do (Stone, 2001:50). The work is poorly regarded, conducted behind closed doors with limited supervision (Gubrium, 1997; McColgan, 2005; Cohen et al. 2010). The tasks care workers perform consist of chores that most people do not want to do leaving their work undervalued (Peace et al. 1997; Henderson, 2001; Secrest et al. 2005). The nursing home as a work setting is commonly a harsh social world, brutalising for the care worker's self-esteem (Tellis-Nayak and Tellis-Nayak, 1989; Innes, 2009; Armstrong et al. 2011). The mere context of the work, lack of upward mobility and devaluation of the job often results in attracting people who view this type of work as a last-resort (Kane and West, 2005; Armstrong et al. 2009; Innes, 2009).

Care work is a commodity typically provided by women that is bought and sold in the public arena; it is socially constructed, gendered in nature, and is devalued (Henderson, 2001:136). The gendered nature of care work provides challenges that are not always recognised (Innes, 2009). Care work in the nursing home is often carried out under poor circumstances and in dehumanising conditions (Gass, 2004; Brooker et al. 2011; Banerjee et al. 2012). The work place frequently lacks resources to perform the expected work leaving care workers with low morale (Gubrium, 1997; Innes et al. 2006; Bourgeault et al. 2009). As a result of the above features, care workers in nursing homes, are stigmatised and marginalised as a workforce.

Workplace Stress in Nursing Homes

Recent researchers have identified the intensity or high levels of workplace stress as one of the most important factors affecting work conditions and lower quality work (Innes, 2009; Daly and Szebehely, 2012; Karantzas et al. 2012). Workloads according to Daly and Szebehely (2012) involve both the level of the work and the amount of time that care workers are allowed to carry out their duties. Increases and challenges in health and functional status of the current resident populations are exacerbating the already demanding work (Stone and Harahan, 2010). Daly and Szebehely (2012) reveal that when care workers are not able to provide good care according to their own standards, this also influences care for residents receiving such care. Moreover, this accentuates the negative conditions that create stressful work places for the care workers and places for the residents to live. Other factors that contribute to stressful work conditions include the paucity of supervisor support, insufficient functional assistance, emotional support and resources (Secrest et al. 2005; Innes, 2009; Daly and Szebehely, 2012). Casper and O'Rourke (2008) and others echo these assumptions maintaining that providing supportive assistance in the workplace is associated with increasing (both) the care workers' sense of value and the delivery of quality care (Bishop et al. 2009; Schneider et al. 2010; Stone and Harahan, 2010).

Care workers in nursing homes are among the lowest paid groups of healthcare workers, frequently working in poor conditions with a high risk of work related injury (Brooker et al. 2011:23). The stressors are augmented when caring for residents with multiple chronic conditions (Twigg, 2000; Armstrong et al. 2009; Stone and Harahan, 2010). The extra amount of time that is required to provide adequate care for these cognitive and functionally dependent residents does, in addition to the challenges of work overload, intensify workplace stress.

High care needs

Wiener and Kayser-Jones (1990:93) reveal that residents in nursing homes are at a point with their chronic conditions of needing partial or complete assistance; urinary and/or bowel management and need high levels of cognitive support. Kelly (2013:2) argues that current resident admissions to nursing homes are increasingly frail with a high number of complex cognitive and physical needs. The delay in resident admissions intensify the likelihood of acute health conditions leaving the residents vulnerable to poor health and quality of life outcomes as a result of the transition Kelly (2013:2). These residents are often dependent on care workers for three or more ADL and have six or more chronic health conditions and some degree of cognitive impairments (Toles et al. 2013:78-79). When residents with high levels of care needs are ignored, they frequently become agitated which often leads to care worker injury and frustrating interactions for both the care workers and residents (Kane and West, 2005; Armstrong et al. 2009; Comondore et al. 2009). The end results are un-met needs for the residents and missed opportunities for

simple pleasures that are rewarding for the care workers and residents alike (Daly and Szebehely, 2012). This scenario depicting the resident's high dependency levels are consistent throughout the literature and add extra stress on an already limited and inadequately skilled workforce.

Working beyond skill levels

The care worker roles have evolved over time although the industry standards have not kept pace with the changes in residents' characteristics. The residents have more complex medical needs; higher dependency levels; and more diagnoses of dementia (McKenna et al. 2004; HPRAC, 2006; Brooker et al. 2011). Nicholson and Hockley (2011:105) found that nursing home managers are expected to provide the necessary staffing levels according to the resident's dependency increases, yet in reality, the staffing levels have not changed. Therefore, care workers are required to carry out duties and take on responsibilities in health care without the skills or competencies (HPRAC, 2006). Furthermore, according to Innes et al. (2006:52) the training for care workers have not kept pace with the increases in residents care needs.

High Turnover Rates and Insufficient Staffing Levels

Previous researchers have attempted to isolate factors related to and causing care worker turnover in nursing homes. Persistent turnover rates and insufficient care workers have finally thrust this serious issue into national policy agendas. The plethora of research on

care worker turnover in nursing homes is yielding little reliable empirical guidance and few remedies to resolve the problem (Lee-Treweek, 1994; Casper and O'Rourke, 2008; Mittal et al. 2009). High turnover rates are linked to: the delivery of lower quality care, negative resident outcomes, and increases in disruptive resident behaviours (OIG, 2002; Bishop et al. 2008; Comondore et al. 2009). Moreover, it is argued that high staff turnover does not support good care (Eaton, 2005; Bowes et al. 2010; Daly and Szebehely, 2012).

Despite a proliferation of research findings, the nursing home industry and policy researchers continue to focus on chronic understaffing and turnover rates (Zimmerman et al. 2005; HPRAC, 2006; Scottish Executive, 2007; Rosen et al. 2011). During the past two decades staff turnover rates have ranged anywhere from 25 to 400 percent in Scotland and the USA (Brannon et al. 2002; Scottish Executive Statistics Release, 2005; Decker et al. 2009). Insufficient staff levels, high turnover rates, market pressure and increasing regulations to improve the quality in LTC have created a strategic challenge to an industry which produces 'high-quality-non-professional-staff', especially in the USA (Brannon et al. 2002:159).

Care worker turnover is one of the many factors in a complex interplay that includes the management. The absence of care worker continuity contributes to decreases in organisational productivity and stability (Pollock et al. 2005; Castle and Engberg, 2006; Casper and O'Rourke, 2008). Numerous studies over the past three decades in Scotland and the USA have explored staff turnover in nursing homes producing a dichotomy in terms of findings (Banaszak-Holl and Hines, 1996; Twigg, 2000a; Innes et al. 2006).

Furthermore, lower scores on quality indicators are consistently associated with high staff turnover (Castle and Enberg, 2006; Consumer Reports, 2006; Comondore et al. 2009).

Inadequate staffing levels in nursing homes have perplexed the industry for decades across the three countries. Over 30 years ago Vladeck vigilantly states:

> *Nursing homes are perpetually short of staff ..... The patients obviously suffer the most from understaffing, but the aides also suffer. Not only do they have to work that much harder, but they tend to be acutely aware of how little they are doing for each patient, and how inadequate the services are. Demoralization frequently follows (Vladeck, 1980:20).*

Weiner and Kasyer-Jones (1990) reveal a crisis in attracting care workers for over 20 years in an industry hierarchy that places more value on technical skills than human touch and working hands-on with the residents. Turnover and inadequate staffing levels of care workers are repeatedly cited as the two most significant threats that impede quality care for the residents (Stone and Harahan, 2010). The research literature from the past three decades on these factors in nursing homes have resulted in inconclusive findings (Bishop et al. 2009; Innes, 2009; Stone and Harahan, 2010; Rahman et al. 2012).

Task oriented care

According to Tinney (2008) the autonomy of care workers is often restricted by the task oriented routines that revolve around ADL care. Care workers are further restricted by the underlying institutional rules imperative to meet funding requirements and a multitude of goals for efficient resident care. Daly and Szebehely (2012:146) maintain these circumstances create an assembly-line of care that results from a high degree of task specialisation with too many residents and not enough staff or time to provide adequate care. The task oriented routines place more emphasis on accomplishing responsibilities rather than relational aspects (Twigg, 2006). This is critical as Twigg and Atkin (1994) reminds us that care takes place within a relationship. Furthermore, the quality of care is dependent on the relationship between the residents and care workers (Brooker et al. 2011:23).

Relationships and Care

Care workers that provide care under the best circumstances obtainable, do so by having a personal relationship with residents that thrives on familiarity and respect (Marshall, 1996). The meaning of personal care is mediated by relationships (Bourgeault et al. 2009). The knowledge within personal relationships between the residents and care workers' include intimate information, and personal and routine preferences. Jonas-Simpson et al. (2006) and others highlight how good relationships between care workers and residents are an integral component to enhance the residents' well-being (Brannon et al. 2007; Tinney,

2008). Furthermore, rewarding relationships are linked with job satisfaction among care workers and subsequent positive outcomes for residents (Gurnik and Hollis-Sawyer, 2003). The essence of personalised care is often missed when care workers carry out their tasks without sufficient staff. Also, frequent disruptions in routines cause constant distractions in caregiving. The consequence of the lack of time for care workers interrupts decision making, the ability to attend to details that care workers feel are important, relationships, and an overall experience of not having control over their work (Secrest et al. 2005). The lack of opportunities for meaningful interactions is linked to poor relationships, resident outcomes, and reduced job satisfaction (Gass, 2004; Jonas-Simpson, 2006; Brooker et al. 2011).

Lack of time for relationships

The care workers are commonly unable to meet the residents' needs due to inadequate time. Relationship-centred care proposed by Nolan et al. (2008) encompasses aspects of care within relationships, noting that building relationships take time. It takes time to get to know the residents, their preferences, and idiosyncratic behaviours to protect their dignity. Tinney (2008:211) asserts that care workers have to be familiar with the residents well enough to know and understand the preferences of those who are inarticulate to empathize, respect the residents' rights and execute their choices. Tinney (2008), Bishop et al. (2009) and Daly and Szebehely (2012) maintain that care workers are expected to have relationships with the residents but are not allowed sufficient time leaving caring as an activity with mismatched titles of what a care worker is supposed to do. Care work is

organised for efficient and practical delivery under contractual arrangements which create ambiguities and conflicts making care work paradoxical (Bishop et al. 2009). Unfortunately as Tinney (2008) points out these interactions have the potential to provide critical opportunities for communication and social exchanges that help make meaning of the care experience for both the care workers and residents.

Care

Although the word 'care' implies emotional connectedness, emotional care and care work on bodies interact in convoluted ways (Twigg, 2000a). Furthermore, Twigg, (2006:393-394) maintains that care workers often complicate their job description and responsibilities and choose to accentuate the more pleasant and genteel aspects of care. "*Care has a warm and loving quality to it, and it is difficult wholly to detach it from this halo effect*" (Twigg, 2006:393). Twigg (2006:394) however, acknowledges that care workers who work on bodies, emphasise the social, emotional and interpersonal elements of care work. This avoids recognising the less attractive aspects of the body and decline, and places care in a special realm where the care workers downplay the dirty bodywork characteristics of dirt, decay, decline and death (Twigg, 2006:393).

Social care

The division of labour within nursing homes is hierarchal with demarcation in responsibilities between the distinct levels of staff (Daly and Szebehely, 2012). This

division of labour and organisation of care leaves little or no time to attend to the social care needs of the residents. Care encompasses more than everyday practical ADL work responsibilities (Daly and Szebehely, 2012). Hubbard et al. (2003:100) report from their findings on social interactions in nursing home settings that residents sit and do nothing for many hours, bereft of social interaction and activity. The residents are frequently deprived of many social aspects, consistent with their former lives. These concerns express the inability for care workers to provide more than minimum care (Weiner and Kayser-jones, 1990; Banerjee et al. 2012; Kelly and Innes, 2012). The organisation of work does not allow time or support for social care needs (Wardhaugh and Wilding, 1993; Gubrium, 1997; Daly and Szebehely, 2012:145-146). Nevertheless, mandatory staffing requirements only permit enough care workers to cover basic physical care, leaving little time for meaningful social interactions (Gass, 2004; Eaton, 2005; Bourgeault et al. 2009).

The resident's social world

Tellis-Nayak and Tellis-Nayak (1989:134) argue that for the most part, care workers are the social world for the residents. The care workers become the resident's primary social world which makes those interactions significant opportunities to enhance the resident's well-being. Goffman (1961) describes how residents experience shrinking social worlds as they are cut off from the outside life in institutions. Care workers become the resident's primary social world as they are the people the residents have the most contact (Tellis-Nayak and Tellis-Nayak, 1989; Tinney, 2008). Henderson (1995) and Tinney (2008) argue the demands of low staffing levels, the resident's high cognitive and physical needs, and

the additional tasks only allow time for superficial social interactions. Jonas-Simpson et al. (2006) and colleagues emphasise how positive interactions between the care workers and residents are vital components to enrich the resident's wellbeing (Brannon et al. 2007; Nolan et al. 2008; Tinney, 2008). Innes (2009) recognises the residents decreasing opportunities for meaningful interactions which help to define self and nurture relational aspects that are critical for care workers and residents. Furthermore, it is these interactions that have the potential to enrich care and relational features for both the residents and the care workers.

Reflexive practices

Reflexive practices for care workers are defined in this research as applying insightful, perceptive or instinctual knowledge learned from previous experiences (adapted from Schön, 1983). In the absence of time and resident preferences or information the care workers use reflexive practices that are based on their personal experiences, to make care decisions for residents. These intuitive, perceptive, or insightful skills are not included in training but are relied upon when care workers responsibilities place them in situations that they are not prepared to manage.

Relationships develop through day-to-day interactions. Respectful and endearing terms correspond with Kitwood's (1997) concept of people with dementia that emphasise communication and relationships "*with its emphasis on authentic contact and communication*" (Brooker et al. 2011:17). Paid care work is reflective of traditional roles

of women and involves their 'mothering' and 'daughtering' skills as Berdes and Eckert (2007:346) describe. These skills include making beds, toileting, feeding, bathing and fixing hair (Foner, 1995b:104). According to Foner (1995b) and others while providing nurturing care at work, care workers are using skills and behaviours learned or practiced at home in unpaid roles (Berdes and Eckert, 2007; Nolan et al. 2008; Kontos et al. 2010). In the absence of biographical or historical information about the residents care workers have to rely on their intuitive abilities to relate to the residents for cooperation and to provide individualised care (Kontos et al. 2010).

Willcocks et al. (1987:63) describes how care workers use a common sense to approach the challenges of care work and disclose how care workers are placed in contradicting roles between professionals and extended family. In two separate studies over 20 and 25 years ago Tellis-Nayak and Tellis-Nayak (1989:312) and Mercer et al. (1993:108) describe how care workers bring their reflexive skills or experiences from the past to work with them in the nursing home. Diamond's (1995:237) narratives of care workers in nursing homes suggest that care workers practice 'mother's wit' that relies on unwritten emotional and intuitive skills. These are what Henderson and Vesperi (1995:53) call 'mother-child interactional patterns'. Likewise Foner (1995b:104) identifies these interactions as 'mothering work' and demonstrates how the care workers draw heavily on their roles as mothers. Lee-Treweek (1996:122) describes care workers as mimicking kinship ties by embellishing residents' care with gestures such as tucking the residents in at bedtime. Furthermore, Berdes and Eckert (2007:346) made a distinction between instrumental care and affective care. Instrumental caring tasks are required responsibilities and affective care

is an added option that enriches the experiences for the residents. In a qualitative study Pfefferle and Weinberg (2008) determine that the mental models care workers use to guide the delivery of care are based on their personal experiences. More recently, Kontos et al. (2010:358) found that when care workers use 'imaginary kin ties' that these interactions result in genuine affection. As demonstrated, an extensive body of literature exists on how care workers draw on their own experiences and use reflexive practices for care and these skills are a rich resource of knowledge (Berdes and Eckert, 2007; Kontos et al. 2010).

Body Work

When body work in nursing homes takes place without emotional connections the possibility of negative interactions escalate. As Twigg (2006) suggests care work without some aspect of emotional care can be cold, indifferent and abusive. Moreover, care workers are typically not shown respect at work by superiors (Eaton, 2005; Innes et al. 2006; Berdes and Eckert, 2007). According to Brooker et al. (2011) new staff are socialised to the culture of care i.e. tacit and overt assumptions, and communication styles from experienced staff, positive or negative. Cohen et al. (2010) maintain that the accurate prevalence of negative interactions or neglect in nursing homes are lacking because care work is obscured from direct observation. To maintain resident privacy, care usually takes place behind closed doors due to the risk of invading the privacy for those receiving care (Peace and Holland, 2001; Wolkowitz, 2006:158). The hidden nature of care work removes direct observation from the 'sphere of moral issues' according to Wardhaugh and Wilding (1993). Neglect by care workers is linked to: insufficient staffing; the stressful

nature of care work; the inability to complete care tasks and the lack of supervision and support (Glendenning, 1999). Kelly (2010) argues that neglectful behaviours appear most offensive because it involves ignoring the resident or the absence of any interaction at all. Although care work is a professional relationship based on contractual arrangements some argue that inherent in caring work is the 'position of trust' which muddies the waters (Dixon et al. 2010:412).

Wolkowitz (2006) argues that until recently, researcher's debate on the body highlight the production and consumption of the body as a fluid and dynamic feature of social interactions. Wolkowitz (2006) proposes a new distinction in carework (on the body) and views emotional labour and care work as separate issues. This places work on bodies as a topic well suited for sociology. According to Wolkowitz (2006:158) the relative absence of literature in sociology on the relationship between the two constructs arises because the location of body work is obscured in a sphere that takes place away from the public eye. By exploring the discourses within carework, bodywork, and care on the body, Twigg (2006:122) argues that better understandings are possible. This provides more sophisticated challenges to these ambiguous terms. When these ideas are anchored within the context of bodywork in sociology the scope of application transcends country, systems, culture, and more.

Therefore, when work within sociology places the body at the core, new impetus allows aspects on: the body, embodiment, and work. This also provides a framework where multiple perspectives of body/work can integrate (Wolkowitz, 2006). Recognising body

work as a central phenomenon encourages an array of perspectives. Twigg (2006) and Wolkowitz (2006) agree that these new aspects allow researchers to explore commonalities and differences to comprehend specific features, and understand the ambivalent status of body work within this vast occupational category.

Twigg (2006) and Wolkowitz (2006:147) distinguish bodywork occupations as types of employment where the body becomes the immediate site of labour (e.g. beauticians, midwives, nurses, masseurs, sex workers, tattooists, and mortuary workers). Furthermore, *Body work occupations are among the fastest growing in Britain and the US* (Wolkowitz 2006:148) and Canada (Bourgeault et al. 2009). The majority of bodywork occupations are recognised as invisible (performed behind closed doors), low-waged and dominated by women (Lee-Treweek, 1996; Henderson, 2001; Gass, 2004; Wolkowitz, 2006).

Most recently, Twigg et al. (2011) and colleagues conceptualise body work within the realm of health and social care. They extend the distinction of body work that link concepts, locations and resources. "*Body work fits poorly with 'clock time' since many bodily needs are difficult to constrain to 'working hours'*" (Twigg et al. 2011:177). In addition, the unpredictability of body work creates spikes in demands for care.

Because of its capacity to bridge the gap between large-scale planning and practitioner-patient interactions, the concept of body work is germane to a number of policy issues. Body work needs to be studied within and across healthcare regimes, so that one can trace the tangible effects of changes in the organisation of services, funding, and other 'external' constraints on how body work is structured, measured, monitored and experienced (Twigg et al. 2011:182).

Body work involves work on both an object and a subject, but routines and standards in health and social care practices construct the recipients of care as tractable and predictable, transforming their bodies into appropriate objects of labour (Twigg et al. 2011:179).

Poor Working Conditions

Twigg et al. (2011:181) argue that the performance of body work is linked and shaped by, the wider social and economic forces in less obvious ways. Body work in health and social care is now deeply integrated into the wider global political economy of care (Tellis-Nayak and Tellis-Nayak, 1989; Armstrong et al. 2011; Twigg et al. 2011; Banerjee et al. 2012). Furthermore, acknowledging the importance of the location of body work provides the opportunity to determine if the level of care guaranteed is obtainable or if an individual is vulnerable to the violation of human rights (Banerjee et al. 2012; Emmel, 2012; Kelly and Innes, 2012). Banerjee et al. (2012:391) maintains that the heavy workloads, low levels of

autonomy, and rigid routines contribute to the low status of care workers. These factors are considered as obstructing the marginalised care workers from adequately doing their jobs and providing the level of care they know is possible (Ho, 2007; Armstrong et al. 2009; Banerjee et al. 2012). Care workers are more likely to suffer from the poor work conditions and stressful workplaces in the nursing home (Brannon et al. 2002; Bourgeault et al, 2009; Innes, 2009). Under such circumstances, poor working conditions are seen as detrimental to the care worker's physical and mental wellbeing (Mercer et al. 1993; Henderson, 1995; Banerjee et al. 2012:390). Poor working conditions were defined in a number of ways in this chapter that overall create barriers that prevent dementia care workers from providing the quality care they know the residents need and are possible given better situations. Most recently, Kelly and Innes (2012:61) argue for the application of human rights and citizenship to dementia care as a way to address inequity in dementia care and support good practice. Armstrong et al. (2011) and Banerjee et al. (2012) contend that the care workers are not given the resources needed to deliver care practices with dignity and respect. Concerns are expressed across the countries over the inability for care workers to provide the residents with basic care needs. Not only are the residents essential care needs left undone, but their social care needs are often left unaddressed (Weiner and Kayser-Jones, 1990; Banerjee et al. 2012; Kelly and Innes, 2012). These gaps in knowledge for care work in nursing homes underscore a call for research exploring the care workers experiences, perceptions, and environments.

Gaps in the research literature

The recurrent themes have produced contradicting results that have hindered the research from moving forward to find resolute solutions to the issues besieged in nursing homes. Absent from the literature, however, are studies conducted to foster or advance the understanding of care workers' experiences of work in nursing homes. Scant attention is aimed at examining the care workers view or perception (Wiener and Kayser-Jones, 1990; Squillace et al. 2009). This highlights a significant gap in the literature. The goal of this comparative research is to explore multi-dimensional aspects of the care workers' experiences, perspectives and understand the impact of their working environment. This will add to a current gap in research and knowledge. Casper and O'Rourke (2008:S256) recommend that future research incorporate a comparative component that includes personal characteristics, perceptions and experiences of care workers -- which is the primary aim of this thesis. Recently, Daly and Szebehely (2012:139) claim that very little is known about national differences in working conditions for care workers in nursing homes. Comparative studies are timely and suggest that policymakers and stakeholders could benefit from applying an international perspective to develop solutions for long-term care issues to address an ever growing care crisis (ILC-SCSHE-USA, 2006; Cangiano et al. 2010; Suzman and Beard, 2011).

Overall the limited cross-national comparative studies have overlooked the valuable knowledge that this research aims to encompass that can only be achieved through cross-national comparisons. The location, government, size, and country are all irrelevant

because the comparisons of care workers take place at the micro-level as long as the nations have nursing homes. Furthermore interactions between the care workers and the residents are important as well and have the possibility to link nursing homes and the broader context in which they exist. General characteristics of care workers in each nation provide valuable information for future planning of services to prepare to care for ageing populations in different societies.

The basic characteristics of care workers and the scope of work in an average day are absent in the current research literature from a comparative perspective. Care workers' perspectives are sporadically discussed primarily in the context of relationships. For instance, Bishop et al. (2009) report findings that corroborate with other studies on work conditions, relationships, and the need for better staffing levels while exploring job satisfaction. A significant body of literature exists in Canada that focuses on working without adequate staff (Casper and O'Rourke, 2008; Kontos et al. 2010). Furthermore, the absence of acceptable staffing levels and turnover in Scotland and the USA leave little time for relationships, team work and influence the quality of care (Kasyer-Jones, 1990; Gass, 2004; Jonas-Simpson et al. 2007; Tinney, 2008; Ball et al. 2009). Comparative researchers have the potential to identify variations in specific areas that can be linked to inform practice decisions. Nevertheless the stressful work environments and conditions for care workers in nursing homes at the micro level are rarely linked to the larger structures and institutions at the macro level in which they exist (Armstrong et al. 2011; Twigg et al. 2011).

Summary

This chapter has outlined care workers in Canada, Scotland, and the USA to describe the work they do. Care workers are primarily responsible for ADL care for residents but their role encompasses much more. They are referred to as the eyes and ears for the residents and have considerable responsibility but lack the authority or resources to provide proper care. Care work is gendered, physically and emotionally demanding. Care workers perform approximately 90 percent of the hands on care for the residents and work under difficult conditions. These workers form the back bone of the nursing home and provide the majority of the care. They make or break the nursing home's reputation as the primary care providers.

The residents' needs have increased over the years as people delay admission to nursing homes. By the time the resident's arrive they have high physical and cognitive needs with approximately six chronic conditions. Care work is provided in task oriented routines that are focused on efficiency and often without adequate staffing and skill mix; with a lack of resources and inadequate time to meet the resident's care needs. Care work is poorly regarded, performed behind closed doors with limited supervision and typically provided by women. The tasks consist of responsibilities that most people do not want to do and the workers have to assist or perform almost every step of care with the residents.

Historically, the poor status of care work has been literally and figuratively viewed as dirty work and the negative view is reinforced by society. Care at its best, exists within a

relationship and thrives on familiarity. Yet, in the absence of time and knowledge of resident preferences, care workers rely on reflexive practices based on their own experiences to provide resident care, especially when the scope of work is beyond their level of skill. Regrettably, those who provide the most care are without articulation to have a positive impact on the circumstances. The view of body work in health and social care has been extended to link concepts, resources, and locations. Placing body work at the core provides a framework where multiple perspectives of body work can be integrated.

Chapter 2 has highlighted specific aspects of the job and conditions of work as a care worker while chapter 3 will link the care workers to the nursing home as a place for work. The institutionalised work setting hosts various forms of stigma, new routines, rules, and regulations that offer little time to provide care for the residents that is the intended goal.

Chapter 3: Nursing Homes as Institutions

Issues related to care workers have historically received little attention from policymakers, researchers, and the nursing home as an industry. However, the media has begun to document the awareness and crisis status of the labour shortages for this workforce in nursing homes (Stone and Harahan, 2010; Suzman and Beard, 2011). The global ageing populations increase the demand for care workers underscoring the impact a potential shortage of workers can have on quality of care and quality of life (Suzman and Beard, 2011). Negative images in the media dominate the industry although there are some excellent nursing homes that provide high quality standards of care (Kelly, 2013). However, care workers in nursing homes are commonly viewed by the public as low-wage employees in unpleasant occupations that primarily consist of caring for incontinent, confused older people (Stone and Wiener, 2001). This image is exacerbated by media reports that feature poor quality care as the sole responsibility of the providers (owners and care workers) (Stone and Wiener, 2001; Stone and Harahan, 2010). Furthermore, this perspective ignores the influences of the larger social structures on the nursing home as an institution outlined in the introduction (Tellis-Nayak and Tellis-Nayak, 1989; Twigg et al. 2011; Armstrong et al. 2011; Banerjee et al. 2012).

Institutionalisation

Institutionalisation identified by Goffman (1961) is the process of embedding, adhering and adopting the social roles and norms of the institution. The resultant social control

creates barriers between the institution and the outside world giving into the demands of total institutions. This chapter seeks to identify institutional and organisational characteristics of institutionalised nursing homes that will link to specific aims within the wider thesis.

Goffman (1961) reveals that institutions establish a set of formalised rules to maintain predetermined responsibilities and purposeful actions within routines. The institutional social structures provide a place for such activity to occur as Goffman describes:

> *A total institution may be defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life (Goffman, 1961:XIII).*

The underlying assumptions of total institutions are the similarities that exist between them. Not all institutions are total institutions although some may have more distinctive features that are typical of classic total institutions. The four common characteristics of total institutions are described below and include: batch living, binary management, inmate role, and institutional perspective. Goffman (1961:4-5) describes the basic social arrangements in everyday life for individuals as consisting of three spheres: sleep, play, and work. These spheres of life for most, take place in separate areas, with different people, under various authorities, and without an over-all rational plan. The fundamental notion here is to recognise that people do not continually experience all of these spheres of

life in the immediate company of others. In contrast, for total institutions, batch living becomes a barrier that condenses these separate spheres of life into a non-domestic setting. According to Goffman (1961:6) total institutions breakdown the barriers that typically separate these three spheres of life by the following:

1) Every aspect of life is conducted in the same place and under the same single authority;

2) Each phase of a person's daily activity is carried out in the immediate company of a large batch of other members, who are all treated alike and required to do the same thing together;

3) All of phases of the daily activities are tightly managed and scheduled, with one activity beginning at a prearranged time leading into the next, with the entire sequence of activities intentionally imposed by a system of explicit formal rulings from above by a body of officials;

4) The various enforced activities are brought together into a single rational plan that is purportedly designed to satisfy the official goals of the institution (Goffman, 1961:6).

Binary management outlined by Goffman (1961:6) is the process of managing daily human needs by a bureaucratic organisation of whole blocks of people, whether necessary or not, or effective means of social organisation. Important implications of binary management include: people moved in blocks can be supervised by personnel whose primary responsibility is surveillance to see that everyone does exactly what they have been told and what is required (Goffman, 1961:6-7). In total institutions a basic split exists between two specific groups: the managers and the managed. The point here is that each is made for

the other (Goffman, 1961:7). The managers frequently operate in shifts and are socially integrated to the outside world. Those managed are called inmates and are typically sequestered from the outside world (Goffman, 1961:7). Furthermore, social mobility between the two groups is grossly restricted and the social distance is typically excessive, and often formally prescribed with few exceptions (Goffman, 1961:7-9).

The inmate role is started upon the admission process where the individual is stripped of their former identity. In this case, the total institution becomes the first barrier between the inmate and their social supports that help to define the self. This process separates the identity and relationships from his former self to be inconsistent with his new role (Goffman, 1961:13-16). According to Goffman (1961:35) adaptation to the inmate role can trigger defence responses called 'looping'. These looping patterns in are expressed by withdraw, obstinacy, colonisation and transformation (Goffman, 1961:61-66). Last, the institutional perspective denies the individual's view or interpretation of life which and in turn validates the institutions existence (Goffman, 1961:109). Institutions provide the mechanics for social order and stability while the new view becomes the frame of reference and people adjust to the institution. Several examples are provided in the next sections that are directly related to the institutionalised nursing home.

Goffman (1961) further suggests that there are five types of total institutions: jails and prisons; military and boarding schools; religious retreats such as abbeys and convents; mental institutions and old TB sanatoriums; and those created to help the helpless and harmless. Goffman and others place nursing homes into the last category, distinguishing it,

nevertheless as characteristic of total institutions (Foner, 1995b; Gubrium, 1997). All nursing homes manifest some of the characteristics of total institutions, where daily routines are conducted in the same place, the same manner and ideally by the same person (Gubrium, 1997). For the most part these activities are carried out in the immediate company of other residents who are treated similarly and expected to be doing the same activity (Bland, 2005; Dobbs et al. 2008). According to Sennett (2003) residents are not officially required to attend any of these activities. However, for residents who do not or cannot participate in these activities in the absence of extreme medical conditions, the general course of action is to report the resident as challenging and in need of some type of intervention or attention (Sennett, 2003). This process often stigmatises the resident as a problem and titles such as: the *moaner, whiner, complainer,* or *aggressive* are nevertheless assigned (Goffman, 1961; Twigg, 2000b; Dobbs et al. 2008; Whitaker, 2010).

The admission process to a nursing home

Admission to a nursing home is generally an event that people do not anticipate and arises out of a crisis where choices are often made for the residents but not *by* the residents. The need for nursing home care usually transpires as the result of significant changes in circumstances that "*forces such a consideration*" (Willcocks et al. 1987:31). Living the last part of life in a nursing home is typically not part of a lifelong plan but more likely the consequence of a combination of incidents encountered that render us unable to care for ourselves at home (Gustafson, 1972; Gubrium, 1997; Whitaker, 2010).

The move from living in the community to any institution is seldom regarded as positive for anyone. The "*process of crossing the threshold into institutional care*" represents a symbolic defining moment recognised by professionals as detrimental for the resident (Willcocks et al. 1987:31). The time in life when residents enter nursing homes is a fragile or tenuous point when multiple losses are usually experienced. Moreover, for the residents this process imposes a new set of regulations embedded in institutional living for safety, efficiency and cleanliness (Schwarz, 1996:7; Willcocks et al. 1987:x). Goffman (1961:31) argues that throughout admission to total institutions a persons' self is mortified, shamed or disgraced by engaging in activities with symbolic implications that are incompatible with their previous identity. The mortification process is fairly standard and starts as vital supports of established social roles and identities in the outside world are slowly stripped away for the purpose of conformity (Goffman, 1961:14). Upon entrance and leading to admission, are a series of degrading, humiliating profanities of self (Goffman, 1961:14; Brissett and Edgley, 1990). A person's belief system or moral career is put into a sequence of change where vestiges of perceptions about significant others, themselves and the process of accepting a new view of self are slowly or radically shifted (Goffman, 1961; Gustafson, 1972). In total institutions the process of mortification can be unquestionably intentional or merely consequential (Brissett and Edgley, 1990). For example, prisons intentionally humiliate or shame its clientele unlike nursing homes where mortification is unintentional. Furthermore, regardless of whether the mortification of self is intentional or not, the outcome of the mortification process is the same (Goffman, 1961; Whitaker, 2010).

Conformity to Rules, Regulations, and Routines

The regularity of routines in nursing homes can be likened to that of other total institutions with the exception that *scheduling* a routine is not equivalent to *accomplishing* a routine. For example, in nursing homes care workers assist the residents through almost every step of the ADL routine (Goffman, 1961; Gubrium, 1997). The recognition of daily ritualistic routines anchor care in the rigid conformity and obedience to the rules (Gubrium, 1997; Casper and O'Rourke, 2008). Residents are often confronted with their own vulnerabilities as they are made visible or exposed to others (e.g. residents, all staff, and visitors) in common areas such as the dining room through the strictly scheduled routines. Moreover, the formalised routines are maintained within a set of inflexible rules that establish predetermined responsibilities that account for every minute in a daily routine in public and private places (Willcocks et al. 1987). Unfortunately for the residents, the routines, procedures and environments are not designed to make the residents' lives more natural, liveable or meaningful (Schwarz, 1996). For example, the dining rooms are designed to accommodate several tables of residents rather than a family dining room in a home. In this sense the broad concept of privacy or the awkwardness of having visitors in your room could be compared with a bedroom. Needless to say, "*there are important aspects of life which do not translate well to institutional settings*" (Willcocks et al. 1987: 91).

Care work viewed through the lens of task oriented routines is frequently in contradiction to the goal of the residents' rights and safety with independence and choice (Tinney, 2008). The routines established within institutions allow for continued caring in nursing homes through the 'circular timelessness' shaped by the rituals of care that take place around the clock 24/7 (Willcocks et al. 1987:70). The daily dilemmas for care workers with unrealistic expectations as the norm are magnified by the regimented rules and the organisation of care (Karantzas et al. 2012; Dill et al. 2013). A common characteristic of institutionalised nursing homes is the strict obedience and compliance to the rules (Gubrium, 1997; Casper and O'Rourke, 2008). To demonstrate, an analogy of the experience of living in a nursing home is compared to flying on an aeroplane (Andrews et al. 2005). This analogy highlights the organisation of everyday life in nursing homes and demonstrates how both settings are heavily managed according to time and space. Certain behaviours are allowed while others are restricted, but the strict adherence to daily routines and rituals is a necessity. Such illustrations depict many of the negative aspects of nursing home life. The authors say:

....not having a choice of whom one sits besides and risking that this seatmate may smell, slurp food, chatter endlessly or refuse to participate in even occasional exchange of pleasantries; having to stuff the few allowable personal belongings away so they do not encroach on one's neighbors or aisles; eating on the schedule imposed by the airline not when one is hungry and, moreover, having little choice over what one eats; having to use and wait for communal facilities, such as bathrooms and not being able to get to the toilet when needed because there is a cart in the aisle or the seatbelt sign is displayed; having television sets turned on regardless of one's interest in watching them; having to wear a restraint to protect against the rare possibility of injury; and having nothing to do and nowhere to go (Andrews et al. 2005:110).

The similarities end when the aeroplane lands. At that point the passengers may leave the aeroplane and can continue their journey. As travellers we tolerate these temporary constraints because the trade-off is that we usually arrive at our desired destination. Nursing home residents however, will probably spend the rest of their life in the nursing home which in many cases was not their desired destination (Eaton, 2000; Nolan et al. 2008; Whitaker, 2010). For the residents there are few trade-offs.

This analogy provides a vivid image of the intrinsic nature of most institutions, demonstrating how particular places are characterised by substantial management and regulations. It also reminds us of how nursing homes are so much more than just a location. They are an organisation of purpose and human activity in a physical place (Willcocks et al. 1987; Hockey, 1999; Andrews et al. 2005).

Stigma and the Nursing Home

With multiple forms of stigma related to various aspects of nursing homes I have conceptually defined stigma for this research as encompassing three interrelated components. These traverse boundaries from the person to the location. First is a cultural belief linked to an undesirable characteristic, second are the prejudices from labels resulting in unequal treatment, and third a distinct category for the separation a of physical location (adapted from Dobbs et al. 2008).

In the USA nursing homes are rated by the Centers for Medicare and Medicaid Services (CMS) on a website that compares nursing homes in the public domain. Higher scores are given to those homes that overall, perform well in these three categories: health inspection; staffing and; quality measures (CMS, 2012). According to Mukamel et al. (2009) some managers are now selective about only accepting residents with specific conditions in an attempt to improve their CMS score. The process is called 'cream skimming' or 'cherry picking' (Mukamel et al. 2009:794). These scores are frequently compared by individuals in the USA to select nursing homes. To improve scores, a manager would ideally select

residents that are more likely to have good outcomes which would result in higher CMS scores. The least desirable resident characteristics that would lower CMS scores are pain and memory loss (Mukamel et al. 2009). This finding is consistent with Dobbs et al. (2008:518) who found that "*disability as it relates to cognitive and functional decline is a common stigmatising trait for older adults*". Therefore, "*The most pervasive stigmatizing attitudes and behaviors appear in the context of dementia and cognitive decline*" (Dobbs et al. 2008:524).

Unfortunately for the residents "*one of the most frequently cited reasons for institutionalization is the loss of cognitive function linked to dementia*" (Caron et al. 2006:195). Across the three countries, the residents consistently represented the most dependent vulnerable, frail, oldest people in each society with dementia who can no longer care for themselves or live independently (He et al. 2005; Caron et al. 2006; Innes, 2009). Furthermore, the residents are more likely to be over aged 85 and more functionally dependent requiring extensive assistance. Residents with dementia have high levels of care needs that do not easily fit into the routines in nursing homes (Innes, 2009). According to Banerjee et al. (2012:390-391) the residents with dementia exhibit more agitated behaviours particularly when they are left uncomfortable or alone. This profile is consistent with the typical nursing home resident in each country (Samus et al. 2005; National Advisory Council on Aging [NACA], 2006; Nolan et al. 2008; Canadian Institute for Health Information [CIHI], 2011).

Robertson (2010:1) argues that dementia has been identified as one of the most stigmatised conditions for older people and regarded as an affliction worse than death. The attitudes toward people with dementia are reflected in the negative views of old age and stigmas surrounding mental health (Innes, 2009:39). As a result, dementia is identified as one of the least desirable characteristics of nursing home residents (Bourgeault et al. 2009; Innes, 2009; Mukamel et al. 2009). Moreover, from this view, stigma is not only attached to individuals with cognitive decline *but also to* institutions that provide care and services for these people (McCabe, 2011:155). Within this context, "*perceived institutionalisation*" stigma is extended to include the location as the nursing home, the care provided in the nursing home as well as the people providing the care (Dobbs et al. 2008:525). Stigma of the nursing home as an institution is derived from the view as complete infirmaries, no longer the destiny of just the destitute and are as terrifying as the historical images of the old workhouses for the poor (Willcocks et al. 1987:28-29; Innes, 2009:106; Gilleard and Higgs, 2010). Furthermore, the assumptions of institutional stigma are reiterated by the WHO's pamphlet on *Home Care in Europe* by stating that home care is the best option to avoid institutionalisation (Tarricone and Tsouros, 2008).

Life and death

Nursing homes can be stigmatised as places of illness and death (Laslett, 1991; Gustafson, 1972; Gamliel and Hazan, 2006; Whitaker, 2010).

> *For many of the elderly, admittance to a nursing home marks the onset of dependency, a late-life rite of passage, announcing loss of capacity and control. For those who see the nursing home as life's final habitat, placement in this setting can be a dark omen of separation, isolation, and, rejection, which they dread more than death (Schwarz, 1996: 4).*

People with dementia are often referred to within the same context as those who are dying and in some cases are thought of as already dead ignoring the terminal state of the disease (Gubrium, 1997). This stigma creates barriers for care workers to establish emotional ties or bonds given the circumstances. The process of developing relationships is fragile regardless, even when recognising the lack of reciprocity because of residents' impending death (Berdes and Eckert, 2007). In a similar sense, medical occupations are taught the greatest professional reward is for patients to recover and return to normal physical and social life. Gustafson (1972:229) argues the nursing home setting cannot provide this type of 'recovery reward' for the residents. These factors combined with the stigma of death leave the nursing home as the least prestigious place for medical personnel to work (Gustafson, 1972:229).

The death of residents in the nursing home setting is entwined with complexities beyond stigma but is rarely acknowledged. Wiener and Kayser-Jones, (1990) recognise the difficulties in maintaining relatively stable conditions in a place of life and death where the boundaries between deterioration and dying are blurred. The high mortality rates of residents in nursing homes are frequently devastating and affect the care workers (Karantzas et al. 2012). While life and death are present at all time in nursing homes this engenders continual challenges as the staff cope with these diametric realities (Österlind et al. 2011). As Gustafson aptly reveals the nursing home is a place of life and death and the "*death includes both a physical termination and a final social separation*" (Gustafson, 1972:227).

Admission to a nursing home launches a series of cascading events (previously discussed) and has been called the 'ultimate failure' both physically and socially (Goffman, 1961; Gustafson, 1972:227; Whitaker, 2010). Taking this into account, moving into a nursing home is often viewed as the last stop for the residents, where they are sequestered from society as opposed to being offered the possibility of rehabilitation (Townsend, 1962; Pollock et al. 2005; Gamliel and Hazan, 2006; Bourgeault et al. 2009). According to Whitaker (2010:97), death in the nursing home evokes images of undignified deaths. Likewise it has been argued that the decline of nursing home residents physically and psychologically are the consequence of the care received in these institutions. This augments the perception of nursing homes as houses of death (Eremia, 2002). In contrast, death in hospice and palliative care is associated with a 'good' and 'dignified' death.

Reframing the nursing home 'as a place where residents come to die' changes the moral career of the nursing home patients compared to mental patients (Gubrium, 1997; Whitaker, 2010:99). The career of nursing home residents is regressive and this changes the definition of the situation, the experiences, interactions and outcomes for everyone involved (Gustafson, 1972; Berta et al. 2006; Whitaker, 2010). When dying becomes the career of people being cared for, the nature of the institution changes (Gustafson, 1972). Acknowledging the lack of reciprocity over the residents' looming death offers few rewards (Berdes and Eckert, 2007). As a result maintaining relationships are especially difficult for the care workers under these circumstances. Inadequate time and staff, compounded by the stigma of death contribute to negative aspects of relationships that are an integral component to enhancing the care workers well-being (Jonas-Simpson et al. 2006).

Ageism

Robert Butler (1969) coined the term ageism to identify the concept of age discrimination as parallel to other forms of discrimination i.e. racism and sexism. According to Macnicol (2010) at the ILC-UK:

> *Ageism in social relations refers to those attitudes, actions and vocabularies whereby we accord people a diminished social status solely or mainly by reference to their chronological age. Ageism can be directed against people of any age, although it is perhaps most egregious when directed at older people (Macnicol, 2010:3).*

Ageism is based on a combination of factors such as 'social justice' and 'economic efficiency' (Macnicol, 2010:3). It has further been argued that youth is linked to i.e. energy, strength, resilience, biological fertility, and so on across modern human societies. Furthermore, ageism contributes to the perspective that views older adults as vulnerable and in need of protection in contrast to younger individuals with disabilities. Young people with disabilities in need of protection commonly have the option to accept the risks associated with their vulnerability and participate in society (Dobbs et al. 2008:518). The differing perspectives in attitudes towards younger disabled people in comparison with older people also influence the funding available and many other support services such as public programs, community care options and independent living (Dobbs et al. 2008).

In age stratified societies, older people can be assigned a lower social status in the absence of such vibrant youth like qualities coupled with a reduced lifespan remaining (Macnicol, 2010). This presents a thorny debate given that people naturally place emphasis on positive youthful qualities. Ageism approached from this perspective puts into question whether age discrimination can realistically be eliminated? The only possible method to rationally eliminate ageism would paradoxically be to abolish ageing and death itself (Macnicol, 2010).

In the review of literature a common coding of age categories is currently in use with the census data. As people live longer those aged 65 and over will become more visible (Suzman and Beard, 2011). Researchers who use age stratification suggest that the social and cultural separation between age groups assigns people at different stages of the life course to distinct segments of society. Laslett's (1991) original argument outlines the first age, second age, third age, and the fourth age. In defining each category the third age is simply described as an ambiguous location in between the second age and the fourth age. However, the fourth age represents a period of frailty in late old age and is defined as a dying trajectory (Nicholson and Hockley, 2011). The subjective losses common in the fourth age confirm the belief that living longer poses a risk for human dignity (Nicholson and Hockley, 2011:101). "*In becoming frail, people begin to inhabit the space between living and dying*" (Nicholson and Hockley, 2011:103). In this sense, frailty in late old age as a dying trajectory arguably links ageism to life and death in the nursing home discussed in the previous section.

Organisational Characteristics of the Nursing Home

Nursing homes are an essential component in the LTC continuum serving primarily older adults (Zinn et al. 2005). The organisational characteristics of nursing homes can be broadly defined to include the following: type of ownership and profit status[2]; chain affiliation; top management; nurse and care worker turnover; facility size as number of beds, layout and location; occupancy rates; hospital-based versus freestanding; rural versus urban; staffing levels; residents' age distribution, acuity and case mix; and types of care provided. Positive correlations are related to more stable staffing patterns identified with organisational characteristics such as: non-profit ownership; smaller facilities by number of beds; lower occupancy rates (Pollock et al. 2005) and a low percentage of Medicaid residents (Zinn et al. 2005; Mueller et al. 2006). These features are increasingly important because of their potential impact on the care workers' and residents' lives.

Pollock et al. (2005) argue that during the last two decades (before devolution of Scotland within the UK) of the twentieth century the unwillingness for the UK government to invest and build high quality, publicly owned LTC facilities have created significant repercussions. This opened the market to for-profit ownership, resulting in a rise in the average number of beds per nursing home. Even though the number of beds increased per facility in the UK the change is minimal in comparison to Canada and the USA. Larger nursing homes are often more profitable but the increase in size also makes them more institutional and less residential. This is seen as a drawback from the resident's perspective

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[2] Canada uses the term proprietary and Scotland uses the term private to denote for-profit ownership.

(Pollock et al. 2005). In line with the expansion of larger for-profit nursing homes, Canadian and Scottish policy emphasis on operational efficiency made large facilities more viable than smaller. Researchers and policy analysts in Canada conclude that decreases in funding along with more stringent regulations have established an operational environment that discriminates against smaller facilities (Berta et al. 2006). Banaszak-Holl et al. (1996) point out that smaller nursing homes often have fewer accessible assets and are unable to take advantage of resources available to larger organisations. Therefore, smaller facilities are at a disadvantage in meeting costly provincial standards (e.g. required upgrades to financial reporting, physical improvements, and new staffing regulations). According to Armstrong et al. (2011:125) in Canada practices have shifted from viewing nursing home care as a public good to the commercialisation seen in the for-profit sector. This suggests potential reductions in the resources to support dignity and respect in resident care (Armstrong et al. 2011:125). Furthermore, the high rates of work related injury and illness have contributed to absenteeism that are often misunderstood within individual attributes of the workers instead of a product of the support structures for care work. The findings highlight the need to understand how support for care is influenced by the wider institutions and structural processes and how these are linked to care practices (Armstrong et al. 2011).

In Canada and the USA it is suggested nursing homes with for-profit ownership have lower staffing levels in terms of fewer absolute numbers of staff in comparison to non-profit organisations (Banaszak-Holl and Hines, 1996a; Castle and Enberg, 2006; Berta et al. 2006). Although public funds pay for care for older people in all three countries, the

for-profit market dominates the nursing home industry. In Canada the LTC sector regulatory conditions have favoured for-profit ownership and particularly multi-chain operators. Multi-chain nursing homes are rewarded for their ability 'to realise economies of scale' over independent non-profit organisations (Berta et al. 2004:79). According to Pollock et al. (2005) it is implied that Scottish provisions of care for older people in nursing homes are now seen as a source of profit as public funds pay for care in private homes. In the USA most nursing homes are funded with public money through Medicaid and Medicare (Eaton, 2000; Kash et al. 2006). Nursing homes run as businesses are more likely to have the goals of maximising profits and reducing costs. The wider implications for care dominated by for-profit ownership are central to organisational characteristics and this influences the philosophy of care as a business priority. Care in nursing homes under such circumstances often become secondary to business goals (Berta et al. 2004; Pollock et al. 2005; Kash et al. 2006; Armstrong et al. 2009). Comondore et al. (2009:14) suggest that across the countries in this study for-profit facilities have strong incentives to minimise expenditures which could lead to lower staffing ratios (Comondore et al. 2009:14).

In the USA Tellis-Nayak and Tellis-Nayak (1989:312) emphasise that overall profit seeking nursing homes are known for investing minimum resources, seeking maximum returns, which create difficult working conditions for care workers. Mercer et al. (1993) report management will skimp on equipment, supplies and the number of care workers in an attempt to cut costs. When a place of care becomes a profit making venture many organisational characteristics change and the focus befalls one of making money and efficiency at the cost of care (Wiener and Kayser-Jones, 1990; Gubrium, 1991; Henderson,

1995; Berta et al. 2006). Bennett et al. (1997:96) reiterate these findings by claiming that "'*Healthcare values' and 'business values' are always different'*". Pollock et al. (2005) describes this dynamic:

> *When care for older people becomes a profit-making industry this inevitably affects the type of care that is provided. When profit margins are tight – and the care home sector has been plagued by low levels of profitability in recent years – owners often cut back on staffing levels, freeze staff pay or cut back on 'additional' services for residents… (Pollock et al. 2005:190).*

Gass (2004) implies that poor working conditions for care workers exist while profits are made by nursing home owners. Furthermore, Berta et al. (2006) argue that if making a profit governs a nursing home's mission, this in turn influences certain behaviours towards improving organisational characteristics. Likewise it would also hold true that money making organisations are obligated to their owners or shareholders, and managers of facilities run by such organisations have little or no say in how profits are allocated. According to Bennett et al. (1997:96) nursing homes are labour-intensive businesses and the greatest costs are staff wages. McGregor et al. (2005) suggest that lower staffing levels are likely to be one of the best options available to generate profit in a system with fixed costs for wages. As a result, when reviewing the business operating budget, the choice to eliminate a care worker position is very different on paper than in practice. Therefore, it is not surprising to discover lower staffing levels in for-profit facilities (Tellis-Nayak and

Tellis-Nayak, 1989; McGregor et al. 2005:648; Armstrong et al. 2009). These findings imply that financial imperatives of investment ownership in nursing homes operate in a similar manner in Canada and the USA in my research.

Table 1: Organisational Characteristic of Nursing Homes

	Canada	**Scotland**	**United States**
Type of ownership	Proprietary * Voluntary + Government	Private ** Voluntary Government §	For-profit Voluntary ++ Government
Percentage of ownership by facility type	For-profit: 52% Voluntary: 24% Government: 24%	For-profit: 66% Voluntary: 15% Government: 19%	For-profit: 62% Voluntary: 31% Government: 8%
Size of facility by beds	Small: 0-39 beds Medium: 40-99 beds Large: over 100 beds	No defined categorization of size	Less than 50 beds: 50-99 beds: 100-199 beds: More than 200 beds:
Average number of beds by ownership	For-profit: 50 Voluntary: 52 Government: 77	For-profit: 44 Voluntary: 30 Government: 31	For-profit: 107 Voluntary: 110 Government: 121

*   Denotes for profit/proprietary ownership.
** Denotes for profit/private ownership.
\+   Represents Lay and Religious organisations owned and operated as non-profit entities.
++ Represents non-profit organisations.
§   Represents Local Authority/National Health Scotland (LA/NHS).

Sources:
Canada: Berta et al. (2004); Berta et al. (2006)
Scotland: Scottish Executive Statistics Release (2006) Care Homes
United States: CDC: NNHS (2006)

Table 1 discussion

All three countries have two separate categories and utilisation of nursing home beds for purposes other than LTC. The Canadian and Scottish designation for the other beds are identified for short stays and respite. In Scotland the difference is to the extent that the long and short stay beds are categorised for a distinct occupancy and labelled accordingly within the census (Scottish Executive Statistics Release, 2006). The other category for beds designated for short stays in the USA are specifically for skilled nursing facilities (SNF) rather than the more common intermediate care facilities (ICF) or nursing homes. The SNF beds offer more time-consuming nursing and rehabilitation services for residents in need intensive medical care after leaving hospital. Medicare is the primary source of payment for SNF care. After the maximum limit for the number of days paid by Medicare is exhausted, it is relatively easy to transition the residents to ICFs that utilise other sources of payment. These two categories for beds within in one facility create constant turnover for residents with the different designations. In contrast, Canada and Scotland have extensive community and home care support services to keep older people in their own homes for as long as possible. This contributes to a higher average age of nursing home residents in Canada and Scotland in my discussion of demographic trends in the subsequent chapter.

Checks and balances

Across the three countries, checks and balances have been established and incorporated into some government regulations, funding sources, and nursing home policies for the protection of residents. These safeguards have been created for the residents *but not the care workers as well.* The safeguards include: regulations in general; residents' rights; written restraint policy or regulations; procedures for preventing and reporting abuse; and regular inspections (OIG, 2002; Scottish Executive, 2006; Ministry of Health and Long-term Care [MHLTC] the ACT, 2006). In Canada, the ACT (2006) standardised the 'Whistle Blowing' procedures to protect the residents from retaliation; the Residents' Council; and a Zero tolerance framework for abuse and neglect. In Scotland, the National Care Standards were revised to feature the service user's perspective and includes a specific process for 'Expressing Your Views' or 'Blow-the-Whistle' framework for making a complaint with protection from retaliation (The Scottish Government, 2007b). The USA Ombudsman program for nursing homes was developed for different purposes than Scotland and operates specifically for institutions. It is a voluntary advocacy group that works on behalf of the residents making complaints of abuse, neglect, and mistreatment (Administration On Aging, 2010). Furthermore, the Elderly Protective Services and the Centers for Medicare and Medicaid Services (CMS) provide regulatory agencies that require nursing homes participating in Medicare and Medicaid programs to meet specific criteria including protection for the residents (OIG, 2002; CMS, 2012). In addition to each country's individual programs, every nation maintains websites to collect and disseminate information available for the public. The principle is the same across the

countries but they all vary slightly[3]. People do not like to leave monitoring of nursing home care to those who own or manage them and have delegated this responsibility to these watchdog organisations. The rules of daily life do not include mistreatment of the elderly and the fact that all three countries firmly disapprove of abuse and neglect is evident by providing these websites that disclose abuse allegations, accurate charges, and inspection reports. The websites also rank the nursing homes as part of the process to monitor outcomes.

External Quality Controls and Regulations of Nursing Homes

In addition to the checks and balances for the resident's protection, external regulations for nursing homes have been implemented across the countries. Nursing homes are currently one of the most regulated industries in developed countries (Nicholson and Hockley, 2011:105). According to the OECD (2013:248) the nursing home sector in the USA is one of the most heavily regulated markets. The regulations are designed to ensure effectiveness and quality of services. However, the regulations in the USA are hypothesised to exceed those of other industries due to service failures for the residents. The regulations are to ensure that basic services guaranteed by the government are carried out successfully. Service failures for the residents and the consumer's inability to access, monitor, and respond to low standards of care have increased regulation (OECD, 2013:248). The large proportion of public funding provided for nursing home services justifies the extensive

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[3] www.nursinghomeratings.ca
www.bestcarehome.co.uk
www.medicare.gov/NHcompare

government oversight. Although the government owns few nursing homes in the USA, the federal and state governments are the primary sources of payment for services rendered through Medicare and Medicaid (OECD, 2013:248). Eaton (2005) argues that production of nuclear power is the only industry in the USA that surpasses the regulation of nursing homes. However, considerable deficient and unsafe conditions continue to plague the nursing home industry (Eaton, 2005:46).

Concluding points

This chapter has introduced the concept of institutionalisation by Goffman (1961) and the nursing home. It has outlined the various forms of stigma that are related to the nursing home as a setting, a place to live and work, the care work that takes place, the stigmatised residents primarily with dementia, and death. I have begun to draw together the work that care workers do in nursing homes and how the different meanings influence most aspects of work for the care workers and life for the residents. I suggest that the care workers experiences of work are affected by the organisational characteristics explored in this chapter.

The nursing homes in this research were: institutionalised; dominated by an industry of for-profit ownership; and provide care for a similar resident population with high levels of cognitive and physical care needs. The nursing home as an institution is contextualised to highlight the institutional features in a new place called home. Admission to the nursing home introduces a new group of people, a new set of rules, and regulations that are often in contradiction to dignity and autonomy, making personal preference and choice paradoxical terms for the goals of efficiency (Banerjee et al. 2012).

Residents in nursing homes experience shrinking social worlds as they are cut off from the outside world and the care workers become the resident's primary social world (Tellis-Nayak and Tellis-Nayak, 1989). This is difficult as there are always more residents than care workers and the low staffing levels leave little time for establishing relationships

(Twigg and Atkin, 1994). Jonas-Simpson et al. (2006) emphasises how good relationships between care workers and residents are vital components to enhance the resident's wellbeing. However, the relationships between the care workers and residents are unintentionally harmed by institutionalisation and this contributes to low standards of care (Brooker et al. 2011). The heavy workloads are attributed to the low status of marginalised care workers that obstruct them from providing the level of care they know is possible. The organisation of care work in nursing homes leave little time to meet the social care needs or the relational aspects of resident care (Daly and Szebehely, 2012).

Chapter 2 pinpoints the obstacles for care workers to do their job and chapter 3 delineates institutional and organisational barriers that prevent the care workers from providing the standard of care they know is possible. The subsequent chapter will outline significant historical events that influenced the development of each countries health and social care policies along with the nursing home. Demographic information is summarised to identify the populations in nursing homes as comparable. Services within the LTC continuum are scrutinised to demonstrate the nursing home as a comparable service emphasising the need for nursing homes and care workers. The chapter concludes by focusing on care workers and the training requirements across the three countries.

Chapter 4: Historical Developments, Demographic Trends and Care Worker Training

In this chapter I will present a historical overview of the health and social policies in each country to highlight significant features that influenced their development. I will outline the common origins of the nursing home and how it advanced into its current structure by country. Demographic information is organised and presented to illustrate the comparability of the populations and trends across these three nations. The long-term care continuum of services is then summarised to indicate the nursing home as a common service in each country. This information provides support for this comparable service and highlights the need for care workers as a workforce in nursing homes. The complex training requirements for care workers are scrutinised to delineate the differences. This provides information to answer my research question exploring the care workers' training requirements in each country. While the training requirements for care workers vary considerably, the ADL care that is provided shares strong similarities as well as the resident population in the nursing homes across the settings.

The Historical Development of Health and Social Care Policies

Even before an individual's birth, social policy creates the conditions that either enrich or deteriorate his or her life trajectory. Like the soil in which a seed germinates and grows, a child's development into an adult and senior is shaped by the rules and institutions of the concentric rings of family, neighborhood, community, city, nation, and the world surrounding him or her (Zuberi, 2006:176).

The development of health and social care policies is an evolutionary process intricately tied to social, cultural, economic, and political ideologies[4] (Kayser-Jones, 1990). Therefore, it is essential to understand the circumstances that shaped the development of each country's health and social care policies and consequently influenced the establishment of the nursing home. In 1947, the Chronicle of the World Health Organization [WHO] (1947:29) re-framed the definition of health to encompass a preventative perspective. The new description of health includes the elimination of all inequalities and establishes goals to improve health by improving the standard of living (WHO, 1947). Since that time there has been a gradual shift from a curative to a preventative approach to improve health. The extent that each country embraced and

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[4] Political ideologies for this research is defined as: a particular set of ideas, principles, social movement, institution, class or large group that explains how society should work and offers some political and cultural blueprint for a certain social order.

integrated these changes tremendously affected how their health and social care policies were formed (Crombie et al. 2003; Zuberi, 2006; Wilkinson and Pickett, 2009). The countries in my study reflect a sensitivity of health and social problems identified by Wilkinson and Pickett (2009) in relation to the WHOs (1947) new description of health.

Wilkinson and Pickett's (2009:497) index of Health and Social problems in relation to income inequality in rich countries presented below included all of the countries in this study with the exception of Scotland which was depicted as the entire UK. Wilkinson and Pickett (2009) explored stratification or unequal positions individuals occupy in a society in terms of wealth, property, and access to material goods and products and determined that these features were more common in unequal societies. Social dysfunction is identified by Wilkinson and Pickett (2009) and includes problems such as violence, imprisonment, obesity, drug use, teenage births and so on, that underscore societal differences in material inequity (see Table 2 below).

Table 2: Index of Health and Social Problems in relation to income inequality in rich countries
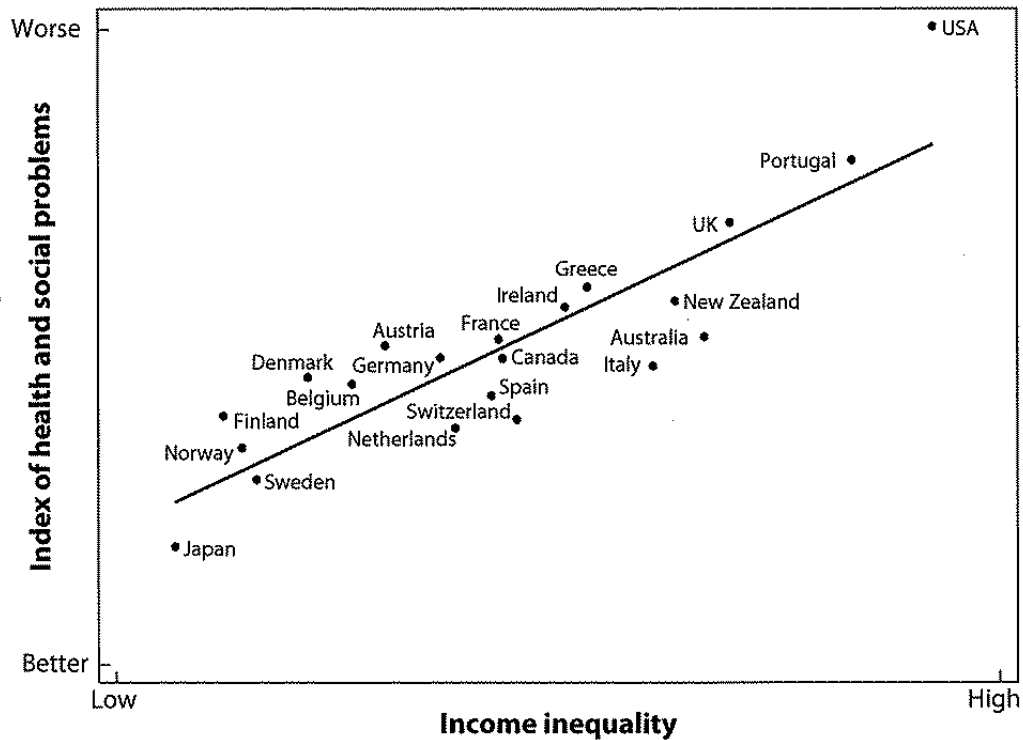
Index of Health and Social Problems in relation to income inequality in rich countries. Income inequality is measured by the ratio of incomes among the richest countries compared with the poorest 20 percentage in each country. Source: Wilkinson and Pickett, 2009.

The first of the three countries in this study to adopt and incorporate the WHO's (1947) innovative definition of health based on a preventative foundation that includes social democracy policy for support was Canada (Crombie et al. 2003; 2005). As a result, Canada has experienced numerous positive outcomes such as having the highest life expectancy. Furthermore, of the three countries in this study Canada has the largest middle class and fewer social problems reflective of income equality by Wilkinson and Pickett (2009).

Canada is followed by the USA from integrating a preventative approach to improving health which also results in increases in life expectancy at birth. In 2006, Zuberi explored social policy and the working poor in Canada and the USA. Zuberi utilises a comparative framework with hotel workers in two demographically matched cities. The outcomes underpin the differences gained in Canada, from the establishment of a safety-net provided for all classes of society guided by the principal of universality (Banerjee et al. 2012:391). The absence of a social policy safety-net in the USA for the working poor leaves this group struggling to break the cycle of poverty (Schwarz, 1996; Zuberi, 2006; Dill et al. 2013). Unfortunately, the magnitude and size of the USA, compounded by the lack of social policies and a safety-net for the poor, leaves the USA inadequately prepared to eliminate inequalities (Schwarz, 1996; Zuberi, 2006). According to McNamara and Williamson (2013) the USA have higher levels of income inequality than most countries and is reflected by fewer financial resources for the working poor.

The considerable size and population differences of Scotland in comparison with the USA provided Scotland with advantages to develop instrumental social democracy policies toward the successful elimination of income inequality. Therefore, I argue that Scotland surpassed the USA in overcoming factors that reflect a sensitivity of health and social problems identified by Wilkinson and Pickett (2009). The significant changes that Scotland has recently experience are consistent with my ranking and Wilkinson and Pickett (2009). These changes for Scotland include a higher life expectancy at birth, the largest population in history (5,254,800), and more births than deaths from 30 June 2010 to 30 June 2011 (National Statistics, 2011).

Historically unique, two of the three countries in this study experienced parallel circumstances. The health and social care policies for Scotland were originally established under the British system. The monumental policy for Britain embodied as the National Health Service Act of 1946 and began functioning in July 1948 (Willcocks et al. 1987; Kayser-Jones, 1990; Pollock et al. 2005). This key health and social care policy evolved to provide a wide range of services (health and medical care), free without regard to age, need or income, funded from general taxation. Britain placed a significant emphasis on developing a broad range of community and social care services in both rural and urban areas. This allows older people to remain in their homes for as long as possible (Kayser-Jones, 1990; Schwarz, 1996). These policies were established before devolution of Scotland from within the UK. The passage of the Scotland Act 1998 which officially convened in July 1999 achieves devolution or the transfer of specific responsibilities and powers to a territorial government from the federal government (Kayser-Jones, 1990; White and Yonwin, 2004). In contrast, Canada transfers specific federal responsibilities or authority to provinces and territories, while Scotland receives distinct responsibilities from within the UK (White and Yonwin, 2004; Health Canada, 2010). Scotland now has the ability to prioritise and establish the health services needed specifically for their country.

In Canada, transferring provincial-like responsibilities to territorial governments from the federal government was a lengthy process. The Canadian government has incrementally transferred authority to the provinces and territories since the 1950s (Government of Canada, 2013). The target date for the last transfer of land claims in the Northwest Territories was set for April 2014. The devolved responsibilities from within Canada to the provinces and territories to date include education, health care, local government and

transportation. This allows decision making abilities and accountability to those most affected by such decisions (Government of Canada, 2013).

Unfortunately for Canada because of its noteworthy land mass, it was difficult to develop targeted policy initiatives (Berta et al. 2006). Devolution served to magnify variations and disparities within health services across the country and created discrepancies in gathering data. These differences revealed inconsistencies in funding to meet the needs of the nursing home residents (Daly and Szebehely, 2012). Devolution also served to identify extremes in population density within geographic regions which emphasise the differences in the availability of services (National Advisory Council on Aging [NACA], 2005a). These regional differences alarm policy analysts and ageing researchers because they transpired before many structural changes in the market place such as the public-private mix, average facility size and operational differences (Berta et al. 2006; NACA, 2005a). Nevertheless, these historical events influenced each country's development of health and social policies considerably with devolution occurring in different ways and under diverse circumstances.

The development of health and social care services

A common characteristic to all three countries was the original aim for the establishment of health and social care services. Although the timeframes differed vastly, the origins were to provide care for the poor and destitute or rejects of society and to keep them hidden away out of sight (Valdeck, 1980; Berdes, 1987; Chappell, 1988; Peace et al.

1997). The poor law systems in each country can be historically traced to providing relief for the poor in infirmary almshouses, work houses, houses of pity, poor farms, accommodations for the destitute, ill, and aged (Willcocks et al. 1987; Chappell, 1988; Kayser-Jones, 1990; Schwarz, 1996). The primary aim of these institutions was not caring for these people, but rather to control, order, and keep them out of sight from the general public. This highlights the establishment of each long-term care system with roots in care for the poor (Schwarz, 1996; Peace et al. 1997; Sawyer, 2011). In Britain the National Health Service Act of 1946 grew to offer health and social care for the poor (Willcocks et al. 1987; Kayser-Jones, 1990). The Medical Care Act of 1966 provided Canadians with universally-insured hospital and medical services in an effort to eradicate pauperization as a consequence of illness (Sawyer, 2011). In the USA, the Social Security Act of 1935 (discussed in the following section) was one of the first social welfare programs with the inclusion of assistance for the poor (Kayser-Jones, 1990; Schwarz, 1996).

The Historical Development of Nursing Homes

> *....long-term care facilities in the United States are embedded in the cultural history of aging and are a physical reflection of the political and social policies toward the elderly in this country (Schwarz, 1996:9).*

The Ministry of Health and LTC Canadian Health Act known as Medicare is the key piece of federal legislation that governs the requirements for participation in federal financial health care (Aminzadeh et al. 2004). After devolution from within Canada the health care responsibility for program development and service delivery was delegated to regional health authorities similar to the structure of local authorities in Scotland. Currently, Canada has 13 interlocking provincial and territorial health insurance plans which have a common feature with little standard coverage from the federal government (Health Canada, 2010). The funding arrangements and the organisation of care across the provinces and territories allowed broader economic factors to influence services in the nursing homes.

Standardisation is currently a major goal for the Canadian Institute for Health Information (CIHI) (Berta et al. 2006; Health Canada, 2010; CIHI, 2011). Nursing home care is not a publically insured service under the Canadian Health Act leaving services unavailable in areas (Bourgeault et al. 2009; Health Canada, 2010). In fact, nursing home care is missing from the Canadian Health Act, the primary legislation the health care system is based upon (Armstrong et al. 2009:12). Health care services provided in nursing homes are paid for by the provincial and territorial governments, while the room and board costs are paid for by the individual. Frequently payments for room and board are subsidized by the provincial and territorial governments and additional extended health services are funded in part by the Canada Health and Social Transfer Act (Bourgeault et al. 2009).

In Canada the construction of nursing homes has deliberately not kept pace with demographic trends of their older population. Old building conversions are historically what nursing homes became (Bourgeault et al. 2009). The plan was designed to support growth and greater use of community-based care and intentionally excluded social care from nursing home schemes. The full continuum of support services include home care, adult day care, respite care, day hospitals, acute care, physicians care and other health professionals. Other broad social services involve pensions, affordable housing, senior centres, older adult centres, senior educational programs, and age-integrated social programs (Health Canada, 2010). Social care is funded differently leaving it as not included in the care covered by nursing homes (Armstrong et al. 2009; Bourgeault et al. 2009; Health Canada, 2010).

In contrast to Canada, devolution of Scotland within the UK allowed Scotland to review service availability, service delivery, and the growing number of people with dementia (Bland, 1999; Bell et al. 2006). The National Health Scotland (NHS) and Community Care Act in 1990 divided the role of local authorities and health authorities by changing the internal structure allowing local authorities to assess the needs of the local population and purchase services from service providers when necessary (White and Yonwin, 2004). The internal changes from devolution resulted in significant variations and growth in community care that occurred rapidly. In comparison with the other two countries, the size of Scotland has proven to be beneficial. Therefore, it was realistic to focus on outcomes, identify gaps to inform the development of new policy and practise of social care services for older people (MacDonald, 2004). This led to better dissemination of successful

programs and initiatives, creative service delivery that included social and health care, housing, benefits and pensions with policy development based on user satisfaction, need, and culminating with free personal nursing and care. The goal was to establish more flexible support services to shift the balance so more people can be cared for at home (Bell et al. 2006).

The establishment of the Dementia Services Development Centre (DSDC) in 1989 at the University of Stirling was a catalyst for much of the continued success and progress. DSDC offers a variety of educational and training opportunities, a library including information and publications, various consultancy and audits for service providers and other governments. It was through active collaboration between researchers and practitioners who realised the importance of including service users in the original Care Home Standards of 2001 (revised in 2007 and 2011). The Care Standards were written from the service user's perspective based on rights, i.e. I have the right to an accurate diagnosis (The Scottish Government, 2011a). This unique approach allowed addressing, cultural differences, minority and ethnic groups, care services in rural areas, and how the person with dementia perceives care. Scotland made dementia a priority in 2007 and the first National Dementia Strategy was published in 2010 with the primary focus on improving all aspects of quality for dementia services (The Scottish Government, 2011a; 2011b). The *Standards of Care for Dementia in Scotland* were published in 2011 along with *Promoting Excellence: A framework for health and social services staff working with people with dementia, families and carers* aimed to implement a wide range of initiatives. These include, updating professional qualifications, enhance existing workforce

competency, and develop leadership champions within the dementia workforce (The Scottish Government, 2011a; 2011b). With the support of DSDC and the University of Stirling, current research agendas will now seek a leading role in creating an environment to offer the high quality services in dementia care with the goal of incorporating Stirling into a dementia friendly city (Voices Of Experience, 2014).

In the USA, the Social Security Act of 1935 was one of the first social welfare programs (Kayser-Jones, 1990; Schwarz, 1996). The Social Security Act of 1935 mandated funding for the inclusion of 'Old Age Assistance' for poor older people (Kayser-Jones, 1990). For the first time, indigent people aged 65 and older were provided with a guaranteed monthly income for to pay for part of their living accommodations (Vladeck, 1980; Kayser-Jones, 1990; Schwarz, 1996). This historical Act represents monumental change by maintaining that the only way to care for poor people was through institutionalisation and thus provided impetus for the development of the nursing homes (Schwarz, 1996). Thirty years later, Congress enacted the Social Security Act Amendment of 1965 in the USA creating Medicare and Medicaid. The federal government therefore assumed a major role in the financing of health care for all older people and the poor. The establishment of a funding source for older people Medicare, and Medicaid for the poor created a surge in the utilisation of nursing homes (Schwarz, 1996).

The expansion of nursing homes in the USA was fairly systematic and results from three key developments that in a historical context are comparatively recent events. These comprise the increase in life span, the increase in urbanisation of society leading to

structural changes in the American family, and the passage of the Social Security Act of 1935 and later Medicare with the Social Security Amendment of 1965 (Schwarz, 1986:22; Vladeck, 1980). The funding for the establishment of the USA nursing home can be easily traced back to funding for hospital construction. The federal funding and hospital legislation to support hospital construction known as the Hill Burton Act of 1954 was expanded to include the construction of nursing homes (Vladeck, 1980; Schwarz, 1986:22; Kayser-Jones, 1990). This process embedded the medical model of care into nursing homes that was consistent with hospital language, operation and legislation. The process and the funding created nursing homes that physically resemble and operate like mini-hospitals (Schwarz, 1996).

This historical overview provides a summary of key legislative policies, acts and initiatives enacted across the countries starting with the WHO (1947) new description of health. The policies have highlighted whether the nursing homes in these countries developed intentionally, advanced with strategic plans, or simply evolved. The subsequent section outlines demographic trends for the baby boom populations in each country comparing and contrasting the impact of the increase in the number of people in society. I will delineate key information to support my argument that the nursing homes are comparable in these three countries regardless of the overall differences in overall the populations, size of landmass, and the type of government.

Demographic Trends

The economic necessity for care workers is expected to grow as demographic characteristics change and the population ages globally (Suzman and Beard, 2011). Shifts in the leading causes of death have significantly improved life expectancy and the expansion of an ageing population (Suzman and Beard, 2011). The global changes in demographics will have a radical economic impact (Daly and Szebehely, 2012). These demographics changes have necessitated substantial concerns regarding the availability of a well-trained and stable health care workforce (Dill et al. 2013). Across the countries in this study the older population is expected to increase rapidly over the next decade escalating the need for workers throughout the long-term care continuum. Therefore, the retention of a sufficient number of well-trained, qualified care workers for economic and quality of care reasons will be of greater significance in the future (Suzman and Beard, 2011).

The current demographic trends have led to wide-spread concern about the ability to provide health care services for the baby boom populations, especially in North America (Canada and the USA). The senior populations in North America are the major consumers of health services. As their numbers increase over the next two decades researchers predict a 'bulge' in the population profile as the baby boomers move through (Berta et al. 2006:7; AARP, 2008). In North America, the expansions are envisaged to represent a compressed bulge and occur over a shorter period of time as opposed to Europe (Berta et al. 2006). In the UK the baby boom population has been called a 'demographic time bomb' (Pollock et

al. 2005:167). However in Scotland specifically, an 'Echo Effect' is predicted in the population as the baby boomers have children (National Statistics, 2011). This phenomenon will generate an immense surge in the need for health and social care services within a short time frame. The baby boom populations across these countries are significantly larger than any prior cluster of people requiring LTC services in history. Furthermore, these groups are expected to be more cost conscious and demanding (Thompson and Foth, 2003; Scottish Executive, 2007; Fowler, 2008). The unique circumstances create an urgent need to secure a well-trained, caring and dependable professional workforce who can provide care services for this growing ageing population.

Country populations and those over aged 65

The entire population of each country in this research is presented on Table 3, along with the overall population of those aged 65 and over and the percentages that each group represent. While the total populations by country vary extremely, once the category of those aged 65 and over is identified the percentages representing the groups are extremely homogeneous. The remarkable similarity of the percentages of those aged 65 and over highlight the comparability of that populous once extricated from the total populations in each country.

Table 3: Country Populations and those over Aged 65

	Canada	Scotland	United States
Total population	33 million people	5 million people	309 million people
Population over aged 65	5 million approximately 14%	620,000 approximately 12.5%	40 million approximately 13%

Sources:

Statistics Canada: www.stat.can.gc.ca catalogue, no. 98-310-X2011001 (2011)
National Records of Scotland: www.scotland.org/facts/population (2011)
U.S. Census: www.census.gov/prod/cen2010/doc/sf1.pdf (2011)

Currently, Canadian senior adults as a group are healthier and living longer than any other nation in my study. In 2011, the largest group of people in Canada's history turned aged 65 years and moved into a new category identified as accelerated aging. This group aged 65 and over is expected to almost double to represent approximately 25 percentage of the total population by 2036 (Statistics Canada, 2010). Similarly, Scotland's population aged 65 and over is at an all-time high according to the 2011 Census. For the first time in history, the number of people aged 65 and over exceeds the number of those aged 15 and under (National Statistics, 2011). Furthermore, the overall the population aged 65 and over is growing expeditiously and is projected to almost double by 2033 (General Register Office for Scotland [GROS], 2011). In the USA the older population aged 65 and over is

predicted to experience a rapid growth from 40 million in 2010 to 86 million in 2050. In addition, the USA population composition will become more racially and ethnically diverse as the overall aggregate minority population is predicted to become the majority by 2042 (U.S. Census, 2012).

Globally, it is estimated that worldwide, the number of people older than aged 80, the group most likely to need LTC, will increase by 233 percent between 2008 and 2040 (Applebaum et al. 2013). Suzman and Beard (2011:2) argue "*Since the beginning of recorded history, young children have outnumbered their elders*". It is further projected that in approximately five years those aged 65 and older will outnumber children aged 5 years and younger (Suzman and Beard, 2011). As the global population aged 65 and older increases, the need for nursing home services and a stable workforce will drastically increase.

Life expectancies

Life expectancies for this research are identified as the numbers of years at birth that people are expected to live. These numbers are based on averages determined by explicit characteristics of populations within different regions or nations. The average ages are calculated in relationship to features i.e. gender, location, economic opportunities disparities, inequities, health and personal life styles (Zuberi, 2006). Given the worldwide increases in life expectancy and the sheer numeric growth of older populations, the demographic momentum will substantially raise the demand for all long-term care services

(Suzman and Beard, 2011:23). Nevertheless, the projected population expansion of older

people, specifically the countries in this study will necessitate an increase in care workers.

Table 4: Life Expectancies

Males	Females	
79	83	**Canada**
75	80	**Scotland**
76	81	**United States**

Sources:

Statistics Canada: Life expectancy, at birth and at age 65, by sex, Canada,
provinces and territories, annual CANSIM (2012)
National Records of Scotland: www.scotland.org/facts/population (2011)
U.S. Census Bureau, Statistical Abstract of the United States (2012)

The continuum of long-term care of services

The LTC continuum of services literature across these countries highlight various

provisions of care services that are consistent with the type of assistance delivered in each

category. Table 5 provides a summary of the distinct levels of services offered, and are

identified within the four rows commencing with the least amount of support in residential

housing and concludes with the highest level of care in hospital wards. In all three

countries there are a large range of housing options that provide basic custodial care, often

with congregate meals, light housekeeping, and some group activities but no nursing

services. The designations given for this specific level of support across the countries

range from senior citizens lodges, group homes, sheltered housing, and congregate housing. The next row pinpoints services that include supervision, congregate meals and personal care if needed.

The third row in Table 5 isolates the specific services that are the focus of this research. The distinction in this category from the previous one is the need for nursing care, supervision, and the provision of activities of daily living 24 hours a day, seven days a week (24/7). The assortment of classifications includes intensive personal care and residential care with nursing, care homes, intermediate care facilities and nursing homes. Across the countries the term *nursing home* is used interchangeably throughout the literature and is determined by the level of service provided to an unrelated group of people and the designated level of care services in this thesis. The final specialised services on the last row on Table 5 are equivalent to care received in hospital.

Table 5: The Continuum of Long-term Care Services by Country

Canada	Scotland	United States
Room and board (with custodial care) Senior citizens lodges Group homes	Medium-Dependency Housing Sheltered Housing	Housing Urban Development (HUD) Housing Congregate Housing
Type I: Residential Care Limited and/or Personal Care Hostel Care (Alberta: Nursing Home Care)	Adult Residential Homes Very Sheltered Housing	Independent Living Assisted Living: 1) General 2) ADL Management 3) Cognitive
Type II: Nursing Homes Intermediate Care: Levels I & II Intensive personal/ Nursing care Personal care/ Extended care Intensive personal care (with nursing supervision)	Care Homes Residential Homes Nursing Homes	Nursing Homes: ICF & SNF Intermediate Care Facilities: ICF 1) General 2) Rehabilitative 3) Cognitive Skilled Nursing Facility: SNF
Type III: Intermediate care – Level III Extended care – Level III & IV Chronic care Extended hospital care Auxiliary hospitals	Continuing Care Wards Long-stay Geriatric Wards Long-stay hospital	Hospital: Skilled Nursing Facility: SNF Long Term Acute Care: LTAC

Sources:

Canada: Berta et al. (2006); Statistics Canada (2011)
Scotland: Bland (1999); Joy and Fong (2000)
United States**:** Schwarz (1996); Joy and Fong (2000)

As a service, the arrival of the nursing home within the LTC continuum[5] varied by country. However the services provided within nursing homes and the additional services identified on Table 5 are very similar across the three countries (Kayser-Jones, 1990; Government of Canada, 2006; The Scottish Government, 2007a). Historically LTC policies progressed in divergent manners, influencing multiple aspects of nursing homes ranging from regulation to funding across the different countries.

The following, Table 6, depicts the actual number and then percentages of the population over aged 65 that live in a nursing home in each country and further divides the aged into groups consistent with the census categories. This population requires nursing care, supervision, and the provision of ADL care 24 hours a day, seven days a week. Across the three countries, the residents represent the most dependent vulnerable, frail, oldest people in each society with dementia who can no longer care for themselves or live independently (He et al. 2005; Caron et al. 2006; Innes, 2009). Furthermore, the majority of the residents are primarily over aged 85, more functionally dependent, requiring extensive support and additional care, characteristic of people with dementia. This profile is consistent with the typical nursing home resident in each country with more than half of the residents having a diagnosis of dementia (NACA, 2006; Samus et al. 2005; Nolan et al. 2008; CIHI, 2011).

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[5] The long-term care continuum refers to the wide range or spectrum of services available and varies from minimal housing support to high levels of care in hospital.

Table 6: Country Populations Aged 65 and Over Living in Nursing Homes

	Canada	Scotland	United States
Population Aged 65+ Living in a Nursing Home and percentage	200,000 approximately 4%	39,150 available* 33,941 (long stay) approximately 4.5%	1.5 million approximately 4.5%
Aged 65-74	9%	10%	17%
Aged 75-84	28%	34%	32%
Aged 85+	43%	51%	37%
Total percentage of population	80%	95%	86%
Unexplained missing population	20%	5%	14%

Sources:

Canada: Statistics Canada (2009/2010) Catalogue no. 83-237-X (2011)
Scotland: Information Services Division (ISD): Care Home Census (2010)
United States: U.S. Census Bureau 65+ in the U.S. Nursing Home Population (2010)

Table 6 discussion

Table 6 provides the number and percentages of the population over aged 65 that live in a nursing home in each country. The percentages represent the entire (100%) of the population in each country that are over aged 65 and living in nursing homes. The total populations are further divided by age groups representing the categories of those aged 65 to 74; aged 75 to 84; and those aged 85 and over. The percentage from each age segment totalled depicts the populations living in nursing homes. The difference from the total percentage (100%) of the population over aged 65 living in nursing homes and the missing resident populations are explained by different rationale for each country discussed below.

Canada includes people of all ages living in residential care facilities labelled as homes for the aged. The institutional census groupings begin at aged 10 and over including persons up to aged 64 and over. This represents approximately 5 percentage of the total resident population (Statistics Canada, 2011). The remaining percentage of the population that do not live in nursing homes but do reside in some institution includes those for persons with mental disorders and an "other" category (Statistics Canada, 2011).

Scotland is the only country to specifically distinguish the population group aged 65 and over living in nursing homes exclusively for older people. This feature in nursing home census explains the highest percentage of the total nursing home population compared with Canada and the USA. In Scotland the 5 percentage difference from the total population living in institutions includes nursing homes for physically disabled people, adults with mental health problems, and adults with learning disabilities (ISD, 2010).

In the USA, a trend began in the early 1990s to de-institutionalise individuals with developmental disabilities. The de-institutionalisation movement was the result of a series of class action law suits over the appalling conditions and poor treatment of the developmentally disabled population (Davis et al. 2000). The older population within this category that are unable to live in group homes within the community reside in nursing homes and a few public institutions. This provides rational for part of the higher percentages of residents in the group aged 65 to 74 years old in the USA compared with Canada and Scotland. The remaining portion of people unexplained in the total population (100%) of those aged 65 and over living in institutions are predominantly an aging prison population. According to Wilson and Barboza (2010) an increasing number of prisoners are being incarcerated for life. The rise in the older inmate populations are expected to increase and reflect the general aging of an American society (Abner, 2006).

Discussion of Tables 3, 4, 5, and 6

The total population for each nation in this research is presented in the first row of Table 3. The second row contains the raw numbers in addition to the percentages of those aged 65 and older. Overall the ratios of those aged 65 plus are substantially proportional. Life expectancies by country are then exhibited as Table 4 to demonstrate the variations between the total life expectancies of each populace at birth between males and females.

The information in Table 5 describes the continuum of long-term residential care services for each country. The various provisions offered across the countries are consistent and identify levels of services or assistance delivered in each category. This highlights the

notion of a broad range of necessary services for the ageing populations in each country. The different levels of service needed are outlined across the rows in the Table 5 commencing with the least amount of support in residential housing to the maximum level of care delivered in hospital. The titles and terms vary considerably, however the services provided within the distinct categories consistently reflect similarities. The information in Table 5 provides considerable evidence of analogous services for the aging populations recognising a continuum of care and the comparability of services across the countries.

The total population (100%) living in nursing homes over aged 65 and the percentages of those people are summarised in Table 6. The resident populations are based on those aged 65 and over and specifically focus on people living in nursing homes to point out the resemblances of this group across the three countries. The residents aged 65 and over are further divided into groups representing the following resident proportions: aged 65 to 74; aged 75 to 84; and aged 85 and over. More than half of each country's resident populations in nursing homes are located within the category of those aged 85 and older. Row five in Table 6 presents the totalled percentages of the resident populations living in nursing homes in each country. The resident percentages that are identified as living in nursing homes are then compared to the total percentage (100%) of those aged 65 and over that are reported as living in nursing homes. There are considerable discrepancies between each total by country pinpointed on row six. These population percentages vary depending on the different accommodations and services such as homes for physically disabled people, adults with mental health problems, people with mental disorders, adults with learning disabilities, and those living in prisons. The small percentage differences in each country

are provided by other support services and institutions discussed throughout. The resident populations aged 65 and over and percentages by age groups living in nursing homes in each country are outlined on Table 6 and reveal comparable demographic information.

In the next section I focus on one specific research question and explore the training for care workers in each country. I then conclude with Table 7, which includes the hours or units of training required, the training location, whether previous education or experience is necessary, is there a certificate, registry, or permit to practice, and if so, what are the requirements, and last, is a background check required. The additional information outlines pay, benefits and other characteristics central to care workers. For this section the following acronyms are used: Canada PSW; Scotland CA; and the USA CNA.

Care Worker Training Requirements by Country

Canada (PSW)

In Canada, until recently each jurisdiction (provinces and territories) was responsible for the training curriculum for the PSWs. The lack of standardised training has resulted in disjointed and conflicting information on PSWs, programs, titles, and fundamental principles (HPRAC, 2006). In addition the PSW skills have not kept pace with the resident's changing needs (Armstrong et al. 2009). Unfortunately for Canada, these inconsistencies in training and the absence of standard regulations for nursing homes or their workers leave critical components of the industry operating with few quality assurance procedures in place (Health Canada, 2012). This underscores many of the obstacles within nursing homes for PSWs struggling to meet the escalating cognitive and physical care needs of the residents.

Canada witnessed dramatic changes in their LTC system with the implementation of legislation entitled the Long-Term Care Homes Act, 2006 (the 'ACT') (MHLTC), 2006; Ontario Ministry of Health and Long-Term Care [OMHLTC], 2006). The HPRAC (2006) developed a working report gathered from information on the implementation of regulatory procedures from other countries. Particularly, the consultants reviewed how regulatory issues are approached for care workers in Australia, the UK and USA to formulate the 'ACT'. The report provides a foundation for the development of national educational standards by offering a snapshot of the training curriculums for care workers in other nations (HPRAC, 2006; MHLTC, 2006).

Over a hundred years ago, Canada developed an extensive network of Career Colleges to provide skills for its citizens to obtain gainful employment. The National Association of Career Colleges (NACC) was established in 1896 and acts as an umbrella organisation for the affiliated provincial Career Development Institute (CDI) Colleges. The NACC was the first to develop a Personal Support Worker (PSW) training program and offered the curriculum package to its member colleges across Canada (Health Canada, 2012).

The Association of Canadian Community Colleges (ACCC) was formed in collaboration with other jurisdiction organisations (i.e. NACC) to develop standard national educational curriculums for care workers (Health Canada, 2012). Health Canada released the Pan-Canadian educational standards as a benchmark for training care workers from funding obtained in 2009 (Health Canada, 2012). The new curricula were developed to follow the ministry standards and the Canadian government advocates voluntary integration of the national standards into the existing educational programs throughout the jurisdictions (Health Canada, 2012). Currently, across Canada, the provinces and territorial educational systems are at different stages of incorporating these new standards.

Several initiatives were targeted for implementation with standardisation across Canada as a primary goal. In 2012 the Canadian Institute for Health Information (CIHI) initiated a three-year plan to standardise information reported to the Canadian health system to measure and compare outcomes across jurisdictions. This initiative builds on more than 10 years of work to develop Pan-Canadian health indicators aligned with international standards for national comparisons (CIHI, 2011).

The development of national education standards were augmented and aligned with additional nation's health and human resource initiatives currently underway. The federal government has a vested interest in supporting a sustainable standardised national model designed to meet the health care needs of Canadians (Health Canada, 2012). The targeted objectives for the PSW training initiative were to develop core standards that can be easily integrated into the various PSW programs (i.e. the choice of English or French offered in Quebec). The standards were designed to enhance existing jurisdiction frameworks with the potential to incorporate the diverse needs into the curricula of each region or community.

The traditional training contents for PWS are conducted over a minimum of 28 weeks with a maximum of two years to complete. The program averages are approximately 755 hours in length. The class room hours combine theory and lab accounting for 453 hours and the clinical practicum consists of an additional 302 hours. The aims of the programs are to provide students with opportunities to acquire knowledge and an appropriate skill set for their chosen career. Incorporated into the training includes the clinical practicum in a nursing home setting where the students learn to apply their new knowledge and skill set under the supervision of a health care professional (Health Canada, 2012). There are several locations to obtain these qualifications that take about eight months or two academic terms (Kontos et al. 2010). The potential PSWs rank their clinical practicum sites (nursing homes) for future employment upon completion and the nursing homes rank the PSWs as well. Canada is the only country in this study to offer a double matching

opportunity for PSWs as part of the training and placement process which is culturally specific to Canada. This matching process is also recommended by the WHO to prevent staff burnout according to Bennett et al. (1997).

The majority of nursing homes in Canada belong to home unions. The Canadian unionised workforce has steadily increased after 1970 (Zuberi, 2006). Unions provide collective bargaining, representation, better wages, and added benefits which offer more power to negotiate queries that includes media coverage when needed (National Union of Public and General Employees [NUPGE], 2007). On average the PSWs earn $17.32 to $21.48 CAD per hour and are entitled to union benefits according to seniority in addition to government benefits (Health Canada, 2012). Turnover of PSWs is not a typical dilemma in the nursing home industry in Canada. On the other hand, as discussed in the previous chapter working without sufficient PSWs or extremely low staffing ratios is a common widespread struggle (Casper and O'Rourke, 2008; Kontos et al. 2010).

Approximately 90 percentage of the PSWs are female and those employed before the legislative changes from the ACT (MHLTC, 2006) are exempt from police background checks which are now mandatory (HPRAC, 2006). These valuable workers provide assistance and supportive care services to residents with defined health needs. The training prepares graduates to work under the supervision of a nurse or health professional in accordance with the resident's individual plan of care. The typical residents have complex medical needs and more than half have cognitive disabilities (CIHI, 2011). The PSWs are

trained to provide physical and emotional care, assist residents to maintain independence for as long as possible, and end-of-life or palliative care but frequently lack the time to use these skills (HPRAC, 2006; Health Canada, 2012). Upon completing a training program the PSWs qualify for a certificate of education (Church and Diamond, 2004). Nevertheless, there are no professional certification agencies or formal regulatory authorities to verify the individuals are competent to carry out a specific skill set (OMHLTC, 2006). The absence of such authorities or a national scope of practice impedes the transferability of skill competency for PSWs within the country (HPRAC, 2006; Health Canada, 2012).

PSW graduates can continue education in related health care fields through a process referred to as career laddering. The PSWs who choose to pursue additional career training at a higher level commonly pursue RPN (registered practical nurse) position (Health Canada, 2012). Many students benefit from life-long learning opportunities and occupational growth. The decision to move vertically through education within health care sectors helps to prevent the loss of PSWs to other disciplines (Health Canada, 2012).

Scotland (CA)

The history of nursing in the UK highlights the substantial contribution of untrained workers by acknowledging and accepting these workers within their profession. Even though excellence is consistently demanded in the preparation of its own members, the nursing profession is peripherally involved in the training and development of care workers who support their work world (Edwards, 1997). Further, Innes et al. (2006) identified one of the most significant barriers to positive images of care workers as the lack of knowledge and understanding the tasks they are required to perform. The work responsibilities of care workers often exceed the original scope of the job in ways that are not always beneficial to the residents (Innes et al. 2006). The current residents are more likely to have dementia, multiple morbidities with higher acuity levels, all resulting in more complex care needs (Brooker et al. 2011).

In the late 1980's Scotland started a fresh approach to health care education and developed a range of health-related qualifications under the competency-based Scottish Vocational Qualification (SVQ) system (Scottish Qualification Authority, 2005). In the rest of the UK the comparable qualifications for care workers in Scotland are referred to as National Vocational Qualifications (NVQs) (ILC-UK, 2012). More flexibility exists in the attainment of Scottish qualifications because SVQs are competency-based qualifications (achieved through assessment and training) and there are no standardised hours they must be achieved within. The theoretical component to support a competency area can be learned in a classroom setting or on-site in a nursing home. Comparable to PSWs

certificates of education, SVQs are not a permit to practice but instead cover a range of tasks in which proficiencies have been successfully demonstrated. Scotland uses care assistant (CA) as the generic term for these workers. SVQ training takes place in many forms and the contents are continually updated. The SVQs in health and social care available were developed along with the Scottish Social Services Council (SSSC) (Scottish Qualification Authority [SQA], 2007). The SSSC represents a variety of stakeholders that are employed in a wide range of job roles and occupations that fall within the health and social care sectors (SSSC, 2009).

Canada and Scotland both offer programs entitled "Recognition of Prior Learning" (RPL) designed to support individuals, identify and link prior learning experiences to meet current learning skills. Support for employees who lack particular skills are often reluctant to engage in learning. Stakeholders identified the need for a career structure or career ladder that was not previously identified (SSSC, 2010). Considerable turnover still exists among the CA position which creates loss in many ways. For example, the residents experience the loss of continuity of care workers familiar with their preferences and relational aspects. For the nursing home, the financial costs impact on recruitment, selection of new staff, induction, and initial training. Many care providers expressed concerns that they have to hire unqualified staff to meet the regulations (Scottish Executive, 2006).

The SSSC developed a sector skills agreement with its employers and partners to identify gaps in order to provide a competent workforce (SSSC, 2009). The sector skills assessment

was built upon the original agreement that highlights the skills needed for CAs. One of the original goals of the SSSC was a registration framework as a major push for higher standards in social services. A registry was proposed to begin in 2009 for the social service workforce but the registration was delayed until 2014 (SSSC, 2009). CAs are required to complete four core units and two additional units to be on the registry as a SVQ 2 designation. The SVQs are structured as levels from one to five for different levels of employment titles (SSSC, 2009). Overall CAs remain an unregulated, sizable group of employees (McKenna et al. 2004). According to Bell et al. (2006) the CAs jobs sector grew more quickly from 2000-2004 than any other occupation in Scotland. It is estimated that a predominant female CA group, work on average, about 30 hours a week (Bell et al. 2006; Official Statistics Publications, 2012). The workforce is characterised by two aged group peaks, one representing workers in their late 20's and the other in their late 40's, yet both are represented by a predominantly female workforce (Official Statistics Publications, 2012).

The SSSC was changed to reflect the Official Statistics Publications from the Scottish social services sector: Report on 2011 Workforce Data (Official Statistics Publications, 2012). The new workforce data overview distinguishes the differences in the sub-sectors and employment types within the social service workforce published in October 2012 (Official Statistics Publications, 2012). These services range from those provided for adults to care at home and housing support, to day care services for children, residential child care, school care accommodation services and local authority social work non-registered services (SSSC, 2010). The report summarised the social service workforce as: growing

faster than any other workforce as a whole and maintains a low percentage of skill shortages in comparison to the overall workforce (SSSC, 2010). Other relevant skills that are identified for the workforce include: requiring a registration, essential interpersonal training, proficient literacy, team working skills, contract and partnering for skills, promotion of autonomy for the staff updates in technology, new tactics for future workforce recruitment, skills to support people with dementia, how to develop rural populations, and last, funding for targeted training for the social services sector (SSSC, 2010). The private sector for care homes is the largest employers of the social service workforce followed by the voluntary sectors (Official Statistics Publications, 2012). The key message from the report is the importance of a qualified workforce with skills, experience and qualifications. Furthermore, this report highlights a decrease in public and voluntary sectors and a substantial increase in the private sectors reflecting the highest area in numbers for CAs (Official Statistics Publications, 2012).

The USA (CNA)

The 1987 Omnibus Budget Reconciliation Act was mandated and referred to as OBRA 87 in the USA. The federal government requires State-approved certified nurse's aides (CNA) training programs to provide a minimum of 75 hours of training which includes 16 hours of supervised clinical training. CNAs must pass a proficiency exam to become certified and complete at least 12 hours of continuing education annually to maintain their certification (Office of Inspector General [OIG], 2002; American Association of Retired Persons [AARP], 2006; Stone and Harahan, 2010). The USA is the only country in this

study to provide a license to practice with a registry for care workers. The federal government mandated training requirements through the Nurse Aide Training and Competency Evaluation Program (NATCEP) to establish minimum standards for competency. The Centre for Medicare and Medicaid Services (CMS) is also responsible for setting regulatory standards for the State CNA training programs and provides funding for programs sponsored or located within nursing homes (OIG, 2002). Nursing homes participating in Medicare and Medicaid programs cannot employ CNAs for more than four months or until they have completed a State-approved training program and passed a competency exam (OIG, 2002).

The OIG report (2002) explains that the CNA training curriculum has not kept pace with the changes resident care needs and the nursing home industry. The report cited insufficient hours in the curriculum and particularly dementia specific training, inadequate clinical exposure, outdated teaching methods, and in-service training that often does not meet the Federal requirements (OIG, 2002). In-service training is a mandatory monthly, one-hour educational session provided by the nursing home to allow the CNAs to keep their certification current. There are annual required themes on subjects such as safety, infection control, falls, nutrition, dementia and the other topics determined by the manager. More recently Castle et al. (2007) suggests that significant retention efforts could be made through training improvements which include increasing the required training, changing the content and/or the method of training. Furthermore Castle and Engberg (2006) acknowledge that CNAs need more support and advocacy, possibly benefits garnered by a union (Castle et al. 2007).

In the USA, older people are being discharged from hospital 'quicker and sicker' (terminology commonly used in the USA) to nursing homes as a consequence of Medicare funding cuts (Gubrium, 1997; Eaton, 2005; Gleckman, 2009). This has resulted in increased acuity levels for the residents over the past decade (Eaton, 2005). The diagnostic related codes dictate how many days a person is allowed to stay in hospital and receive funding from various sources (i.e. Medicare, Medicaid, and private insurance) according to their diagnosis. Consistent with Innes et al. (2006) and the CAs in Scotland, this situation regrettably leaves the care workers ill-prepared to manage high levels of health care responsibilities with the additional care needs. The lack of training to provide complex levels of care, combined with inadequate staffing to deliver sufficient attention to these fragile residents contributes to CNA turnover disrupting the continuity of care for this frail resident population (Castle et al. 2007; Eaton, 2005).

According to Montgomery et al. (2005) it is no surprise that the LTC industry in the USA has difficulties recruiting and retaining CNAs given their stressful work conditions, lack of benefits, and the offering of little or no financial incentives. Bishop et al. (2009:616) report that CNAs with family responsibilities especially those with children may experience more stress on the job. CNAs make up a particularly vulnerable portion of the low-wage health care worker in the USA (Zuberi, 2006). These CNAs are predominantly single mothers who earn the primary source of income. Not only are their wages low but there are few opportunities for advancement (Dill et al. 2013). Likewise, Stone (2001:50) and Vladeck (1980) assert the chore of finding certified or qualified care workers has become so difficult that recruiting 'warm bodies' even if they are unskilled workers is an unfortunate goal just to meet the regulatory standards.

During the same time I was conducting my fieldwork, one of the largest nursing home initiatives in history of the USA was written. Better Jobs Better Care (BJBC) was a four year $15.5 million dollar demonstration program aimed at improving the workforce quality and reducing the high turnover and vacancy rates of direct care workers. The research conducted between 2002 and 2006, is reported in July 2008 of *The Gerontologist*. A special issue (Vol. 48) is devoted entirely to the BJBC initiatives. After a thorough evaluation, the outcomes are not as significant as anticipated. Cost is identified as a primary barrier underscoring the need for policy and funding changes to improve the standards of care for the residents and work conditions for the CNAs in nursing homes (Morgan and Konrad, 2008). A recent explanation is offered as to why the current research

findings are not implemented into practice by Rahman et al. (2012). They conclude that more research is needed:

> *.... these improvements alone are unlikely to wholly transform nursing home practice, a goal that ultimately may entail fundamental changes in how nursing homes are staffed, financed, and regulated (Rahman et al. 2012:597).*

This conclusion is from research and practice in the USA, yet in sharp contrast, size may allow Scotland an advantage in identifying and implementing innovative changes to improve care based on policy's directed from research and practice.

Table 7 below summarises care worker requirements for each country and includes the number of hours of training or units based on competency required, the options for training location (i.e. classroom, community, vocational, technical, career college, school boards) or nursing homes, previous education and experience required, certification, registry or permit, and concludes with background checks for criminal convictions. Scotland and the USA comprise two options for training, the classroom or nursing home. Canada incorporates a third option through Education Boards for Adult Education of older adults seeking job qualifications in addition to a high school diploma.

Table 7: Care Worker Training Requirements

	Canada	Scotland	United States
Hours/units Required	775 hours = 14 modules Competency based on Completion of courses 8-10 months full-time**	6 Units = SVQ 2 **Competency** based on proficiency evaluation **not hours**	75 hours Pass a written and Proficiency exam Within 4 months
Training locations: Nursing home **or** Vocational College	**Both**: plus Boards of Education for adults seeking job skills and a high school diploma	**Both**	**Both**
Previous education required	**Yes**: traditional paths **No**: Boards of education	**No**	**High School** diploma or equivalent with few exceptions
Previous experience required	**None**	**None**	**None**
Certification/ Registry/permit To practice	**No**	Voluntary: 2009 Mandatory: 2014	**Yes**
Background check	**Yes**: only on new employees as of 2006	**Yes**	**Yes**

** The hours vary slightly throughout the provinces and territories in Canada.

Sources:
Canada: HPRAC (2006); MHLTC (2006); Health Canada (2012)
Scotland: SQA (2007); SSSC (2010); Official Statistics Publications (2012)
United States: OIG (2002); AARP (2006); ILC-SCSHE USA (2006)

Chapter 4 summary

This chapter pulls together various issues that underscore the timeliness and significance for this comparative research. This begins with the WHOs (1947) reframed definition of health to encompass a preventative perspective with the goal of the eliminating all inequalities. The order that each country embraced the WHO (1947) definition of health is correlated with Wilkinson and Pickett (2009) index of health and social problems in relation to income inequality in rich countries. Key historical developments of nursing homes are identified that influenced factors of each country's health and social care policies. The demographic information from the three countries is then organised in a comparative format summarising relevant information. The services that currently exist in the LTC continuum are defined to underpin the similarity of services across the nations placing the focus on nursing homes. The population percentages utilising nursing homes are accentuated to demonstrate a comparable service highlighting again the necessity for care workers. The care services that are provided in nursing homes by care workers across the three nations are substantiated although differences emphasise the extremes in requirements to become a care worker in each country. The work performed by care workers is essentially the same ADL provisions provided for a very similar resident population across each country.

A historical overview of care workers is presented to contextualise the remainder of the chapter. A summary provides training requirements and related information on dementia care workers for each country. There are unique approaches to the number of hours for

training, units or competency based requirements. No standardised regulations are applicable for all of the workers and no previous experience is required. The significant common feature across the countries is the requirement for a background check before anyone is hired. Several options for training are available from the classroom - to on the job training and vary in location. The USA is the only country to have a mandatory registry however Scotland has developed a voluntary registry for the social service workforce (SSSC, 2009). The USA requires low levels of training but once the requirements are met a certificate to practice is provided.

Chapter 5: Research Design

In this chapter, first I discuss my theoretical stance and then my methodological approaches and explain how these allowed me to gain a better understanding of the work experiences of dementia care workers. Employing cross-national comparisons at the macro level on secondary data helped to identified features to explore with ethnographic methods for comparisons at the micro level to move the knowledge of care worker's experiences forward. The comparative approach underscores insights of the workers experiences within the explanatory context of symbolic interaction. The framework guided interpretations which facilitated understanding of how shared meanings are ascribed to language, actions and objects that influence care workers perceptions. I then describe the process of securing ethical approval for this research in a setting with a vulnerable population, although the residents are not the population of my research interest. Moving on, I explain the details of my research design, inclusion and exclusion criteria, and outline the participants planned for data collection. I expound on the development of the observation component designed in the field along with the experiences of traversing three countries, cultures and how I managed the emerging themes through the analysis process.

Research aims and questions

This study seeks to explore and understand the work experiences and perceptions of dementia care workers in nursing homes in Canada, Scotland and the USA. To achieve these aims my research questions are:

- What are the care workers' experiences and perceptions of care?

- What are the care workers' training requirements in each country?

- How do organisational characteristics influence the delivery of care in the settings?

- How do care workers define the concept of care and make distinctions of care?

- How are reflexive (insightful; perceptive; instinctual) practices used by care workers in each country?

Theoretical Perspectives

Symbolic interactionism

The process whereby researchers move from theory to methods is through research activity. Order is given to theory, methodology, and research activity through the use of what Mills (1959) called the 'Sociological Imagination.' Theoretical perspectives offer insight into research activity. These perspectives or frameworks allow for organisation of descriptions, lead to explanations and furnish foundations for prediction. This mixed method research was theoretically grounded in the symbolic interaction tradition. Utilising a symbolic interaction approach along with ethnographic methods provided a way to collect information that allowed me to actively enter the world of the care workers. This approach was selected as a way to examine how care workers create, recreate, negotiate and derive a definition of self through interactions, and the extent to which they define themselves (Mead, 1934).

Symbolic interaction emerged as a loose perspective developed from a wide range of intellectual sources. George Herbert Mead (1934) in *Mind, Self and Society*, outlines three basic assumptions that helped form the symbolic interactionism tradition. Human beings act on the basis of meaning that they have for objects; meanings arise in social interactions; and those meanings are modified through an interpretive process (Mead, 1934). Symbols have meanings that we arbitrarily assign to them and are shared with others. When humans are presented with a stimulus, a symbol comes to mind, that is interpreted and a response is given. For example, with time constraints, a care worker rushes into a resident's room to perform ADL care with little time for conversations. The interpretation from the rushed interaction can result in the resident feeling unimportant or objectified which can alter their sense of self, mood or feelings. For the care worker, inadequate time for meaningful interactions can lead to the lower quality of relationships with the resident and the workplace. Furthermore, the work experiences influence how the care workers define themselves through their work. The symbolic interaction perspective emphasises the dynamic interaction that exists between people and their social worlds. Meaning is shared and created through interactions (Mead, 1934). The following assumptions serve as the philosophical underpinnings of the symbolic interactionist view: (1) the nature of human action; (2) the makeup of society; (3) the relationship between society and the individual; (4) the importance of the social act; and (5) the appropriateness of 'naturalistic' inquiry for studying human conduct (Sandstrom et al. 2003:14). Therefore, meanings established through interactions that shape interpretations are best understood by care workers in their natural setting.

Comparative research approach

There is a growing interest in cross-national comparative research, especially in long-term care (ILC-SCSHE-USA, 2006). Several factors have played a major role in the development where international and comparative issues have made significant contributions within research agendas. Some factors include changes in demographic trends that impact population characteristics and inequities that are experienced by the growth of industrialised nations discussed in chapter 4 by Wilkinson and Pickett (2009). Developments of this nature also have a tendency to put pressure on conventional social policy and stimulate national debates regarding policy reform (Hantrais and Mangen, 1996; Clasen, 1999; Tester, 1999). A comparative approach is essential to identify equivalent components within the different country's (Harris, 2007). Sartori (1991) argues that the selection of countries in comparative studies affects the quality of the research because the data must first be comparable. Moreover, how the questions are stated and what is compared also determines comparability. The expectation is to gather and compare data to make comparisons for greater awareness and deeper understanding of the concept studied (Hantrais and Mangen, 1996; Clasen, 1999). In relation to health care, Gusmano et al. (2007) outlines the following aims for cross-national comparative research on health systems in different nations. First, is to seek a better understanding of the evolution and the impact on the different health systems. Second, is knowledge about other programs, practices or policies that might be transferable from one nation to another. Third, is to evaluate the performance of other health systems with regard to dimensions such as service use, access, and/or health outcomes (Gusmano et al. 2007).

Several large scale comparative studies relevant to this research are currently collecting valuable data on care workers and include COMPAS, PANICOA and NORDCARE research discussed below. The Centre on Migration, Policy and Society (COMPAS), is an on-going international collaborative research organisation investigating immigrant or migrant care workers in ageing societies in Canada, the UK, Ireland, and the USA. The COMPAS studies are dedicated to understanding the relationship between social change and migration. These studies recognise, that the mobility of people is a key dimension that contributes to shape ageing services in society today (Bourgeault et al. 2009; Cangiano et al. 2010). The executive summary specific to the study "the role of immigrant care workers in an aging society: the Canadian context and experience" aims to address gaps in knowledge about the role of immigrant care workers in the home and Long-term care (LTC) sectors in Canada (Bourgeault et al. 2009:1).[6] However, *the broader intention* is to provide comparative data applicable to similar situations in the UK, Ireland and the USA (Bourgeault et al. 2009:1). These studies are timely and suggest that policymakers and stakeholders can benefit from applying an international perspective to develop solutions for long-term care issues and the ever growing care crisis (ILC-SCSHE-USA, 2006; Cangiano et al. 2010).

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[6] Several contributing organisations make the COMPAS studies possible such as: the Canadian Institute of Health Research (CIHR); the Irish Centre for Social Gerontology (ICSG); and the Institute for the Study of International Migration (ISIM) in the USA. Other affiliated organisations contribute as partners through various projects and include: the Refugee Studies Centre (RSC) established as part of the Oxford Department of International Development and the Community Health Research Unit (CHRU) at Ottawa University, in Canada.

The Prevention of Abuse and Neglect in the Institutional Care of Older Adults (PANICOA) is a joint research initiative in the UK between Comic Relief and the Department of Health. PANICOA is built on the robust findings of earlier studies published in 2007 (Lupton and Croft-White, 2013b). The subsequent PANICOA initiative includes eleven linked but separate studies to improve the understanding of the context, causes and consequences of mistreatment[7] in institutional settings i.e. hospital, residential and care homes (Lupton and Croft-White, 2013a:2). In sum, in the UK the PANICOA summary report acknowledges that good care is evident yet, the issues identified are still relevant today (Lupton and Croft-White, 2013a:2). Practical steps for action are outlined to promote good practices and help prevent circumstances where abuse, mistreatment and neglect prevail (Lupton and Croft-White, 2013a:2). The Nordic comparative research project *NORDCARE*[8] is collaborative research between three Canadian provinces and four Nordic European countries with the focus on care workers in LTC. Several comparative studies on long-term care workers have collected data in tandem that is now being utilised by researchers from multiple universities throughout Canada and in Sweden.

A recent Global Health and Aging report emphasises the value of utilising existing data sets for cross-national comparisons for research and policy development. Suzman and

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[7] The definition of 'mistreatment' was intentionally broad, including: physical and mental abuse; neglect or loss of dignity resulting from the actions, or inactions, of care staff; as well as the behaviour of residents/patients and care organisations (Lupton and Croft-White, 2013:3).

[8] The Nordic comparative research project *NORDCARE: The everyday realities of care in the Nordic welfare states – similarities and differences mirrored by care workers,* funded by FAS, Swedish Council for Working Life and Social Research, NORDCARE led by Marta Szebehely, University of Stockholm (2004-2006). Szebehely, M., together with (PI) Armstrong, P., York University, Toronto, Canada, headed the comparative research project *Long-term Care Workers & Workplaces: Comparing Canada with Nordic Europe* (Extension of NORDCARE, funded by Canadian Institute for Conflict Resolution (CICR, 2005-2008).

Beard (2011:24) argue that cross-national ageing-related data sets and initiatives offer comparable demographic indicators. These data sets reveal historical trends and offer projections to help international organisations, governments, planners, and businesses design more salient policies that result in better outcomes (Suzman and Beard, 2011). Cross-national comparative methods have the potential to identify specific policies, rules and regulations in each country in this thesis that influence the work conditions and shape the perceptions for care workers and the outcomes for residents. The approach also helped to answer my research questions and is outlined in analysis chapters 6 to 10 of this study.

The strengths of cross-national comparative research are particularly evident when comparisons at the macro level guide exploration in the field for discovery and comparisons of data collected are utilised for analysis at the micro level. For example, for this thesis, the development of each country's health and social care policies distinctly vary on a macro level. Comparative exploration of these policies at the macro level offered information to guide comparisons at the micro level. These findings at the micro level contributed to understanding how the policies significantly influence care workers and contributed to the influence and impact in everyday work for this workforce. The three features for nursing homes that are identified and consistent across the countries include the nursing homes as institutionalised, dominated by for-profit ownership, and provide care to a similar resident population. This knowledge led to investigation at the micro level for comparisons on how these features influences multiple aspects for care workers. The strengths of the macro and micro comparative approaches allow for the identification of a broad spectrum of interrelated variables at the lowest possible level.

Seeking the perspectives of dementia care workers provides a way to understand the influence of factors from a macro-comparative framework down to the micro-level personal comparisons for experiences, interpretations, and the meanings they attach to things. Over the course of this research, care workers descriptions offered insight to answer my research questions. This approach also created a way to identify common institutional and organisational characteristics within the nursing homes and across the countries. This provided commonalities for framing questions from a comparative perspective in order to incorporate issues that were highlighted in the literature. Discovering key features that are similar amongst countries but vary between countries allows for the explorations of practices that might be transferable. The larger picture of these macro and micro comparisons exposed gaps in the literature making this approach complementary to symbolic interactionism and applicable for this research.

Research Methods

Cross-national comparative methods

There were two separate phases for the examination of cross-national comparative methods outlined in the theoretical perspectives section above. The aim of the first comparative phase of this research was to utilise secondary data for macro level cross-national comparisons and organise this information and develop it in to Tables. The second phase of this cross-national research was to apply the information gathered from the ethnographic methods for micro level comparisons. Although the purpose was to compare dementia care

workers in nursing homes within the LTC continuum, to achieve that goal it was essential to delineate the advancement of each system to their current existence. Therefore, as a starting point, it was critical to develop a comparative framework that historically outlined each path to establish the context before examining the respective country's LTC system. As set out in chapter 4, the study summarises each country's policy and practice journey before focussing on the specifics of nursing homes. An understanding of this information was necessary for cross-national comparisons to narrow the focus of investigation and perhaps offer new perspectives (Dogan, 2002). This method moreover, has the potential to identify gaps in the research literature and knowledge that could pinpoint key issues to examine in future research (Hantrais and Mangen, 1996). Although each nation currently faces similar challenges in regard to LTC a comparative perspective was employed to identify the care workers unique situations and how each country has approached various solutions (Lowenstein and Daatland, 2006).

The rationale for my country selections includes Scotland, where the University of Stirling is located, and where I have previously worked. I am a citizen of the United States of America and Canada is adjacent to the USA, although its historical roots were more closely allied to Britain. Furthermore, each country is predominantly English speaking, have a legacy of large government data sets on demographic information, health and social care policies, and long-term care policies, all have comparable products, the nursing home, similar resident populations, and care workers that provide the majority of hands-on care for the residents. The countries have unique approaches to regulation and training care

workers and these, in part, are related to how the nursing home developed. The nursing home advanced into its existing institutionalised structure and is intricately tied to the development of health and social care policies and services within the individual healthcare systems.

The nature of cross-national comparative research traverses cultural and linguistic boundaries even given the use of a common language. It is more than a medium for conveying concepts and communication, but an overall cultural system that uses nomenclature to reflect a society's values and ideologies. Language implies the underlying meaning of a topic, in this case, the development of public health policy and the long-term care system. All of these factors affect the interpretation and application in relation to expression (Hantrais and Mangen, 1996; Clasen, 1999; Tester, 1999). To appropriately deal with inherent issues of cultural and linguistic boundaries, it is necessary to first be aware of the effects of these boundaries. By placing a greater emphasis on contextualisation or the interrelated conditions in which something exists or occurs, it is essential to take into account a wide range of variables (Hantrais and Mangen, 1996; Tester, 1999).

Language differences, even if researchers have a proficient understanding of a language, require a cultural understanding of words to allow for the equivalence of meaning. This becomes particularly important when dealing with dialects where the meanings of words vary or entirely different words may be employed in referring to the same phenomenon. From a methodological vantage point, it has therefore been argued that a sensitivity to the context in which beliefs are generated needs to be accompanied by the employment of complementary methodologies to investigate the language, vocabulary, and structure of people's attitudes and beliefs, May, 2001:215.

Following May's (2001) structures, complementary methods discussed in the next section are essential for a thorough understanding, especially qualitative techniques such as ethnographic methods, symbolic analysis and discourse which all have the potential to add depth and breadth to the data collected. Geertz (1983:46) emphasises that understanding people's culture exposes their normalness. Where interpretations come from does not determine where these interpretations are impelled to go. "*Small facts speak to large issues...*" (Geertz, 1983:54). It is in behaviour or social action "– *that cultural forms find articulation*" (Geertz, 1983:49) and qualitative interpretation relies on linguistic and cultural understandings. This is particularly relevant to my research as it traverses three countries and the interpretations in the analysis rely on cultural understandings. It is through the everyday routines and mundane activities that the similarities and differences

are realised. Therefore my epistemological position is that I might gain a deeper understanding of the care workers' experiences of work through the interactions and interpretations and how knowledge given to the subject can be obtained. Studying care workers in their 'natural' environments with the goal of then comparing the information gained across settings at a micro level can push the ontological underpinnings of this study forward with cross-national macro and micro comparisons.

Ethnographic methods

In this research the nursing home was defined as the location and dementia care workers as the subjects. Comparing workers in the same job in three different settings cross-nationally has the potential to advance our understanding of the work experiences of dementia care workers in nursing homes. For this research, the ethnographic inquiry uses the method of purposive sampling where all sampling is done with a purpose in mind (Lincoln and Guba, 1985). Purposive sampling is an informant selection tool based on qualities the researcher wishes to explore. The non-random sampling technique does not require a set number of participants. Instead, once the researcher has determined what they need to know and identified research sites the goal then is to find people who can and are willing to provide that information. Purposive sampling is commonly referred to as a judgmental sample that is based on the knowledge or a specific characteristic of the population (Berg, 2001). The goal is to have iterations repeated using the same research instruments across different settings to ensure a degree of comparative validity. This is extremely important if

comparative approaches are to be applied to the information gathered from the different settings, in my case three different countries (Lincoln and Guba, 1985). Under such circumstances comparative validity strengthens the epistemological foundations for initiating cross-national comparisons of groups such as dementia care workers in nursing homes that potentially challenge and produce significant outcomes for the populations under investigation.

Ethnographic methods place the researcher's role at the centre of the study in a way that is not an essential component in other type of study. The phenomenon under study is best placed within the natural setting for the fullest understanding. Entering the world of others allows for close observations of their behaviour and the opportunity for social dialogue. Observations would not be possible without the setting in which the interaction takes place. In the nursing home the researcher engages with the care workers using qualitative research methods. Ethnographic methods can offer a deeper understanding of the care workers world by identifying and distinguishing features of their actions (Berg, 2001; May, 2001). As Parks (1971) remarks "*In short, gentlemen, go get the seats of your pants dirty in real research*" (Lofland and Lofland, 1971: v).

Researchers often utilise ethnographic methods as a means of making research interesting and come alive through the write-up (Becker, 1998). It can become expressively aesthetic and an instrument to provide justifications for change. The researcher cannot enter a situation with the goal of changing it, but rather appreciate the situation to learn all that is

possible. In order to do this the researcher does not have to agree or disagree with the informant's situation but simply accept the participants' perceptions and offer empathy (Becker, 1998; Berg, 2001).

Our personal histories impact on what we choose to explore and depending on the location it also impacts how we go about negotiating access. Roberts and Sanders (2005:301) argue "*Ethnography is enmeshed within its own local knowledge production*" and seeks to describe a variety of practices woven together to form an inter-subject reality that we call culture (Henderson and Vesperi, 1995). Therefore, we often serendipitously come to understand our local culture through the experiences of others (Roberts and Sanders, 2005).

Ethnographic methods involve extensive fieldwork using various types of investigation to collect data based on empirical descriptions of the social and cultural worlds of a particular group (Emerson, 1988). According to Mead (2005), ethnographic interviews allow the researcher to draw upon their personal experiences and empower participants to discuss their experiences using their own language. Ethnographic methods provide the opportunity to collect rich information for interpretations and descriptions of the social expressions and experiences in the particular setting or as Geertz (1983:6) said, the goal is to provide a "thick description" of the arena one is trying to understand (Emerson, 1988; Berg, 2001).

There are numerous obstacles to navigate for successful ethnographic work in nursing homes. It takes access that is primarily based on a set of relationships between those being

researched and the researcher (Berg, 2001; May, 2001). At times, gaining access requires a bargaining process and gatekeepers that frequently play a critical role to enter a particular setting. Access to the field is a negotiated process and is often achieved by knowing a contact in a place that fits the researcher's specified criteria (Emerson, 1988; Berg, 2001; May, 2001). According to Dowling (2007) the goal of gatekeepers especially in health care is predominantly a collaborative and collective process.

Ethical approval

This research was granted approval from the University of Stirling, Department of Applied Social Science ethics committee on 9 October 2007. Everyone and every location have been anonymised.[9]

Statement on vulnerable groups

Several ethical considerations emerged early on in planning fieldwork. First, the nursing home setting itself was a sensitive location for research and data collection. Numerous staff, residents, visitors, as well as other service providers, were considered during all aspects of planning and conducting research. Carrying out any research in this setting can be seen as potentially intrusive and compliance with the British Sociological Association's (BSA) ethical standards was followed. As a result, several important features were

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[9] The DASS Ethics Committee had requested that I have a consent and information sheet in Spanish for one of my fieldwork sites. After contacting the manager and being told that there is no need I was given permission to conduct fieldwork through an addendum dated 5-12-2007.

implemented as safeguards to address these dilemmas. The staff interviewed posed their own set of concerns for ethical consideration but also the residents and other persons in the setting. The following principles from BSA were designed to guide the researcher through these sensitive areas:

- Professional integrity of the researcher;

- Participant rights of informed consent;

- Anonymity;

- Privacy;

- Confidentiality;

- Protection from harm;

- The right to withdraw or refuse to participate without repercussion or consequences (BSA, 2002).

Minimising any harm or distress to the participants, residents, researcher and others that may be present was observed at all times. If any participant or resident were to become upset by any aspect of this research they would be asked if they wanted to stop or continue and then if they wanted to discuss their concerns. I was also interested in asking other staff to express their personal opinions on basic nursing home information and training required for their position. All participants, cities, nursing home names, residents, families, and visitors were kept in the strictest confidence. In accordance with the ethical requirements, I stored all signed consent forms and hard data in a locked file cabinet in my office in the USA. The data was made anonymous and locked in a file cabinet and will be destroyed

after five years. As a result of the vulnerability and circumstances of those in this setting, special ethical consideration was additionally considered. The BSA's (2002) statement of ethical practice was used as a guide for direction with sensitive issues. I revisited the BSA (2002) statement of ethical practice on a continual basis as I reflected on the goals of my research, while making plans to enter the field, conduct fieldwork, and on leaving the field.

Research Study Design

There were three phases to this research which I have outlined in chapter one under the 'structure of the thesis'. Phase one has already been reported in chapters 2, 3, and 4 to identify gaps in knowledge and the research literature. Drawing on the information gained through macro comparisons I established inclusion and exclusion criteria below. The criteria were used as a guide for selecting a nursing home in each country for fieldwork. The second stage of my research was to gain access to a nursing home in each country that met my inclusion and exclusion criteria to conduct my fieldwork. This information along with the literature review on care workers provided a broad base of knowledge for the development of my qualitative ethnographic research tools. These included a short structured interview, an unstructured interview, an observation check list, and field notes for data collection. The '*continuum of care workers engagement*' while providing residents care was developed in the field for the analysis based on the observation check list and will be discussed towards the end of this chapter. The overarching aim of my fieldwork was to understand the work experiences and perspectives of dementia care workers in nursing homes.

The third stage of this research process was to apply the rich data from my qualitative methods of inquiry, for analysis to identify themes. This required the write-up of each fieldwork experience descriptively and then to combine the descriptive analyses using a comparative framework. My theoretical perspectives offered insight into understanding the research activity. Comparative perspectives were utilised at the macro and micro levels, while the symbolic interactionist perspective provided a way for the organisations of descriptions, interactions, and process to thematically write up my findings from each country. Then the comparative approach provided two levels for the thematic comparisons. Making use of information from the first two stages, insights, and experiences from the field provided me with information for iterations, to compare, look for similarities, differences, and patterns among and between countries. This also allowed me to identify unique features for care workers and care practices within the nursing home settings.

Statement on criteria: The majority of residents in nursing homes have some form of dementia. Although the care workers may not identify with being dementia care workers, the primary population they provided care for had some form of dementia. Initially I viewed them as dementia care workers, however, if I had the option, I would not use that term again. Also, in the exclusion criteria I specified a nursing home that did not have a special care neighbourhood or unit for people with dementia. I originally thought that on-going dementia training might skew my data and the care workers would be very knowledgeable about dementia. However, the residents with high cognitive needs were separated at every fieldwork site although that was not what I was originally told, so this criterion was technically not met. Also, I had set criteria for a nursing home that did not

have on-going training. In Scotland at Shady Pines, there was a full-time training coordinator employed to provide and arrange SVQ training. They did provide continual training but it was general training designed for care workers who had no experience so they did not disclose or view that as on-going training.

The parameters selected for inclusion and exclusion criteria were:

Inclusion criteria

A nursing home that:

- was proprietary/private/for-profit;

- had an average number of beds reflected by each country, i.e. the USA 113 beds; Scotland 37 beds; and Canada 65 beds;

- was located in a city/council area that was approximately 1 percentage of each country's total population.

Exclusion criteria

A nursing home that:

- currently was or has been involved in research during the past 5 years;

- had a designated special care unit for people with dementia; and

- was involved with special on-going dementia education.

Research sample

The nursing home as an institution offered several advantages for fieldwork. Nursing homes-potentially provide an abundant arena to gather concentrated data from a wide range of people who were in the nursing home for different reasons yet still an interconnected group. The time I estimated for fieldwork reflected the size of the average nursing home in each country. Therefore I expected the data collection process to take more time in the USA and Canada simply because the size of the average home and the additional staff. My goal was to spend approximately 4 weeks in the USA; about 3 ½ weeks in Canada; and 3 weeks in Scotland collecting my data and this goal was achieved. The following is a breakdown of my fieldwork from left to right: country; the amount of time in hours spent in each nursing homes; N represents the number of care workers in each sample; followed by the number of residents in each nursing home; and last is the month and year that I conducted my fieldwork.

Country	Hours	N	Residents	Date
USA:	140 hours	N = 27	117 residents	January 2008
Scotland:	106 hours	N = 15	37 residents	March 2008
Canada:	120 hours	N = 17	57 residents	July 2008

In my ethics application, I originally estimated 33 participants and that included managers/matron; members of the nursing staff with various titles; and care workers. My actual sample was more than double of what I expected. Including all departments there were: 3 administrators/matrons/directors; 14 nurses with various titles; and 59 care workers

with a total sample of 76 participants. During my fieldwork I spent a total of 366 hours in the three nursing homes, in three countries during 2008. The number of nursing homes for this comparison was three, one in each country.

Access to fieldwork

The ethics application required a background check for me from Scotland because that was where the university was located and one fieldwork site. I had to fill out the application knowing it was going to be denied because I am not a citizen of Britain. The nursing home where I conducted fieldwork first in the USA conducted a background check on me before I started fieldwork and gave me a copy. I was able to use the background check from the USA in Scotland and Canada.

Once I received ethics approval I was allowed to start searching for a nursing home in Scotland that met my criteria. Gaining access to a research site was a negotiated process that I had given a lot of thought to but did not foresee obstacles until I had to start making phone calls for appointments. It was both an experience of humiliation and personal growth. After several appointments I did get three 'yes' responses and chose the nursing home that most closely fit my established criteria.

Access to the nursing homes

Upon returning to the USA later that month, I started to search for a nursing home. I began by contacting people that I knew who owned nursing homes that were located in other States. After successfully making appointments with several nursing homes, going to visit and meet with the managers to discuss my research, I received three 'yes' responses again. At that point my goal was to select a home that most closely matched my criteria and the nursing home I had already chosen for my fieldwork in Scotland scheduled for spring 2008. At the study site in the USA, I was introduced to staff during their monthly meeting and was allowed to explain my work and answer questions. I had already been approved for my fieldwork in Scotland however all of the paperwork and introductions that I was able to carry out in person in the USA was not possible. Therefore, all of the correspondence with home in Scotland was carried out via mail and email. When I arrived for my first day of fieldwork, there was a letter I sent, that had been framed and placed on the mantle for everyone to see upon entering the home. An announcement was also placed in the nursing home's newsletter. It was a nice welcome that took a great deal of coordinating from a distance.

In Canada, finding a nursing home for research was completely different. Canada required their own an ethics application and approval from their provincial research committee. I initially contacted the LTC director in August 2007 and submitted the form via email in March 2008 after successfully completing fieldwork in two other countries. They had never had a request for cross-national research or research that was already approved by

another ethics committee, let alone a university in another country. After a lengthy process, my research proposal was approved and an email bulletin from 430 for-profit nursing homes was sent. Within approximately 3 hours I had sufficient responses expressing interest so I made my selection by choosing the nursing home that most closely fit the established criteria and the two previous fieldwork sites.

The participants

The goal was to collect data from the following employees:

- **Executive Director/Matron/Administrator** – one at each nursing home using a structured interview (see Appendix D) to gather general information about the nursing home; training required; the staff; lay out of the building and safety issues.

- **Care Coordinators/Nurse Manager/Director of Nursing** – one at each nursing home using a structured interview (see Appendix E) to gather general information about the nursing home; training required; the staff and shifts.

- **Care Workers - Personal Support Workers/Care Workers/Certified Nurse Aides** using a short structured interview; an unstructured interviews with open-ended questions and a set of hypothetical work situations (see Appendices B and C); and observations of interactions with the residents during meals.

Gatekeepers

When I first started this project, I had absolutely no idea how important 'gatekeepers' would be to the success or failure of my research. Overall, my first gatekeepers were my supervisors and then the DASS ethics committee. Beyond the university, at my first fieldwork site in the USA the first gatekeepers were the owners of the nursing home, then the manager and the director of nursing (DONs). The gatekeepers after that in the USA were the CNA who were responsible for scheduling the care workers and the Licensed Vocational Nurse (LVN) who were on duty when I was at the nursing home for interviews. When there was an opportunity to interview a particular CNA, the LVN would be the person that would allow me to take the CNA 'off the floor'. In Scotland, my second fieldwork site, my first gatekeeper was the matron. After that, the staff nurse and sister nurse were my gatekeepers, followed by the training coordinator and then the senior care workers controlled access to care assistants (CAs) on duty.

In Canada, the research committee was my first gatekeeper followed by the provincial committee. Choosing a nursing home in this country was especially difficult because I was not able to meet any of the gatekeepers in person or even physically see the nursing home. My selection came down to the closest home I could find to approximately meet my criteria. The morning I started fieldwork, the Corporate Care Coordinator Nurse picked me up and took me to the nursing home. Until that time, I had never seen or stepped foot in the building. So, the corporation that owned the nursing home was my third gatekeeper followed by the corporate care coordinator nurse who was my contact person.

During the previous year, this nursing home in Canada had experienced a high degree of turnover for the manager and nurse care coordinator positions. To add to the instability on my first day, the new nurse care coordinator resigned and the new manager had only worked there for three weeks. During the first meeting the manager asked why it would take so long to collect the information. So, the key informants were the day and evening registered staff and PSW union representative. After a few successful interviews the PSWs that had worked there for several years became my gatekeepers.

Consent and information: gaining the trust of participants

My research would not have been possible without the consent of my participants. Consent and information forms had already been approved by the ethics committee but I quickly learned that they all had to be tailored for each country because of the local colloquialisms (see Appendices F, G, and H for general information sheets). I developed a basic script to use as an introduction for the care workers to let them know that I had worked as a nurse aide and had spent most of my career in the nursing home working in various positions. I felt that it was important for the care workers to know that I had worked in their position before and had a basic idea of what they do. Letting them know that I have some understanding of what their work entailed allowed me to establish rapport rather quickly because I could empathize with their situation. As Becker (1998) states, my work experience in LTC also provided me with a general understanding of the rituals, rules and regulations of the setting.

Gaining the trust of the care workers and others in the nursing home was a challenge. Most of the staff were leery of inspectors, surveyors and researchers wanting to come into the nursing home because of the existing and potential negative publicity (Henderson and Vesperi, 1995) not to mention that I was asking very sensitive questions. As a researcher I had to persuade my audience (the care workers) that their perspective was a topic worthy of exploring and that I was genuinely interested and invested in what they had to say. I also had to convey why their perspective was so important to my research. Lincoln and Guba (1985) discuss four beneficial reasons for researchers to conventionally pose as inquirers:

(1) Truth value: How can the inquirer (researcher) establish truth with the respondents in the context in which the inquiry was carried out?

(2) Applicability: How can the inquirer determine if the findings are applicable with other respondents or in other contexts?

(3) Consistency: How will the inquirer determine if the results would be consistent if repeated in the same manner with similar respondents?

(4) Neutrality: How can the inquirer establish whether the results are determined by the conditions and respondents answers and not from biases, interests or perspectives of the researcher (Lincoln and Guba 1985)?

I had to reassure the participants specifically in the USA that no one except me and possibly my supervisors would see or hear the information. The concerns were consistent with Dodson and Schmalzbauer's (2005) research on mother's in poverty and their habits of hiding additional income and Secrest et al. (2005:93) work highlighting the pervasive

undercurrent of suspicion about being 'told on'. Repeated reassurance was needed for some CNAs even though they had read, signed, and understood what they were consenting to and had several opportunities to ask questions. At these times my previous work experience in their position was especially beneficial. After the care workers were comfortable with me asking questions I was frequently amazed at how willing they were to give me more information than I expected.

Ethnographic Methods and Data Collection

Completing the interview schedules were a tricky issue to balance because most of the time the care workers were working without sufficient numbers of staff. This meant that on several occasions there were not enough care workers to meet the regulations or carry out basic care for the residents. The interviews had to be completed at times that met operational requirements when I could take a care worker off the floor or interview them during a break or meal. The slower times were after residents' meals and after the residents had been taken to the toilet. This was when many of the care staff would take breaks or had their own meals. On several occasions I had to conduct an interview while a care worker was eating or start and stop an interview when they were available. A couple of times I went to the floor to interview care workers while they were working. During those particular times the care workers were putting away resident's laundry, washing wheel chairs or were alone in the hallway and no one else was around.

Structured interviews

A structured interview schedule was developed for more senior staff (see Appendix D and E). I was interested in knowing how much they knew about: the care workers; residents; census; staff to residents' ratios; turnover and recruitment; and what percentage of residents had some form of dementia. For safety reasons I also needed to know the layout of the building and safety plans. In addition, I developed an emergency contact sheet and protocol for each country in case of an emergency as requested by the DASS Ethic's board.

I started with a short structured interview for the care workers to gain general information (see Appendix B). Questions included asking respondents for job-title; training, registration required and length of current job. I was also interested in knowing if they perceived their job as more physically, mentally or emotionally challenging and how they cope with the demands. Then I asked for personal background information.

Unstructured interviews

The unstructured interviews were designed specifically for the care workers (see Appendix C). I wanted to explore their work experiences, how they define and make distinctions of care, and how they would respond to hypothetical work situations. My overall research questions aimed to gain insight about their working world, their definitions and distinctions of care and assess if they were reflexive practitioners applying their knowledge regardless

of the source. With this in mind, my questions skirted the issue around dementia and were woven throughout therefore I only asked a few questions that directly addressed dementia. At the end of the unstructured interview I asked my participants if there was anything they want to tell me or say. This gave them the opportunity to comment on my research or tell me their story.

Observations: what was planned and what happened

The focus of my observations was on the interactions between the care workers and residents. I wanted to get a glimpse of what takes place under day-to-day circumstances and to see if the care workers actually do what they said they do in the prior interviews. I was curious to know if they were being reflexive practitioners and putting their knowledge (whatever their knowledge was) into practice. Symbolic interaction was a useful approach for understanding how shared meanings were created, recreated and influenced by continuous interpretative process (Goffman, 1959).

In the USA, health and safety regulations, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Centers for Disease Control and Prevention and the United States Department of Health and Human Services, [CDC & USDHHS] HIPAA, 2003) limited where I could observe the interactions between the care workers and residents. I had originally designed basic observation guidelines without limitations to location. After I realised that my observations would need to take place in common areas because of regulations I developed my guidelines into an observation check list to be

specifically used while the care workers assisted the residents during meals. The items on the check list (see Appendix A) included observable interactions such as:

- was the care worker making eye contact with the resident;
- was the care worker watching the resident's body language or talking to other care workers; and
- was the care worker fully focused in attending to the resident's needs?

The observations were only one of my qualitative modes of inquiry. I observed each care worker on at least on one occasion during a meal in order to consider all of their data sets complete. Meal-times were the most predictable care task that took place in common/public areas, large and small. My goal was to observe the care workers but my presence would never be covert. The observation component was my last ethnographic method in each setting and as anticipated the care workers would be used to my presence and me writing away on a clip board. The first week the care workers were very aware of my presence and tried to follow every procedure according to the regulations. For example, they did not chat socially while assisting the residents during meals they would ask the residents when possible if they had preferences about certain food choices or seasonings. In Canada after the first week the show plate procedure discussed in the next chapter (6) did not happen unless someone was in from the corporate office. Also, the first week at each fieldwork site, the care workers were careful to knock on the resident's door, introduce themselves and state their purpose, but that changed as time went on too. Goffman (1959) reported that workers can only maintain front stage behaviour or

performances while providing care for about 15 minutes. Therefore from my experiences the care worker's behaviours changed as time passed.

As mentioned earlier, the observation component was changed because of regulations and it was to my advantage. During the second weekend of fieldwork in the USA the nursing home was understaffed so I helped serve soup in the dining room as a visitor. Consistent with Tinney's (2008) ethnographic research in nursing homes, after the first week at each fieldwork site I was seen as an extra pair of hands. Any assistance or work I participated in was as a visitor. The residents, staff and families were familiar with my presence and viewed me as a resource.

Field notes

The last qualitative method for gathering data in the field was field notes. I kept detailed field notes, organised on a daily basis which provided me with a journal of my experiences, conversations, people's actions and others reactions, a look at front and back-stage behaviour, reflections on events, nuanced national holiday celebrations and daily occurrences within the field that I could reflect upon for accuracy. The field notes provided rich accounts of daily mundane work experiences, hours spent in the field, the logistics of getting to and from the different countries, and the place I would call home for a month. These thorough field notes offered a place for descriptions of the rules, regulations and routines, conversations and interesting interactions, observations of various care workers and how I felt entering and leaving each setting. All of this provided the opportunity for

catharsis and reflections about what had taken place in terms of my interests, values, and speculations, ideas for insights, goals, objectives and accomplishments. Consistent with Foner (1995a) field notes also provided me with an outlet for my thoughts, interpretations, new understandings and a place to continually write about the novel descriptive contexts in the fieldwork settings.

Data analysis

Once I was finished with fieldwork, but before I left each city, I put all of my completed data sets in order. I organised them by individual participants with the first interview on top, followed by the second interview and my observation check list last with two blank pieces of paper on top and stapled the sets together. I coded them by participant number and country to assure that all participants would be anonymous once I left the field during the analysis process. The goal was to have iterations repeated using the same research instruments across different settings to ensure a degree of comparative validity. This was extremely important if comparative approaches were to be applied to the information gathered from the different settings, in my case three different countries (Lincoln and Guba, 1985). Furthermore, it was helpful to think of my empirical data analytically in a framework consistent with symbolic interaction. This encompassed how meanings were continually defined and re-defined, including the relevant symbols, objects and interactions. Central to these interactions were the people involved (actors), cultural contexts that included rituals and routines (norms), the settings or environments where the interactions took place (stage), the outcomes of the interactions (performances), and failed attempts at impression management that lead to mortification.

According to Roberts and Sanders (2005) analysing the interviews and ethnographic data requires personal and emotional investment that can make for a lonely journey. Data analysis was a lonely process in comparison to fieldwork. Leaving the field was especially difficult because I got to know my participants. It took a lot of work to separate my

feelings subjectively and objectively, and to see what was emerging from my data. These people shared very sensitive data and personal information with me so the physical distance was helpful and allowed me to approach my data more analytically in an effort to make sense of the massive amounts of information accumulated in the field.

It became apparent that contextualisation included my participants' descriptions, their perceptions as well as how they act upon their ideas, experiences and the meanings that they had negotiated and established. Powers (1995) suggests that the repeated events and experiences that became patterns were identified across settings and allowed validity of the data based on accumulated evidence from the interviews and observations. These patterns were used as support to confirm my interpretations. These concepts all fit within the four reasons to approach research as inquirers noted earlier by Lincoln and Guba (1985), to encourage truth value, application, consistency and neutrality. By systematically repeating questions and restating ideas, I was able to identify interpretations. As the ideas and understandings were repeated from one setting to another there was the possibility of the meanings and interpretations being transferable. Using the same tools in each country provided validation through repeated questioning and observations. Textual analysis of the interview notes allowed me to record recurring or clustered themes.

The themes were centred on key issues such as:

- working with insufficient numbers of staff;

- the continual lack of resources that included large mechanical equipment such as an elevator, mechanical lift to get residents in and out of the bath-tub, wheelchairs for transportation and soft resources that included bedding, towels, wash cloths, and continence products;

- working in stressful conditions and environments;

- the influences of working in institutionalised nursing homes;

- the influences of working in for-profit organisations;

- what were the wider social structures that influenced care;

- the lack of time to complete the work;

- the lack of time for relationships with the residents;

- the lack of communication with the nurses and managers;

- the lack of autonomy;

- negative opinions about insufficient training;

- the care workers' descriptions and distinctions of care;

- the care workers' perceptions of their work experiences;

- the understanding (or not) of dementia;

- not meeting the resident's needs;

- separation of people with dementia;

- the differences of care workers as a workforce in each country.

I organised my transcripts into descriptive accounts from questions that were answered consistently that might lend insight to a concept to explore that could eventually become a finding. The relevant passages were then analysed for their thematic consistency. I separated my data and roughly categorised key topics that emerged. I used '*the continuum of care workers'* engagement while providing resident's care developed in the field discussed at the end of this chapter to support key ideas. The emerging themes were established from consistent data that was repeated regularly across the settings or definitions that were repeated.

Once clear patterns began to emerge based on how many times the response was given this helped to define and set criteria. The criteria I set for definitions or descriptions had to be represented in approximately one third of the sample from a fieldwork site. This was a reasonable percentage that started to develop significant patterns. I had asked the care workers how do you define care, and later asked them to make a distinction between good care, okay care, and bad care. They had no problem with making those distinctions. At my first fieldwork site in the USA the respondents shared graphic, detailed descriptions of such care practices. After I realised how consistent the descriptions were I did add one question that was not originally included in my interview schedules with the approval of my supervisors via email. That question was, "Does bad care happen here"? My participants were giving clear, detailed answers about care practices and this information followed logically and would be helpful knowledge to understand their responses. After that I included this question on all of my unstructured interviews for the other fieldwork sites.

After I was finished with fieldwork and back in my office I generated a list of answers/responses from the interview schedules that could possibly be linked or developed into themes. I stapled a copy of the responses on each interview and circled specific answers with different coloured markers. Then I would sort the interviews according to colour code of responses, and could easily look back to see if there were corresponding answers that were related. The themes developed and emerged from analysis of my data using a comparative framework. When a group of responses were repeated I would go back to my transcripts to review themes against quotes looking at the different countries and the participant's location on the continuum. This was a time consuming process but provided a good application for the rich data. Eventually, after I had themes clustered, I could logically organise them according to a particular topic. Questions that were answered the same way as well as ideas from the literature led me to look at my data in as many ways as possible. My supervisors questioned how I came up with some of the topics and why I looked at certain questions thematically. At their suggestion I placed my data on the continuum based on observations that are on Table 8 at the end of this chapter (5). To tie my findings together I kept going back to institutionalisation of the nursing home, specific organisational characteristics and various aspects of care. I was able to identify features of each nursing home that were related and common across the settings, while at the same time there were other facets that were very different. The responses from my participants kept drawing me back to the topics that began to emerge as themes. To stay focused on my research questions I printed them out and placed them next to my computer. This helped me stay on track.

Fieldwork reflections

From my field notes:

> *Today on the bus coming in I was reflecting on this research adventure. I am amazed at all of the details that I had to plan and considered but I also had to laugh at some of the different details that never crossed my mind, such as planning, navigating and carrying out research in 3 countries. Each country has its own currency and unique obstacles but none that were big enough to stop my determination. These ranged from air fares, making reservations, finding a place to call 'home' for anywhere from 3 to 4 weeks at a time in a foreign country or state. All of this has been a challenge in itself. Once I arrived at each destination there were always transportation issues to overcome. In Canada and Scotland I managed to survive without a car. I relied on public transportation, my own two feet and the kindness of those who so willingly gave me rides. One of the greatest personal challenges I faced once I safely arrived at my location was getting food and then preparation which often ended up being a kettle and the bathroom sink. I could easily write a book on how to creatively survive gluten-free with hot and cold water, canned fish, cheese and crackers. These experiences are something I would never change. I have learned more than I ever anticipated about life, long-term care, dementia care workers, death with dignity, and how care can be with people who genuinely have their heart in the right place (Field notes:11-7-2008).*

During the process of doing fieldwork, I gathered data and then wrote up the accounts in a story form. This presented me with the opportunity to reflect on the experiences and responses of my participants. Along the way I found myself involved in the process of engaging in the workers lives that forced me to move on beyond my descriptions of fieldwork. I learned to see the meaning of the work world of dementia care workers in a different light. This required processing these experiences while acknowledging the emphasis of meanings that were constructed from the interactions of the work experiences. This was very delicate and difficult work and moving beyond the point from participants to research results highlighted the complexity of the research setting (Henderson and Vesperi, 1995). It was fascinating to compare how each setting took advantage of me as an extra pair of hands. For example, in Canada I was a 'retriever' and requested to retrieve items such as silverware, sugar, liquid thickener and other mealtime accoutrements. In Scotland, my designated task was to answer the door when the doorbell rang, whereas in the USA they had me serving food. I submerged myself in their work world to gain a better understanding of their experiences.

It was significant for me to look at the institution from the bottom up as opposed to the top down because my focus was on the workers at the lowest level of care. I rarely saw the managers on the floor where the residents and care workers were unless there was a problem. It appeared that on a daily basis the managers were constantly distracted by other matters. These included preparing for inspections, dealing with complaints and/or angry family members, in meetings behind closed doors or were not at the nursing home at all.

The managers did not know the care workers, as people, that provide the majority of care and were the people primarily responsible for the nursing home's reputation.

The last section in this chapter describes the process of developing the observation check list and 'continuum of care workers engagement.' These were designed at my first fieldwork site after the original plan for observations of interactions were changed because of HIPAA (CDC & USDHHS, 2003).

The Development of the Observation Check List

The development of the observation check list was designed as an observation tool at my first fieldwork site. Motivation to develop this came from the need for an observation component of care workers while interacting with the residents after regulations prohibited locations and my original plan. According to Brooker et al. (2011) observations have been used for many years including the nature of the interaction. Utilising mealtimes for observations provided me with a regularly scheduled ADL that took place three times a day in common areas. The location made it easy to see the care workers interacting with the residents the check list was easy to score and to identify observable behaviours.

I developed my guidelines into an observation check list to specifically be used while the care workers that participated in my study assisted the residents during meals. Each care

worker was observed at least one time for approximately 15 to 20 minutes while assisting one or more resident with a meal so I could accurately record my data. On a few occasions at each fieldwork site I observed the same care worker more than once. When they were assisting several residents during a meal it was difficult to see if they were watching the resident's body language. The observation check list could be easily scored by circling a yes or no response (see Appendix A). Some of the residents needed a little assistance getting their utensils, food seasoned and beverage ready, while others needed total assistance. My goal was to observe the interactions between the care workers and residents.

Several studies have investigated ways to enhance the quality of life for individuals being cared for in nursing homes. The experience of 'being listened to' has been identified as an essential component and cornerstone of quality (Goldsmith, 1996; Kitwood, 1997; Jonas-Simpson, 2001; Jonas-Simpson et al. 2006: Ball et al. 2009). It has been shown that caregivers must listen to those cared for to deliver quality care. Furthermore, Jonas-Simpson et al. (2006:47) report a link between 'being listened to' and feelings of value, care, intimacy and involvement with others. The research of Jonas-Simpson et al. (2006:47) suggests that being listened to help's to clarify and strengthen one's self-identify and assist in the process of defining what is important. When care workers were helpful, willing to listen and talk to the residents living in long-term care, that represented genuine positive regard and care (Jonas-Simpson et al. 2006:47). Likewise, Jonas-Simpson et al. (2006) and Ball et al. (2009) acknowledge that the care workers had the opportunity to

make a difference in the residents' lives and listening has been recognised as the foundation of meaningful interpersonal relationships. This was consistent with the symbolic interaction perspective, where our self is derived through interactions with others and these interactions actively and continually shape our concept of self.

Residents living in nursing homes have marginal interactions with people outside of nursing homes because they reside in institutions (Tellis-Nayak and Tellis-Nayak 1989; Foner, 1995b; Gubrium, 1997). With that in mind what was not adequately acknowledged was that positive interactions with the residents were a key responsibility for care workers because those were the people the residents interact with the most. Jonas-Simpson et al. (2006) and Tinney (2008) note that when residents were being listened to by the care workers they were 'being with' the residents. Then, the residents were an active part of the interaction, actively shaping and participating in a reciprocal relationship. Therefore, when residents were listened to the outcome was an affirming experience, a nurturing and powerful way to enhance a positive self (Marshall, 1983; Berdes and Eckert, 2007). In contrast, the experience of not being listened to or being made to feel invisible poses the risk of the residents losing their sense of value and place in the interaction and relationship (Goldsmith, 1996; Kitwood, 1997; Jonas-Simpson, 2001; Jonas-Simpson et al. 2006).

According to Burgio et al. (2000:449) neutral or impersonal interactions between care workers and residents appear to be the norm in nursing homes. This unfortunately highlights that positive verbal interactions were as uncommon as negative verbal interactions (Burgio et al. 2000). Additionally, Jonas-Simpson et al. (2006) found that

mediocrity or indifference was expected in LTC institutions. For the residents this was particularly tragic because communications between the residents and care workers were critical and had the potential to enhance the residents' quality of life.

The research of Jonas-Simpson et al. (2006:47) on 'being listened to' described ways in a list format that residents had identified to determine if the care workers were listening to them or not. I reversed the focus of the group being studied to reflect care workers rather than the residents from the research of Jonas-Simpson et al. (2006). My goal was see if the care workers were listening to the residents, watching their facial expressions and body language. The descriptions were developed into an observation check list with 18 items designed to be scored at mealtimes observing the interactions of care workers with the residents (see Appendix A). The facial expressions and terms added to my check list were from the work of Lawton et al. (1996).

The observation check list was used to develop a continuum to visually discern the differences in care workers interactions with the residents. Continuums have been used in other fields to help with data analysis (Giddings, 2006). The continuum helped to visually identify patterns and correlations that assisted in analysing my data. Familiar terms used every day were borrowed to identify the opposing ends of the continuum. For example, the opposite of 'being with' a resident was 'doing to' and in this interaction the residents were objectified or ignored (Kitwood, 1997). The words 'doing to' were repeated in my field notes describing interactions between the care workers and residents when the focus was

on the task and not the person. When the interaction was referred to as 'doing to', the person was frequently objectified and seen as invisible in the interaction.

The terms *engaged* and *disengaged* were borrowed from Cumming and Henry (1961, in Hooyman and Kiyak, 1995). The notion of 'being with'[10] a resident was placed on the engaged end of the continuum and 'doing to' a resident on the opposite end with disengaged. The term objectifying would be commonly understood in Scotland or the UK but not widely used in the context of people or interactions in Canada or the USA. To expand on this concept the idea of 'providing emotionally motivated care' was used and consistent with the research of Berdes and Eckert (2007). The opposite end of the continuum represents 'providing task oriented care' or the middle point and was logically in-between. The continuum was developed in the field as an analytical tool and refined by adding terms borrowed from previous research to provide a better way to un-pick some of the findings in this research. I placed all of my participants on the continuum from the observation check list in the field so upon returning to the office the scoring and location would be complete.

All of the 18 questions on the observation check list were written so that a 'Yes or No' response could be marked. Two questions had further options that were just below the question and if needed could be circled. The goal for scoring the observation check list was to be completed quickly, easy, and accurately. The care workers that scored positive responses on all 18 items were denoted by a + sign on the continuum. The criteria set for

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[10] The terms 'being with' and 'doing to' more accurately describe the expressions from my field notes, but were difficult to use in the text so I used 'engaged and 'disengaged'.

the 18 items were divided into three categories of six each for 18 totalled. A score between 18 and 13 represented the engaged group, 12 to 7 identified the middle group and a score below 6 characterised those disengaged. The scores allowed me to determine the care workers location along the continuum (see Table 8 below) based on observations of interactions with the residents. There were three categories on the continuum, however for the ease of descriptions of my data the continuum was divided into two clusters representing the engaged and the disengaged groups. However for practical applications or other circumstances all three categories would ideally be used.

Table 8: Continuum of Care Workers Engagement

Being <u>*with*</u> a Resident	Doing <u>*to*</u> a Resident (Objectifying)

Engaged ___+___ __ __Middle_ _____-_ ___ **Disengaged**

```
C+ C+ C+ C+  C C  C C    C  C      *     C     C  C      CC    C C
S+ S+ S+    S S  S S     S  S       *     S   S   S       S     S S
U+ U+ U+ U+ U+ U+     U U  U U     *    UU   U  U     U U   U U U U
U U  U U   U  U  U
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Providing emotionally motivated care (more than ADLs)	Providing task oriented care (just ADLs)

Total	*Engaged (E)*	*Middle (M)*	*Disengaged (D)*
(C)anada = 17	*C = 8 → 47%*	*C = 5 → 29%*	*C = 4 → 24%*
(S)cotland = 15	*S = 7 → 47%*	*S = 5 → 33%*	*S = 3 → 20%*
(U)USA = 27	*U = 13 → 48%*	*U = 8 → 30%*	*U = 6 → 22%*

+ denotes CWs who all scored positive on all 18 items on the observation check list which is above the CWs in the engaged group or cluster.

I calculated the group percentages for all of the care workers in each country based on sample size. The similar percentages within each group according to country offered validity although the number in each sample varied. The continuum provided categories for identifying groups from my data based on the observations that helped to make links,

explain and understand different concepts. Using a continuum or any scale that requires placing all of the data will result in different categories depicted by the specific features used to denote differentiation. The inherent flaw of the continuum concept was that similar categories would likely occur in any work settings. However, acknowledging the limitations and using the continuum analytically provided valuable insight.

Summary

Decisions made early in the research design phase were critical and influenced many features of the theoretical underpinnings and methodological and conceptual work for the entire project. This research utilised two long standing traditions, comparative and ethnographic methods, demonstrating features that highlight the two as complementary approaches. Comparative research strives to identify the similarities and differences across settings and ethnographic methods seek to describe everyday life in a particular setting. The comparative methods were incorporated first on secondary data for discovery to understand the similarities and differences of the three countries. This allowed me to identify gaps in the literature and essential characteristics for the development of research criteria, and to guide the development of my ethnographic research tools for fieldwork. Ethnographic methods involve extensive fieldwork, and collecting data based on empirical descriptions of the social worlds. These descriptions allow researchers to get a sense of the texture and capture the complexities, contradictions and strains of everyday life. The respondents' accounts from the interviews provided a perceptive lens to insightful interpretations of how the care workers made sense of an ordinary day of work. Discovery

and dialogue with busy care workers in the nursing home setting took more time than I had anticipated collecting information from their perspective. It was difficult for the care workers to be away from their work because of the low staffing levels. Therefore, the in-depth interviews took a lot of coordination and cooperation in order to get the amount information I needed to better comprehend their work experiences. The final aim of this research was to use the knowledge discovered from the interviews and ethnographic methods and apply a comparative approach to find links, similarities and differences among and between the countries. Symbolic interaction provided a framework for the organisation of interpretations and explanations of the data collected in the field as well as a way to inform the analysis and findings.

Chapter 6 sets the scene for each fieldwork site. The descriptions of care workers, residents, buildings, and other related aspects are organised in a comparative framework to present my findings in the subsequent chapters 7, 8, 9, and 10 of my analysis.

Chapter 6: Setting the Scene

In this chapter, I provide the context for each fieldwork site[11] to set the scene for my findings in chapters 7, 8, 9, and 10. A comparative framework is utilised to organise pictorial details that focus on various aspects central to the care workers, residents, and the buildings. A general description of the buildings incorporate information such as size, location, appearances of the interior and exterior, if the nursing home is purpose built or a conversion, illustrations of each break room, and a discussion on the functional capacity of the buildings. Care workers' appearances and characteristics are presented along with the different shifts, staff to residents' ratios, breaks and discussions to point out the differences. The residents' appearances, general characteristics, personal affects and the number of people living at each nursing home are discussed. The overall comparisons of each country's staff to resident ratios are displayed to accentuate the variations. The commonalities and inconsistencies of these assorted features are highlighted and the end of the chapter includes the care worker's knowledge of dementia. The aim of this chapter is to help contextualise the three research sites and allow for a more rounded comparison of the following analysis chapters.

Nursing Homes

Living in a nursing home is a negotiated process that lies somewhere between the need for 24 hour care and death, although many residents have little input in the process. Not many

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[11] All of the nursing homes have been given fictitious names to protect their identity.

people want to live in a nursing home or what Goffman (1961) refers to as batch living (Kane, 2001; Nolan et al. 2008; Bourgeault et al. 2009). Few care workers actually choose the nursing home as their place of employment, especially in Scotland and the USA. As discussed in chapter 2, nursing homes are gendered worlds dominated by women who live and work there.

Embedded in life at each nursing home are daily ritualistic routines (discussed in chapter 3) anchored in care and rigid obedience to standard rules and regulations typical of binary management (Goffman, 1961). These formalised routines are designed to offer a sense of safety, security, and order among the predictable chaos of the routine. Complicating factors or predictable chaos resulted from numerous situations such as a resident admission, death, a trip to the hospital, family outing, doctor's appointment and holidays. These additional interruptions to the routines require laborious preparations. The time consuming preparations are just some of the many job responsibilities for care workers. The situation is often compounded by a lack of care workers to provide resident care for the day.

Canada: South Park Manor nursing home

South Park Manor is a three story building in a neighbourhood on the corner of one of the oldest streets in town. All of the rooms are double occupancy with the exception of a 4-bed suite in the corner on the 2^{nd} and 3^{rd} floors. The building is a 30 year-old conversion to a nursing home. It looks like an office building until you walk through the back door. The

front door is located off a busy street and enters into the second floor[12]. The back door is located off the parking lot and the primary entrance I used on a regular basis. There are flower beds in front of a chain-link fence that separate the small parking lot from the building. There are different signs posted when there are illness outbreaks and on my arrival there is a '*Respiratory Illness Outbreak, Enter with Caution*' sign. There is a 'swipe machine' in this entrance that the staff is required to place a hand on to be scanned, in order to clock in and out.

This for-profit nursing home website is interesting with a description but no picture. It starts off with the following information:

> *South Park Manor is a small long term care facility situated in a neighbourhood minutes from downtown. Opened in 1984, the accredited facility is home to of 57 delightful residents who are cared for by our qualified compassionate staff. There are also short stay beds which we make available for short-term relief to caregivers who are in need of a rest or wanting to go on holiday (South Park Manor Nursing Home website).*

South Park Manor has experienced tremendous management turnover recently and on my first day of fieldwork the new nurse care coordinator turned in her resignation. The new manager had simply been told that research has been approved by the corporate office and

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[12] For this research, the different levels or floors of buildings will be identified as: ground floor = 1st floor; second level = 2nd floor; third level = 3rd floor.

when it will take place. As discussed earlier, the LTC Association in Canada assisted with securing fieldwork placement and this is the only fieldwork site I had not been in or seen prior to commencing fieldwork. My corporate contact is the person I had spoken with to make arrangements. With the new manager and the way the situation is handled, I do not have in-house management support at South Park Manor.

Scotland: Shady Pines nursing home

Shady Pines is a for-profit nursing home in a residential neighbourhood that opened in 1980. The building is not purpose built and has been expanded with several extensions. The elegant atmosphere of Shady Pines is home-like. However, the décor violates most of the environmental recommendations for people with dementia with bold decorative patterned carpets and large framed mirrors throughout (Peace et al. 1997; Calkins, 2001; Brawley, 2005). The owner is only the second in 22 years. There is only one entrance for family and guest that remains locked 24/7 with a doorbell. This is added security which is unique to Shady Pines.

Shady Pines' philosophy states, "it features a home-like atmosphere". On any given day, 35 permanent residents and two respite or short stay residents live in this nursing home with 21 single rooms and 8 shared rooms. As I sit in the entry and wait for the matron, someone is singing "You are My Sunshine". The information booklet on the entry table at Shady Pines says: *"Our aim is to make your stay with us a happy one"*. Throughout my time Shady Pines lived up to their aim.

The United States: Wisteria Lane nursing home

The front door mat said "Welcome Friends to Wisteria Lane" and upon entering, one did feel welcome. Wisteria Lane is for-profit and the only purpose-built nursing home out of my three fieldwork sites. It is largest in my sample reflecting the USAs national average. Wisteria Lane is dually certified for Medicare and Medicaid with a separate rehabilitation facility on-site. There are 62 rooms all for double occupancy or 124 beds. Wisteria Lane is divided into two separate functioning units called *The Gardens* and *The Terrace*. Two rabbits and 117 residents live at Wisteria Lane during my fieldwork. Wisteria Lane is a traditional, colonial style building near a hospital like most nursing homes in the USA.

Life at Wisteria Lane Nursing Home is busy whether you live, work or are just visiting. The constant flow of new faces from the turnover in residents or the revolving door of current and potential employees is overwhelming. But like life in other institutions, the chaos is predictable in an unpredictable sort of way. If all of the care workers scheduled to work actually come in to work, and ready to work, life is different. That is rare.

On my first day, as I walk up to the entry door with my poster for introductions, two police cars drove up rather fast. The manager is at the door waiting for me, so we all arrive at the same time. The manager chuckles and asks the police officers what room they need. She escorts the officers to the room to find two residents contentedly watching TV. When the police ask if either resident have called 911 (for emergencies) neither of them could

remember. The police are cordial as they leave Wisteria Lane. Apparently this is not uncommon which adds to my impression of excitement amidst the chaos.

The Break Rooms

The break room's at all three fieldwork sites are out of view from the general public and residents. Each break room has a typical kitchen set-up with a sink, cabinets, counter top, refrigerator/freezer, microwave and coffee pot or kettle. This is where the care workers take their breaks, eat their meals, take care of some personal business and retreat from work in hopes of revitalising, so they can get back to the high demands of care work. Over time, the staff break rooms took on special meanings for me and where I spend hundreds of hours during fieldwork to get to know the care workers and collect my data. In addition to each break room there is also a designated smoking area for all employees who smoke. This area is willingly shared by staff in general and management which are rare in terms of the cooperation and participation between these groups. The smoking area, from my observations, is the only place where a common activity negates the hierarchy management structures within the nursing homes. The conversation topics in the smoking areas stay focused on non-work related subjects but on occasion information that is beneficial for the residents or staff is shared. In contrast, the management do not share: break rooms; meals; or toilets with the general staff. In fact, across the settings the management consistently used a room designated for other purposes i.e. a small conference room or the family dining room to share their meals together.

South Park Manor (PSW): Break Rooms

The staff break room in Canada is a nice size room with no window and one wall full of lockers that are used regularly. Some lockers have locks and some do not. Most lockers contained 4 or 5 shelves and are shared by several people. There is a typical corner kitchen set-up and food in the cabinets is brought by staff, donated by family members, various organisations and is available for anyone. There are all of the accessories needed for food preparation and meals. Notices are posted everywhere making the room look extremely cluttered. The bulletins and notices are all over the back of every door, on the three bulletin boards, in addition to every possible space on the walls, cabinets and lockers. A TV is hung on the wall in the top corner and is visible from the door. I only observed this TV in use once while a nursing student who is going to work as a PSW viewed an orientation DVD. Just below the TV is a coat rack and on the floor are a couple of mats where everyone throws their street shoes.

The PSWs are very curious about why I am there and asked several questions that led to interesting conversations. Something is mentioned about dirty work and I explain that in Scotland the term 'continence management' is used and in the USA it is referred to as 'bowel and bladder' work. Then several PSWs started openly talking about dirty work while eating. One particular PSW had a brown smear on her work scrubs. At this point, the PSW pointed out the residents' bowel movement (BM) on her scrubs and very causally said *"- like that"* as she continued to eat. A different PSW commented that she worked in

child care for 16 years and the only difference here is the bums are bigger. A comment is made by another PSW stating 'we do all of the butts and baths'.

A large rectangle table with ten chairs is the main focus of the break room. The nursing homes do not offer meals to the staff but as time passes during my fieldwork I observe the kitchen staff bringing in various platters of food to the break room for the PSWs. This is more common when they are working without adequate numbers of staff, which is just about every weekend. There is a clean tablecloth and basket in the middle of the table with Kleenex (used for napkins), hand sanitizer and lotion. Next to the basket is a container of muffins that a PSW brought in to share for Canada Day. The room appears comfortable and well used but there is no toilet/bathroom in the break room. A piece of paper is posted on the back of a door with the cumulative hours for each employee for a lifetime. This is a seniority list for the union separated by departments. My corporate contact is the only person in management that uses the break room and interacts with all of the staff when on-site. The large closet that would have been a bathroom/toilet is used for residents' supplies. The toilet for the care workers is also shared with staff and visitors and located down the hall. The smoking area is located outside through the garden along the side of the building with its own table, chairs, umbrella and plenty of ash trays.

Shady Pines (CA): Break room

The staff break room in Scotland is private and comfortable. There is a typical kitchen set up with condiments and food. In the cabinet above the sink is tea coffee, and sugar, all

provided by the nursing home. There is always dish-washing soap that is used regularly. A sign above the sink said "*Please wash & dry cups, dishes and tables after your break*" and staff do. There are information brochures neatly arranged on a stand that covers a wide variety of topics, primarily SVQ opportunities to further the CAs knowledge and other resource information.

Two fixed tables with four seats are in the room. One table is in the middle of the room and the other by a large window. There are also additional moveable chairs. The lockers are in the corner and along one wall. At the end of the lockers is a door to a small room with a low ceiling and a couple of tables used for various items not put in the lockers such as shoes, umbrellas and coats. The staff actually used the lockers and a £10 deposit is required to get a key. Over the time that I spent in this room, I learned that it is pleasant, well used and very predictable as to what team or department will be in and when. Shady Pines is the only nursing home that provides tasty meals for the staff at a reduced rate and free for me as a researcher.

Not only is the break room always clean, the break times are regular and strictly enforced for the CA, and all departments except nursing. Most CAs and other departments come in as a group for tea time and meals. The nurses are required to stay at the nurse's station and work on paper work during tea time or meals. The toilets are located across the hallway from the break room. The smoking area is located outside and access is through a back door or the side of the kitchen. Outside, a bench is covered by an arbour for protection from the rain. There are several chairs and a large free-standing ash tray. Quite often I

learned some of the best information while in the smoking area. It appears to be a place where the staff escape and talk about life. This gave me a glimpse into their lives away from work.

Wisteria Lane (CNA): Break room

There are three doors in the break room at Wisteria Lane. One door opens into the courtyard where the staff cut through to get to other parts of the building faster. Two additional interior doors open from the different connecting hallways. Through one door are bathrooms across from each other with signs on the door that say "*Men's and Women's Locker Room's*". The locker rooms are rather large rooms with a toilet, sink, a wall of lockers and a high shelf for storage. There are more women employed overall and most of the men work in other departments such as maintenance and dietary although all staff used these bathrooms. Three square tables are lined up in a row with very comfortable chairs. There is a small kitchen set-up in this cramped room with a repugnantly dirty microwave with part of the front missing and an electric can opener on top. In the opposite corner is the time clock with over a hundred time cards in rows separated by departments. There are mandatory notices posted on a corkboard behind one door in English and Spanish, although there are no Hispanic CNAs. There are a few immigrant workers but the Hispanic employees are nurses.

A sign is posted over the lockers in the women's bathroom room that says "*It is against the policies to store your belongings in resident's rooms*". Yet no one kept their personal

belongings in the lockers. This rule is clearly violated so, the sign must be for regulatory purposes. When I asked why there are locks on all of the lockers a CNA said they have been there forever. She pulled a hair pin out of her hair and asked if I would like a locker. She is willing to unlock a lock with her hair pin so I could have a locker, but then that meant anything I put in there is accessible to anyone with a hair pin. The manager repeatedly stresses to me to never leave anything in the break room and made it very clear that the workers in general are not to be trusted consistent with Eaton (2000) noting that in the USA managers do not trust their workers.

The building is non-smoking and smoking staff have to go outside through a door directly across from the break room. There is a lot of action in and out of this locked door that requires a code to enter and exit. Once inside the door, there is a small corridor with laundry, supplies, and the door to the smoking area. Down a sidewalk is a gazebo with seats. Just a few steps out the door are large institutional (tumble) dryer vents where the staff squat and smoke to stay warm. This area is somewhat hidden because the door mechanism is so quiet.

The functional capacity of the buildings

From a comparative perspective, Canada's South Park Manor has the most difficult environmental design to navigate with a very confusing layout. Daly and Szebehely (2012:114) report that the size and design of Canadian nursing homes are more hospital-like than home-like which is historical. This building is the most unfavourable nursing

home in my fieldwork because there is only one elevator. The common areas and access to outdoors are on the 1st floor and the residents' rooms are on the 2nd and 3rd floors. The confusing building layout is compounded by having only one elevator for the entire home. There are no residents' rooms on the 1st floor which make it impossible to transport all of the residents to the 1st floor. Therefore, the care practice of leaving the residents on the 3rd floor all of the time is not questioned even though there was no access to the outdoors. The design of the building made negotiating the space challenging for PSWs, the residents in general and especially those living on the 3rd floor.

Shady Pines in Scotland is pieced together in an awkward way making it difficult for the residents and CAs alike to navigate the spaces. There are three floors in two different parts of the building that do not connect. The two elevators are labelled differently and the three stair cases only add to the way finding confusion. The residents' rooms are on the 1st and 2nd floors and the staff areas are on the 3rd floor. According to Hubbard et al. (2003:110) the structural context (e.g. layout of the building) shapes social interaction. The use of spaces makes it easier for the staff to see the residents if they are all up and out of their rooms and in common areas on the 1st floor.

In the USA, Wisteria Lane is the largest building of the three homes. The layout makes it more functional for the staff because it is designed to operate as two separate nursing homes on one floor with different goals, but is too large for the residents. If a resident strayed to the other side of the nursing home it is not only confusing but is a good distance away. The two separate nurses' stations are the focal points which emphasise the resident's

medical needs and resembles mini-hospitals. The design allows more visibility from the nurse's station of the residents down the hallways, in the day room, and the CNAs as they go in and out of the various rooms. Schwarz (1996) underscores the typical nursing home settings with private spaces that are not really private and public areas that do not encourage fulfilling human social interaction. The environment at Wisteria Lane encourages the residents to engage in passive sleeping or sit and do nothing. The nurse's station is the focus and the TV in this area is watched by the nurses. It is generally assumed that the goal of this design is to foster interaction s or purposeful action. However, from early childhood, Americans are expected to be unique individuals in society. *Yet nursing home, residents are expected to "socialize" with each other in spite of the fact that they may share little besides their age and impairments* (Schwarz, 1996:104).

The comparisons of the physical buildings help to understand the milieu and how the buildings influence the care workers ability to provide care for the residents. The following section describes the overall physical appearances of the buildings, care workers and residents. A short summary highlights the consistencies and inconsistencies.

Appearances of the buildings, care workers and residents

At Canada's South Park Manor the exterior and interior appearances of the physical environment appear to not be considered important. This is reflected in the clutter and lack of space that results in the multiple uses of rooms decreasing privacy. However, the building is clean. In line with the building, the PSWs attire is casual comfortable with

miss-matched scrub tops and bottoms with tennis shoes. They have their hair pulled back out of their faces, and no extreme make-up or nail polish with similar appearances. There are several PSWs with small tattoos that are supposed to be covered while working. My corporate contact tattoo is visible one day and several comments are made about this by the PSWs. The only watches are pinned to their tops and not worn around the wrist for sanitary reasons. Mobile phones are not allowed while working and the PSWs took this seriously and honoured the rule.

The residents' appearances at South Park Manor are also apparently not considered important, consistent with the facade of the building and PSWs. All of the residents on the 2nd floor go down to the 1st floor for meals, activities and have access to the outdoor garden. They are dressed in casual comfortable clothing although I do not see many residents wearing jewellery. The residents have just the essentials in their rooms with a few pictures and occasionally a favourite chair. The residents on the 3rd floor are more likely to be in night clothes during the day, have food on their clothes, and unshaven or not have their hair combed. These residents are more confused and not always ready for public presentation according to Goffman's (1963:26-27) descriptions of appearances in institutions.

Scotland's Shady Pines places tremendous emphasis on appearances and are considered important from the sign in the front of the building to the elegant pictures, mirrors and furniture and the staff room on the top floor. The matron takes great pride on impeccable appearances and is very strict about the building, staff and residents alike. She does not

allow the CAs to wear nail varnish and says it is for hygiene reasons. All of the CAs have to pull their hair back out of their faces and if it is not long enough it is pinned back. Just a few CAs have tattoos that are supposed to be covered but occasionally are not. Watches are pinned to their tops and not worn around the wrists. All of the employees have to wear uniforms that look alike according to their position, including the chef who wears an apron and hat.

There is a no mobile phone use policy while working on the floor and the majority of the CAs honour this rule and leave their phones in the break room. The residents are all up, clean, smartly dressed and out of their rooms. Many of the women have on their original wedding rings and personal jewellery and the men are dressed complete with hats and walking sticks. The CAs are very conscientious about making sure all the residents have on their glasses, hearing aids, and their faces and clothes are nice and clean. This is something I did not see at the other two fieldwork sites. Since appearances are extremely important to the matron a great deal of time is spent on the residents to make sure they 'look good'. Their clothes are changed during the day if food spills or they have an accident, provided there is sufficient staff. Tea time is strictly enforced and from my observations it fills long gaps of time between meals when the residents at other fieldwork sites have no interactions with staff or other residents.

In America at Wisteria Lane obvious attention is paid to details to make the building extremely appealing for visitors and families equally. The impeccably clean, tidy, interiors and manicured grounds provide an inviting curb appeal that is reflected from the street.

(A special procedure is even used to dispose of any soiled clothes, linens and incontinent products (depends) to minimise any unpleasant odours.) During the required one-hour monthly in-service training provided by the nursing home for the CNAs and other staff to maintain their certification, the manager stresses the importance of the 'curb appeal'. Although the residents and CNAs share the same building, the public or common spaces have more attention paid to them.

In contrast with the appearances of the physical environment from the curb are the physical appearances of the CNAs. There is a tendency to violate the rules on appearances specific to the African American CNAs. These CNAs take pride in unique appearances. Most of the younger CNAs have very unusual hairdos and colours, lengthy, false eye-lashes, and long fake decorated fingernails. The older CNAs are more likely to wear large hoop earrings and must sign an agreement to not hold the nursing home responsible if an earring is torn-out while at work. Several younger CNAs have exposed tattoos and piercings (tongue included) which in accordance with the nursing home rules are supposed to be covered or removed. Appearances are an on-going battle between the management and CNAs, but due to the high turnover in CNAs the management allows these violations.

The use of cell/mobile phones is not permitted while working on the floor but that rule is also frequently violated. It is very predictable to determine if CNAs have a phone with them (in a pocket) by whether or not they are wearing a wrist watch. Most CNAs have phones and use them regularly while working. They know where to stand to check messages or text and not be seen. Some CNAs are not concerned about who sees them

using phones while working. For example, during my observations, I watched a lead CNA feed three residents at a half-circle table while talking on her phone.

Very little emphasis is put on the residents' appearances. There are high rates of theft and the residents wear inexpensive clothing and costume jewellery. Wiener and Kaiser-Jones (1990:90) argue the loss of property from theft undermines any hope the residents have and this morally debilitates them knowing there is little regard to ownership of the few possessions remaining. Reflecting on the conditions of the workhouses Kayser-Jones (1990:130) claims that in contemporary American nursing homes, residents not only lose their possessions and many of their rights, in turn they are provided with minimal care. This is consistent with the inmate role described by Goffman (1961) in chapter 3. It is common knowledge in the USA and reiterated when residents move in to never take anything of value to the nursing home under any circumstances.

Care Workers Characteristics; the Shifts; and Staff to Residents' Ratios
Canada: South Park Manor: PSW characteristics

South Park Manor is gendered with predominantly women living and working there. About 2/3 of the PSWs participated in my research with a total of 17 and all but one is female. Many of the PSWs have close bonds of friendship with their co-workers consistent with the findings of Kontos et al. (2010:10). Most PSWs said they chose this kind of work because they love the residents, their co-workers, and find 'caring work' gratifying for them. South Park Manor is unionised like most nursing homes in Canada. There is little turnover for the PSW position and two have worked at this home for over 30 years. The

union dictates many daily operations such as breaks and mealtimes that are not always followed with the low staffing levels. Seniority is taken into account when making schedules and determines who is scheduled to work all shifts on their contract (Brannon et al. 2002). Being scheduled to work all of your shifts is significant because then the PSWs can plan their life around work. If they are not scheduled for all of their shifts, then it is highly likely that they will be called in to cover open shifts. It is apparent that when the PSWs are needed to work, they do. It is a priority to make the sacrifice and change your plans to avoid leaving a co-worker/friend alone to work rather than just getting more hours.

There is a constant air of feeling overwhelmed from the lack of being able to complete all of the resident's care, other tasks, all with a severe lack of supplies and equipment. Banerjee et al. (2012:395) and Armstrong et al. (2009:138) agree there are insufficient PSWs on a regular basis and Canada does not meet the standards established by experts. However the PSWs are the most stable department with the recent management turnover. In the absence of management to coordinate this large group of employees the PSWs have to make decisions beyond their job description (HPRAC, 2006).

South Park Manor: The shifts

Days: 6:00 am to 2:00 pm

Evenings: 2:00 pm to 10:00 pm

Nights: 10:00 pm to 6:00 am

The shifts are 8 hours for all departments except managers and nurses. The nurses (also called registered staff) change shifts one hour later. The Canadian PSWs work an 8 hour day in a shift but only get paid for 7 ½ hours. They get paid for two 15 minute breaks but not lunch or lunch and not the breaks. The difference between the numbers of shifts for a full-time or part-time contract is negotiated between the PSWs and union representative. Over-time consists of working more than 10 shifts in a two week period or 75 hours (with a few exceptions). Some PSWs are full-time with 8 shifts in a two week period and others are full-time with 10 shifts. Part-time is a contract with 4 to 7 shifts in a two week period.

There is a shortage of Registered Nurses in Canada and the RNs get paid for their breaks and lunch unlike PSWs. However, it is not uncommon to see the RN get called to the phone during these times because she also uses the same break room. The staff-to-resident ratios are not publicly posted at South Park Manor but they do post un-met needs. The Ministry of Health and Long-term Care (2006) set the regulations and un-met needs are posted as violations of these regulations. For example mobility devices, including wheelchairs, walkers and canes, must be available at all times to residents who need them on a short-term basis. Using staffing schedules I put the following information together. The PSW ratios are if the shift is fully staffed.

Canada: Staff to residents' ratios (57 Residents)

Shift	Registered Nurses	Personal Support Workers	Care Worker to Residents' Ratios
Days	1	6.5	1-10
Evenings	1	4.5	1-15
Nights	1	2	1-29

At South Park Manor, there is a short shift called a ½ shift in the early morning and then again during the evening which accounts for the .5 person on a shift. There are times that an extra PSW is called in because the daily care or baths are not completed. The day shifts start at 6:00 am but morning care starts as soon as the PSWs can the needed supplies for the process.

Scotland: Shady Pines: CA characteristics

In Scotland at Shady Pines about 3/4 of the CAs participated in my research with a total of 15 CAs and all but one was female. The overall projected attitude is that the CAs are happy to be there and do what they do. This presentation follows suit with all of the other appearances and impression management mandated by the matron consistent with Goffman (1959). Most of the senior care workers are older and said they chose this work because they love the residents and find gratification in care work. Shady Pines is the only nursing home in my research to have a full-time training coordinator to arrange needed

training for CAs. This results in a large number of young CAs with no qualifications and a few older senior care workers. The other CAs are single with no children or have partners with no children. Only one CA has a child under 8 and works full-time. The senior care workers are primarily married or widowed and have grown children that no longer live at home.

Shady Pines: The shifts

Day shift: 8:00 am to 2:30/3:00 pm

Long shift: 8:00 am to 9:00 pm

Back shift: 2:30 pm to 9:00 pm

Night shift: 9:00 pm to 8:00 am

Some CAs work 8:00 am to 9:00 pm 3 days a week on the long shift. This shift typically covers someone off on the morning or on the back shift and is worked by CAs that contracted to work for a higher number of hours. On the other shifts, the CAs get every other weekend off with 7 days on and 2 off, then 3 days on and 2 off. They do not have a time clock to clock-in-and-out. According to the matron unless you only have one entry and exit and strictly monitor it, time clocks do not work.

After 3 months, a CA in Scotland can be offered a full-time contract that ranges from 30 hours up to 48 hours per week, and then several standard government benefits come into effect. One benefit unique for Scotland is home doctors' visits. If the doctor is called in the morning, they made a house visit that day depending on where you live (at other fieldwork

sites the residents had to be taken to the doctor). This applies to residents in nursing homes *and* CAs. Then, the chemist (pharmacist) comes to pick up the written prescriptions, fills and delivers the medication. This process took place on a couple of occasions during fieldwork.

Scotland: Staff to residents' ratios (37 Residents)

The ratios are displayed along with the Certificate of Registration in the foyer.

Shift	Registered Nurses	Care Assistants	Care Worker to Residents' Ratios
Days	2	7	1-5
Back	1	6	1-6
Nights	1	2	1-18

There are three teams all led by senior care workers. On some days a CA called a 'floater' works between the teams as needed. The CAs said the work is more 'physically back breaking' when assigned more physically dependent residents.

The USA: Wisteria Lane: CNA characteristics

A great deal of ambiguity surrounds the title and role of certified nurse's aides (CNA) consistent with (McKenna et al. 2004). The CNAs responsibility is to assist the residents. Therefore using the term nurse (even as assistants or aides) is misleading. The nurses are

ultimately responsible for supervising the CNAs. In an ideal situation nurses would manage 'teams' but from my observations, interventions from nurses are for 'damage control'. Follow-up of a CNAs work is typically in response to a task not completed correctly, executed without good communication or with a bad attitude.

At Wisteria Lane my research sample consisted of 27 female CNAs. The only male CNA works part-time. The majority of CNAs have children but are single, divorced, or separated, a few married and a couple are widowed, in that order. Most of these women have several children or are raising grandchildren or other family's children. According to my findings and Bishop et al. (2008) family responsibilities may add more stress to an already stressful work situation. The CNAs responses on their interviews reveal the marginal role that men occupy in their lives. When they speak of family support it is always about females such as their mother, grandmothers, aunts, sisters and girlfriends. Over half of the CNAs are African American although the national average is 30 percent (Paraprofessional Health Institute, 2011). These women frequently mention doing hair as discussed in chapter 2 in the literature review. Doing hair is a form of bartering or exchange, care and affection, especially with their daughters, female friends and some residents (Foner, 1995b). Dodson and Schmalzbauer's (2005) research underscores how women in poverty hide extra income and commonly barter for services.

Wisteria Lane: The shifts

Monday – Friday

Morning shift:	6:00 am - 2:00 pm
Evening shift:	2:00 pm - 10:00 pm
Night shift:	10:00 pm - 6:00 am (4 days on 2 days off)
Double weekend	6:00 am - 10:00 pm (Saturday and Sunday)

Registered Nurses (RNs) that only work 32 hours a week are considered full-time and get paid for 40 hours. If a nurse only works the two 16 hour double weekend shifts they are paid as a full-time nurse (40 hours a week) with benefits but the same *does not* apply for CNAs. There is a shortage of nurses and this is a standard but unspoken way of attracting nurses, especially for the odd, long double weekend shift. According to Twigg (2000b:390) in nursing, the higher you go up the ladder with titles, status, pay and education, the more you move away from dirty work to clean work using charts, high-tech machines and skilled interventions. At Wisteria Lane, the CNAs do not qualify for the 32 hour work week with benefits as full-time and neither do the Certified Medication Aides (CMAs). The CMA position is only approved in some States and their primary role is to give most medications and some treatments freeing up the LVNs to provide more skilled care, again consistent with Twigg (2000a).

Throughout the week Monday through Friday, the shifts for the nurses and CNAs are broken down into eight hour shifts. The night shift is worked in eight hour shifts with 4 days on and 2 days off. Several CNAs work two jobs. Some work a regular week day job

and then the 16 hour double weekend shift, or from 2:00 to 10:00 pm at one nursing home and then 10:00 pm to 6:00 am at another. It is not uncommon for some CNAs to work shifts back to back at two different nursing homes and say they have been on their feet for over 10 hours. However, when interviewing the CNAs they always know where the empty rooms are located so they could sit for a minute to answer research questions. There is no enforcement of the two 15 minute breaks or the 30 minute lunch times at Wisteria Lane.

The USA: Staff to residents' ratios (124 Residents)

The ratios are displayed along with the nursing home License and Registration in the foyer.

Shift	Registered Nurses	Certified Nurse Aides	Care Worker to Residents' Ratios
Days	1	10	1-10
Evenings	1	12	1-12
Nights	0	6	1-21

The following comparison is for care workers only in each country according to the shift, although the times of the shifts varied slightly.

Staff to residents' ratios by country

Shift	[Canada] PSWs to Residents	[Scotland] CAs to Residents	[USA] CNAs to Residents
AM	1-10	1-5	1-10
Afternoon	1-15	1-6	1-12
PM	1-29	1-18	1-21

In Canada, at South Park Manor, it is a struggle to meet the staffing ratios and they are not always fully staffed. As Banerjee et al. (2012:395) argue insufficient staffing is standard practice in Canada. When South Park Manor was fully staffed (according to the nursing home standards not the provincial standards) it is through a regular negotiation process akin to begging that usually takes place in the break room at the end of a shift once someone realises a co-worker is working a shift alone. Even if a shift is fully staffed there are never enough PSWs to provide basic resident care. From my observations the routine at South Park Manor in Canada is not as rigid as in Scotland or as chaotic as the USA appeared.

Shady Pines is the only place where the CAs have scheduled breaks for tea time and lunch that are consistent, predictable and enforced. During my fieldwork on a couple of occasions the staffing standards were not met because CAs phoned in sick and the matron refuses to use bank or agency staff[13]. In contrast with Shady Pines, nursing homes in

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[13] Bank and agency staff are trained care assistants employed by a company available for temporary work to fill in if a care home does not meet their staffing requirements.

Canada and the USA, work without sufficient care workers is a regular occurrence. In fact, it is more common to not meet the staffing requirements than have adequate numbers of care workers to meet the staffing regulations.

The Care Workers Knowledge of Dementia

There is a general consensus from the managers and care workers that the majority of residents have some form of dementia (discussed in chapter 3) and are not able to care for themselves or live independently. Approximately two-thirds of the residents have some form of dementia and this is reflected across Canada, the UK, and the USA (Nicholson and Hockley, 2011). Recognising that the majority of residents in nursing homes have some form of dementia, I wanted to know if the care workers could define dementia or have basic understandings of dementia. In Canada the proportion of PSWs that gave me an accurate definition of dementia, illustrating basic knowledge, is split about half and half out of my sample of 17 PSWs. Their definitions are either short and simple or detailed like the quote below from respondent # 14 in Canada:

> *Neurologically it's like a spider web that takes over various parts of the brain. It depends on the type of dementia. It can attack the memory first or the frontal lobes and when it gets to your pituitary gland that controls all of your organs, it will just be a matter of time after that (C #14).*

In Scotland the majority of the CAs gave me an accurate definition consisting of a couple of sentences that are very similar to the new care standard definitions (The Scottish Government, 2011). However, when inquiring about how they will respond to hypothetical questions a person with dementia might ask, it appears as if the CAs have memorised a definition but lack the ability to process the information and put it into practice. There is a high ratio of young CAs who had not worked in nursing homes long and will be discussed further in chapter 9.

Only a few of the CNAs at Wisteria Lane gave me an accurate definition of dementia that consisted of more than a couple of words such as: *"Confusion"* or *"Confused…ain't it"*? Respondent # 7 in the USA:

> *Demention, like them bein confused and all that, you know, like a*
>
> *step away from Altimers (USA #7).*

The CNAs often looked at me for confirmation to see if their answers are correct or not. This reflected a lack of understanding of dementia knowledge although most of the residents have some form of cognitive impairment. Overall, comparing the care workers at each fieldwork site reveals vast differences in their descriptions and understandings of dementia. This information is significant knowing that most of the residents have some form of dementia and is typically what brings people to nursing homes.

Summary

Chapter 6 provides important contextual information intended to set the scene for the subsequent analysis chapters. The images presented focus on various aspects of appearances of the buildings, the care workers general appearances (mode of dress or clothing, watches around their wrist or pinned to their tops or the mobile phone in a pocket, hair, exposed tattoos or piercings, and their fingernails length, decorations, and with or without nail varnish), and the residents, to explore similarities and differences of each setting. The break rooms are scrutinised to underscore appearances in contrast to the overall buildings. The purposes of the break rooms are established to reveal how the discourses symbolically reflect the distinctions between the general staff and management. For example, the management may be appalled with the discussion of bowel movements or dirty work while eating, but these topics are normalised by care workers and everyday work. The management nevertheless, do not share break rooms, meals, or toilets with the general staff and use rooms allocated for other purposes to share their meals. In contrast to the break rooms, the designated smoking area for all employees who smoke are cooperatively shared by all staff in general and management. Smoking is the only common activity that these two distinct groups participate voluntarily. From my observations the area and activity diminishes the hierarchy management structures typical in nursing homes.

The functional capacity of each building is accentuated to demonstrate the importance of the physical arrangements and design to serve as communal living settings especially for people with high cognitive and physical needs. The descriptions sequentially reflected

significant features in each setting. In Canada at South Park Manor, the accomplishment of basic resident care holds precedence over impression management or presentations. In contrast, in Scotland at Shady Pines impression management is a high priority. This is evident from the meticulously manicured gardens and building to the residents and all of the workers in tidy uniforms. In the USA at Wisteria Lane the appearances are full of contradictions and the comparisons accentuate this. The impression of Wisteria Lane from the street is projected from the manager's ideal image based on the building's curb appeal, while the CNAs push the limit to the extreme in the presentation of self.

The personal appearances of the residents ***do not*** address comfort in any of the settings. These places are 'home' to residents with high levels of cognitive and physical care and in need of continual support. The presentations of the residents are the result from care practices and for reasons other than personal preferences, choice or dignity. The importance of appearances, interactions, meanings and negotiations demonstrate the relevance of using Goffman's (1959; 1961; 1963) symbolic interactionism perspective as a good fit for this research.

The care workers' appearances vary more across the settings than any other feature discussed in this chapter. The Canadian PSWs are dressed to take care of basic resident care given the low staffing ratios and their appearances reflected that. The Scottish CAs appearances looked very professional and are the only nursing home in this research that provides training for CAs on-site. Wisteria Lane is always desperate to fill the open CNA positions and willing to allow CNAs to violate the nursing home rules on 'presentation of

self' as long as the CNAs are certified and pass a back-ground check. Chapter 9 will explore care worker characteristics further and other features that varied for this group as a workforce by country.

The overall comparisons of the 'staff to residents' ratios by country' are presented to emphasise the differences between the countries. Last, dementia knowledge is considered to highlight the tremendous variations among care workers. These comparisons will help to contextualise my findings in the following analysis chapters that relate to the care workers' experiences and perceptions and furthermore answer my research questions.

In chapter 7, I will focus on multiple aspects of care in nursing homes using a comparative framework. The characteristics considered are central to care i.e. routines, the organisation of care, delivery of care, and the implications that these have on the care workers and residents. Then I will explore working by unwritten rules at each fieldwork site. The aim is to highlight the influences that these various features have on the work conditions and to demonstrate how they shape the experiences and perceptions of work for the care workers and impact the outcomes for the residents.

Chapter 7: The Delivery of Care

The aim of this chapter is to blend the research literature and care worker contributions to the research process from fieldwork to answer the research questions 1) what are care workers' experiences and perceptions of care; and 2) how do the organisational characteristics influence the delivery of care in these settings?

Negotiating Care Work

Institutionalised nursing home characteristics according to Gubrium (1997) collectively create environments that force on-going interactions between the care workers and residents under specific policies, rules and regulations. Within these interactions were daily complex work activities and care tasks to be completed that lingered in the gaps between management imperatives and resident's care needs. There was continual mediation between trying to accomplish and make sense of the governing regulations, make these regulations liveable for residents and achievable for the care workers. This required constant negotiation in an attempt to bridge the external controls, to meet the everyday obligations for the residents and provide manageable work conditions for the care workers (Casper and O'Rourke, 2008; Nolan et al. 2008; Pfefferle and Weinberg, 2008).

As Shields (1995:124) remarked:

> *The nursing home is an intriguing landscape in which ethical dilemmas find fertile soil. Conflicts are played out between the nursing home as 'quasi-hospital' and as a 'home'. The autonomy of the individual is pitted at times against powerful staff members, concerned family members, and the constraints of a bureaucratic institution (Shields, 1995:124).*

Consistent with my findings, Tinney (2008:202) described the ambiguities in the role of institutions that were created and maintained as both a home and a place of physical care and protection. The contradictions inherent in the concept of batch living outlined in chapter 3 by Goffman (1961) accurately reflect this notion. This care worker contends:

> *There's never enough staff to meet their [the residents] needs. You can call it their home if you want....... but it isn't. They don't choose to come here (USA #15)*[14].

The nursing homes in this research were steeped with contradictions and these produced stressful work conditions for the care workers. Foner (1995b:1) maintains there were high expectations that care workers provide compassionate and supportive care. However from

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[14] The quotes in this chapter are depicted by the country letters i.e. (C) Canada; (S) Scotland; and (USA) United States of America, and the care worker's corresponding number in my sample from each fieldwork site for anonymity.

my observations there were significant structural forces that impeded that kind of care. Emphasising the contradictions a care worker stated:

There is false advertisement in the brochures. If I don't want to be here you don't have to give a damn and if you're short staffed you don't have time to give that kind of care (USA #21).

Managers often had one idea of residents care and the care workers had another. The managers were often detached from the care worker's needs and this could make or break the home's reputation. Care workers faced daily pressure to complete care tasks within a set of externally imposed regulations. This created on going dilemmas for the care workers as they had to negotiate the tension between the level of care they knew was possible and the kind of care they were able to provide.

Consistent Findings from the Literature Review

This analysis was based on three characteristics identified in the literature review that were consistent across the countries in this study. The nursing homes in my research were:

- institutionalised;
- dominated by for-profit ownership;
- providing care for a similar resident population with high physical and cognitive needs.

Using a symbolic interactionist perspective, these combined factors altered the situation for all involved. Reframing the nursing home as institutionalised modified the experiences, interactions and outcomes for everyone. Recognising the nursing homes as dominated by for-profit ownership provided a better understanding for care workers' perceptions of the circumstances around inadequate staff, time and resources discussed in chapter 3 by Comondore et al. (2009) and Armstrong et al. (2009). These features changed the expectations and interactions for the residents with high cognitive and physical needs. This contributed to various relational aspects that were significant components that could enhance the care workers well-being. The outcome of the altered perceptions, expectations and interactions combined resulted in both positive encounters that contributed to forming relationships and negative exchanges that provided justifications, excuses or barriers to forging bonds.

The result of these shared characteristics often produced powerful forms of institutional disgrace. Yet within these arrangements the meanings attached to the work constructed a curious mix of devalued and rewarding outcomes. The nursing homes remained stigmatised as one of the least prestigious places of employment established in the literature review. Moreover, the services care that the workers provided were often taken-for-granted and rarely recognised as genuine caring work (Innes, 2009). Several care workers demonstrate how they refused to allow the degraded work affect them by noting:

It would be nice for people to know that we are not just butt wipers

(C #9).

Carers are under rated on how difficult their job actually is. It
should be higher thought of because not everybody can be a carer at
the end of the day (S #15).

People don't realise that we are just not wiping asses but we are
disrespected because we wipe peoples' asses (USA #21).

However, these examples reveal how some care workers feel about the work they provide and the reactions they experienced from other people. The low status of care work and how it was viewed in each society existed regardless of the complexities within the gratifying and/or demoralised work.

Daily routines in the nursing home

> - *Just going through the motions because we don't have the time (USA # 18).*

Daily dilemmas for care workers included unrealistic expectations from the managers as the norm, and were magnified by the regimented rules and organisation of care (Karantzas et al. 2012; Dill et al. 2013). A common characteristic of institutionalised nursing homes was the strict obedience and compliance to the rules in line with Goffman's (1961) notion of binary management (Gubrium, 1997; Casper and O'Rourke, 2008). Furthermore, care work in task oriented routines frequently ignores the residents' preferences, choices and rights (Tinney, 2008). Bowes et al. (2010:26) findings provided support for my own results noting that when the care workers were asked to describe a typical day the routines tend to revolve around care tasks. Social interactions or special events were absent in the participants' responses. Exploring a typical day at each fieldwork site revealed daily routines that revolve around basic care tasks. Out of the 59 care workers in my sample, only one mentioned any special activity, event, or plans other than basic physical care and medical needs. The following care worker made it very clear that her daily goal included an additional responsibility that she viewed as necessary given the circumstances:

> *I check residents on the hall gather up everything and for the next two hours, its showers ....but, they gotta get a good morning laugh. I always joke with the residents and get a smile, then 'turn and dry' [turn and change the incontinent bed-bound residents] as I go and make beds (USA #26).*

Overall, there was tremendous pressure to complete care tasks within strictly enforced time constraints. The most predictable communal activity was eating (noted in chapter 5). The residents made three trips each day to dine in pre-determined locations. However, getting the residents up, dressed and ready for breakfast required the most extensive preparations. Regardless of whether this began at 6:00 am, 6:30 am or 8:00 am the routines shared strong similarities across the fieldwork sites. When asked to describe a typical day the following responses were common and demonstrated how the routine was focused around care tasks.

> *It is hectic because every day is a new day. You have to re-organise to see who is going out to an appointment, who has bowel care, palliative care, sick, going for tests – CAT scans and so on (C #2).*

> *We don't always have time to do it all because everything is like go-go-go all of the time and in the morning I would like to sit and talk to the residents but we have deadlines (S #14).*

> *I shower someone early before time to clock-in, it saves time. On M-W-F there's three and T-Th there's two. Then clock-in and get other people up, make sure bed-bound are changed, get everyone down for breakfast – it just goes from there. I'm goin from the time I get here until I go (USA #5).*

The last quote adds a new dimension to what Pfefferle and Weinberg (2008) argue were extra responsibilities taken on to simply complete the required resident care. This specific CNA was recently widowed and her familiar nurturing skills provided intrinsic gratification that she shared in her interviews. She came to work early every morning to give two or three showers (depending on the day) before clocking in. This allowed her extra time to provide just the basic physical care that she viewed as so important for the residents. The routines of care were steeped in contradictions and ambiguities that produced stressful work conditions for the care workers. Consistent with Willcocks et al. (1987), when care workers were asked to describe a normal day the focal point was on care tasks. Furthermore, Twigg (2000a) elucidates that care routines revolved around a privileged body instead of a whole person, while ignoring the potential daily pleasures for the residents. The following care workers responded with similar observations:

> *The type of residents we have now are really confused, frail and agitated. They need lots of care and we just don't have the staff for that (C #1).*

> *We would like to spend more time with one resident – if they are agitated and need a shave you would like to spend more time rather than hurrying up. When you're short staffed it is a no (S #1)!*

The residents have more confusion and everything takes longer. We aren't meeting their needs. If I have 12-16 residents and we're short there's no way anyone can provide care (USA #19).

These care worker quotes demonstrate the high levels of resident care needs combined with the low staffing ratios. When these features were disregarded the outcomes were resident agitation, care worker injury, frustrating interactions for both parties, and ultimately the resident's care needs were often not met. Basic ADL care was a priority leaving the simple pleasures that were rewarding for the care workers and residents alike absent from the quintessential responsibilities and experiences. From my observations the care workers appeared to struggle with managing highly agitated residents and those in distress.

The continuum

The '*continuum of care workers engagement*' outlined at the end of chapter 5 on Table 8 was used to make links in chapters 7 and 8 with my data in the analysis and the resultant findings. The continuum as an analytical tool provided insightful differences between the care workers based on observations while interacting with the residents during meals. The behaviours observed were intended to reflect the care workers body language and eye contact with the residents. The care workers were located along a continuum identified as engaged or 'being with' the residents in contrast to those who were disengaged or 'doing

to' the residents during the observations. This process was not meant to judge a care worker as good or bad but to help link my observations, interviews, and fieldwork notes.

Working without adequate staff

> - *Imagine changing somebody's clothes in one minute (C #13).*

Wardhaugh and Wilding's (1993:19) description of managers who would often 'turn a blind eye' to working with inadequate staff as long as the outward appearance was one of a smooth running facility perpetuated this practice. Furthermore, these findings were consistent with Bishop et al. (2009) who found that care was frequently rushed or neglected because of decisions that were beyond the care workers control. Without adequate staffing levels, the residents basic physical care needs were only partially met. The following care workers stated:

> *We need more staff. When we're short – which is daily – we already need more time and when you're short it is that much harder (C # 12).*

> *Bad care happens here but it shouldn't. I've seen a lot, most was due to neglect. I was going to leave. These are humans and they deserve to be looked after (S #11).*

Our residents are broken down in so many ways. We can't meet the

resident's needs, too many things get missed and the turnover is

high (USA # 19.)

The lack of time impacted relationships, team work and quality of care. My findings were supported by the work of Gass (2004), Jonas-Simpson et al. (2006), and Ball et al. (2009). Pfefferle and Weinberg (2008) maintain that each day care workers were faced with the competing demands of higher resident care needs and chronic understaffing. This meant that the care workers would be doing both their job and someone else's job too. Bishop et al. (2009) assert that in some cases necessary care tasks might not be completed.

Death

- *This is the last place the residents go before they die (C #14).*

It was established in the research literature that nursing homes were stigmatised and often associated with death. From this negative perspective, nursing homes are considered as a place where people go to die (Gustafson, 1972; Laslett, 1991; Gamliel and Hazan, 2006; Whitaker, 2010). Furthermore, Gubrium (1997) regarded the nursing home as a social arena for identity re-construction from a symbolic interaction perspective. The residents were confronted with the loss of their personal identity commonly ensued in their last stop. Facing imminent death created symbolic bridges between the resident's former self and past experiences with their current position in the collective life as a resident. This links back to the discussion in chapter 3 and the notion of how the impending death of the

resident changed the circumstances. This influences motives central to establishing relationships for those providing care. The care workers had to continually make decisions or balance how much vulnerability they were willing to expend emotionally for the different residents acknowledging their impending death. Each care worker experience the death of a resident differently underscoring that meaning is constructed through interactions. The care worker's differing perceptions reaffirm the appropriateness of symbolic interaction for this research across and within the various contexts. Some of the care workers revealed that being with the residents through the experience of death was rewarding. In contrast others expressed that the experience of death of a residents very difficult. The care worker quotes in the next two sections demonstrate the diverse perspectives of a resident's death.

Rewarding experiences

Our palliative care program is new and we're all just learning, but it makes sense. I've been a PWS for over 20 years and this is how it's meant to be … rewarding comfort care, being there with them [the residents] even if you just hold their hand (C #6).

I think the way I look at it is when someone is on palliative care you're there for them [the residents] and it is the most rewarding to care for those when they pass over (S #2).

This is their [the residents] last stop. I get attached to the residents

and they are not here forever, I find that rewarding (USA #25).

Protective strategies

I don't cope well with work emotionally, especially when a resident dies. I'd

rather be doing something else and let those who want to deal with that do

it! We all have our strengths and being around people dying is not mine (C #

10).

The work is more emotionally challenging than they tell you so sometimes I

just switch it off because it's too much to manage (S #4).

We deal with so many emotions here and no one seems to care. There are

days I just go through the motions to get by, then, before I know it my shift is

over and I'm out of here (USA #15).

The first group of quotes demonstrate the care workers who viewed being an active part of the death process with a resident as rewarding and used terms such as 'being with' and 'being there'. These care workers were located on the engaged end on the continuum compared with those who wanted to avoid any experience of death. The care workers who described protective strategies used terms such as 'doing to'. Moreover the care workers that considered a resident's death as an experience to avoid used protective barriers that

included staying away from the area. These protective barriers were comprised of most of the additional tasks that the care workers questioned as a part of resident care discussed in the subsequent section.

Throughout the interviews, the care workers repeatedly spoke about additional responsibilities that they did not consider as resident care. Cangiano et al. (2009:129) found that the care workers perceived these tasks a taking away from the limited time to provide resident care. The extra responsibilities identified by the care workers ranged from searching and gathering supplies, serving meals or tea, transporting the residents to different locations and doctors' appointments outside the facility, putting away clean laundry, various house-work chores such as cleaning the residents' rooms, and washing equipment that included wheelchairs. These additional duties were categorised by care workers as responsibilities that-increased their levels of stress and took away valuable time available for resident care. The care workers that expressed being an active part of a resident's death as rewarding viewed these chores as barriers to relational features and wanted more time with the residents. However, for the care workers that viewed the experience of a resident's death as difficult and emotionally challenging these activities offered protective barriers.

Lack of supplies and equipment

– You're rushing away and daft because you don't have what you need (S #2).

Across the fieldwork sites, even if a shift was fully staffed the extra tasks, high residents care needs and an on-going lack of supplies and equipment meant that there was little time to provide adequate care. The following quotes depict how the issues applied to all three settings.

We don't have enough face cloths and we have to gather supplies when we need to be providing care. There should be more supplies – you spend too much time looking for supplies and that's wasted time (C #3)!

We were kind of crabbit – going off our heads because we were short on towels this morning which I feel is not right and couldn't get them [the residents] cleaned (S #12).

If you don't get it early you will never be able to get all of your supplies…. which is sometimes a fantasy. It's almost like a treasure hunt (USA #3).

When the care workers were not given adequate supplies to provide resident care it was beyond the care workers realm of responsibility. Searching and gathering supplies for daily care was just another unnecessary chore. A couple of care workers said the lack of supplies was such a problem that they confessed to hiding certain items such as towels and sheets so when they arrived for work the next day, they were able to start work. Hiding supplies would temporarily alleviate the need to search for the limited necessities required to do their work. Therefore, in the USA, Bishop et al. (2009:621) findings support previous studies that underscore the importance of work conditions that provide enough time for CNAs to do their work, good relationships with supervisors and being respected and valued by the organization. Squillace et al. (2009:196) investigated the lack of equipment, and training and identified a correlation between the care workers ability to manage resident's behaviours. Mercer et al. (1993:104) established that insufficient supplies i.e. diapers, pads, towels, bed linens, and lack of time hinder the care workers ability to complete their work. Weiner and Kasyer-Jones (1990:95) reported the CNAs were dispirited by the un-predictability and short staffing. They were denied any sense of working on a health care team and restricted by the limited resources that included Vaseline and mineral oil, and not having enough sheets and towels.

In Canada, Banerjee et al. (2012:395-396) highlighted the lack of resources, such as incontinence products, that obstruct the care workers ability to provide the level of care the residents need. Furthermore, the consequences of not being able to provide such care for the residents, was detrimental to the care workers physical, mental, and emotional health. The Canadian focused COMPAS study by Bourgeault et al. (2009:7) found a general lack

of attention to the shortage of staff, supplies and dignity for the older adult care sector. Casper and O'Rourke (2008:S256) established that access to resources, timely information and support increases efficiency and that allowed more staff and time for the residents to have a choice in care preferences.

Innes et al. (2006:45-46) reported that many services were budget led rather than needs led and the lack of resources severely limited the efficacy for care workers. Time was identified as a limited resource that restricted the care workers ability to provide good care and support hindered their ability to provide quality care. In the UK, most recently, the UK PANICOA summary report (Lupton and Croft-White, 2013a:6) revealed that care workers were frequently frustrated in their efforts to provide good care as the result of limitations on time, resources, and the physical environment.

Rushing though care in task oriented routines

> *– No tub-bath today there's no time (C #1).*

According to Mercer et al. (1993) and Henderson (1995) additional care requirements also included the resident's psychosocial and emotional needs. These needs were often more time consuming than other aspects of care such as choice and dignity. Consistent with Daly and Szebehely (2012:145), many care workers did not want to rush through care because they wanted time to talk and listen to the residents. The care workers expressed these frustrations:

Going in and telling them [the residents] you will be right back and you can't or don't for 20 minutes or when they come up and want to talk and you have to say you don't have the time (C #16).

You don't have time to chat with them [the residents] and if they ask you to get a tissue someone else might need something else and you can't do it all (S #6).

You can't spend time with each person [resident]. There is just time to get the basics done. That means we miss combing their hair, touching them, talking to them or reading them letters, all of the things they need (USA #16).

The rushed nature of caring for older people in the context of inadequate staffing was viewed as preventing care workers from meeting basic resident care need. This included minimum standards of personal care (Cangiano et al. 2009:129). The current conditions negatively affected both the care workers and residents alike (Armstrong et al. 2009:109). The results were frustrating for the care workers as they were allowed few opportunities to become familiar with or support the residents' personal preferences such as social, emotional and spiritual needs.

The care workers become the resident's social world

> *- We are the only people they see for days (S# 12).*

Once residents enter nursing homes they become socially and physically isolated from the outside world (Tellis-Nayak and Tellis-Nayak, 1989; Tinney, 2008). Tellis-Nayak and Tellis-Nayak (1989:134) acknowledge that for the most part, care workers were the social world for the residents. This illustrates Goffman's (1961) view of the institutional perspective. The care workers become the resident's primary social world making *these* interactions some of the most significant for the residents. These interactions had the potential to enhance, enrich, benefit, and improve resident outcomes. On the other hand, the interactions can damage, mortify, or harm the experience for both the residents and care workers. Armstrong et al. (2009) and Banerjee et al. (2012) argue that nursing homes, dominated by for-profit ownership were known for not providing sufficient resources and supplies. There was frequently inadequate time and necessary resources to provide care for the residents according to the care standards. This included employing enough care workers to provide for the residents with high levels of physical and cognitive care needs. It was within this context that I understood why Brooker et al. (2011) stated that the interactions between the care workers and residents were unintentionally harmed by institutional characteristics.

> *Some of them [the residents] haven't had a visitor in months. Their*
>
> *needs are so high and they don't see us till the next meal. They're so*
>
> *lonely (C #3).*

We don't have time to care, like we have to cut corners and the residents are the ones who get neglected. Some days they sit for hours without any one talking to them (S #7).

No one comes to visit these people so we are their family. They go for hours without interacting with anyone (USA #17).

The importance of positive interactions, relational features and the lack of time links back to chapters 2 and 3, and demonstrate how these characteristics influence the delivery of care. Many residents were excluded from the social worlds around them because they cannot provide cues that others look for to determine their awareness. Our concept of self is shaped through our social interactions and it is through these interactions that people establish and maintain their identity (Goffman, 1963). Innes (2009) recognises that these residents were frequently deprived of opportunities for meaningful interactions which helped to define self and nurture relational aspects. These interactions were critical for the care workers and residents alike. The care workers that said they do not have the time to give the care they want reflected more than just doing a task (doing to) and what they were assigned. In their narratives they spoke about insightful and perceptive characteristics using their reflexive practices to enrich care and relational features for the residents.

Working beyond skill levels

> − *75 percent you learn on the floor cuz they don't teach that in school (USA #17).*

The care worker job has evolved over time and can make or break the reputation of a nursing home (McKenna et al. 2004). Care workers were asked to carry out duties and take on responsibilities in health care without the skills or competencies (HPRAC, 2006). According to Innes et al. (2006:52) the training for care workers has not kept pace with the increasing care needs of the residents. Nicholson and Hockley (2011:105) argue that nursing home managers were expected to provide the necessary staffing levels according to resident care needs. Yet, the staffing ratios have remained the same despite the increasing dependency levels. Furthermore, Kelly (2013:2) maintains that nursing homes admit more frail residents with complex needs including dementia. Older adults often delay admission to nursing homes which increased the chances for acute health conditions. As a result, the residents were more vulnerable to poor health and quality of life outcomes as a result of the transition. According to Toles et al. (2013:78-79) newly admitted residents were dependent on their caregivers for three or more ADLs, had six or more chronic health conditions and cognitive issues. Wiener and Kayser-Jones (1990:93) found similar findings over 20 years ago that revealed residents in nursing homes had reached a point with their chronic conditions needing partial or complete assistance. The residents were also urinary and/or bowel incontinent, and experienced high levels of cognitive impairments. This scenario depicts the resident's dependency levels that were consistent throughout the research literature and the care workers descriptions at all three fieldwork sites.

Moreover, according to the participants, across the countries, it was not uncommon for care workers to be asked to come in early, work late, cover an additional shift or work a half shift to simply complete basic resident care. The care workers continually reported the difficulties in meeting the current resident's high cognitive and physical needs, especially as people live longer. My findings were supported by Daly and Szebehely (2012) and the care workers who expressed a desire for more time to talk to the residents while providing care. They recurrently spoke about the tension between: ideal situations; what was expected; and what was realistic. The care workers were relentlessly called upon to do more than what was humanly possible. The following quotes exemplified their frustrations:

> *The government says we only need 6 minutes per person. These residents have too many needs (C #16).*

> *We just can't do everything the nurses should be doing. Sometimes it's a lick and a promise - a half-ass job and things get neglected (C #3).*

> *So many of these residents need more care than we can give. Even when we have training on a topic we can't do what the nurses do (S #9).*

> *I've been here for over 10 years. My Dad had dementia and was in a care home, so I have seen the changes. The resident's we have now are more confused and not able to get around (S # 8).*

These people [residents] need lots of care. Most of them come over to this side after they fail rehab and can't go back home. Their like hospital patients and we just can't take care of them (USA #11).

We can't meet the residents' needs. They're too sick and we are short and there is high turnover here (USA #12).

When there were shortages of care workers it was the literally those at the front lines who were expected to change, clean and dress a resident in 6 minutes, and complete additional tasks as fast as possible. It was not uncommon for care workers to push or pull 3 or 4 wheelchairs at one time to get everyone in their designated location for breakfast and then turn around and make or change dirty bed linens to meet the regulations. These circumstances along with higher cognitive and physical care needs of the current resident population required more medical treatments and bowel care that forced the care workers into situations they were not trained to manage. Most residents required specific care plans to manage their varying degrees of incontinence while others necessitated considerable supervision and assistance with daily care (NCQ LTC, 2007). The care workers reported at these times, they were restricted to simply doing their best.

Social care

> **-** *Sometimes we need to just hold their hand and listen, but we can't (C #3).*

Daly and Szebehely (2012:145) assert that care workers did not have time to provide minimum essential needs for the residents. Moreover, Cangiano et al. (2009:133) maintained that the conditions in which care was delivered, places demands on all care workers. These conditions underscore general issues of concern over the absence of social care. The manner that care was organised, only allowed time for basic physical necessities of care leaving the workers unable to provide or meet the resident's social care needs. In chapter 6 the half shifts discussed were often due to care responsibilities not being completed. On those occasions another care worker would be called in to work a half shift or stay an extra half shift to help finish basic ADL care. This occurred at all of my fieldwork sites but from my observations, it was more common in Canada at South Park Manor. The staffing standards in Canada were established by specialists and Armstrong et al. (2009:138) claimed that the number of care workers determined did not meet adequate resident care. Across the settings the care workers were not able to provide tasks commonly recognised as essential for survival and gave numerous examples such as:

> *We are not meeting their [the residents] other needs – intellectual*
>
> *stimulation, emotional and social needs (C #17).*

The residents have needs we can't meet. Some of them don't have family nearby and we can't take the place of their family. They're so lonely, and they need emotional care, and to use their brains and stay active (S # 3).

Most residents need more care than we can give - emotional, social, (and) mental. Sometimes they go weeks without a visitor. These people are lonely and bored (USA # 8).

Foner (1995b:58) reported that care workers were judged on their performance of tasks recorded in the medical charts while other tasks such as caring for the residents' psychosocial needs were missing. In a review of the literature in the UK, Killett et al. (2011:78) reported that measures utilised for health outcomes did not include any social care indicators or criteria. Armstrong et al. (2011:121) contends that the resident's basic physical care was not always completed and on those occasions social care was frequently ignored. Social care was also the first type of care to be eliminated without the necessary resources. The care workers knew better care was possible but not under the current circumstances. The care workers were not meeting the resident's needs and they were acutely aware of this. The care workers said on several occasions that not being able to complete their work was one of the most frustrating aspects of their job.

Working by Unwritten Rules

The separation of residents with dementia

The nursing homes at each fieldwork site were working by unwritten rules that included the separation of residents with dementia. The manner in which these unwritten rules were carried-out violated the human rights of the residents in relation to choice, dignity and standards of care guaranteed by each country. The criteria for the selection of fieldwork sites excluded nursing homes that had a designated location with special programming for people with dementia. So, I initially asked each manager if the residents with dementia were separated from other residents and they consistently said 'no'. However, after a short time it was apparent that was not the situation. The only nursing home to imply that residents with dementia were separated was Wisteria Lane where the manager said they had more people with dementia on The Terrace compared to The Gardens.

The unwritten rules will be discussed and outlined first in general before exploring each setting individually. This will allow me to give examples that were specific to particular settings. According to Wardhaugh and Wilding (1993:7) in the explanation of the corruption of care, once the residents were perceived as less than fully human, their actions were removed from the 'sphere of moral issues'. The corruption of care then paved the way for various treatments that were unacceptable for those not so stigmatised. The care workers were required to obey the rules of care for those separated and therefore this concept applies to care workers as well. McCabe (2011:155) supports this notion stating

that stigma was not only attached to individuals with dementia *but also to* institutions and people that provided care and services. Furthermore Wardhaugh and Wilding (1993:27) and Peace et al. (1997) argue that once a group of residents were regarded as having problematic behaviours they were placed in one area, out of sight of the general public. The following was observed at each fieldwork site. The residents with dementia were:

- separated from the other residents and placed out of view of the public eye;

- not given the choice to go outside;

- not given a choice of where they spent their day;

- not given a choice to go back to bed if they wanted;

- not given a choice in comfort and dignity;

- not provided with meaningful or engaging activities;

- placed in chairs that were used as a form of restraints;

- given bibs to protect their clothing during meals;

- not always taken to the toilet upon request which would often result in the resident becoming incontinent.

These characteristics link back to chapter 3 and Goffman's (1961) description of the inmate's role in institutions. Across the countries the residents shared strong similarities in reference to ignoring their choice, comfort, and dignity, although their appearances were mandated by the nursing home at each fieldwork site. The above list was all in violation of the residents' human rights as well as the care workers who were forced to comply and

work by these unwritten rules. Moreover, the care workers were not given adequate supplies to provide care for the residents in accordance with the care standards guaranteed to the residents in each country.

Canada: South Park Manor – working by unwritten rules

At South Park Manor, the residents on the 3rd floor stayed on the 3rd floor all day with few exceptions. This was where the people with dementia lived especially if they had challenging behaviours or wanted to get outside. These residents were very agitated most of the time. It was more convenient to keep the most confused residents separated and confined to the 3rd floor and out of sight from the common areas. This practice was preferred by the other residents who did not want to not observe or be around the residents with dementia, especially when agitated. The PSWs were more concerned with keeping the residents on the 3rd floor clean although the residents were more likely to be managed with some kind of restraint. As discussed in chapter 6, maintaining basic ADL care was a struggle with these residents and the PSWs stated the following:

> *There is so much to do on the 3rd floor with feeding the residents*
>
> *that we don't have the time to interact or make it social (C #2).*

> *I deal with it (working on the 3rd floor) by realizing that make*
>
> *believe is a beautiful world for them (C #12).*

The PSWs did not provide any planned activities that were meaningful or engaging for these residents other than turn on a TV. The PWSs did not appear to understand engaging people with dementia and always seemed too busy with the low staffing levels. There were few visitors and the only visitors during the month I spent at South Park Manor were surveyors and people in from the corporate office in dietary. The PSWs spent all of their time focused on task oriented ADL care. The care practices had been carried out in the same manner for years and the PSWs did not question the practices and simply got on with work.

I ignore a lot of the rules – to be good you have to (C #16).

These residents had relatively little choice in anything. The few clothes available were selected by the PSWs and changed when there was time. The residents were frequently not appropriately dressed for public presentation i.e. night clothes during the day, dirty clothes, no shoes, and clothing items put on inside out. Most of the men needed a shave. The determining factor in a tub-bath versus a shower on a toilet chair in a shower stall was made by the location of the only the mechanical lift to get the residents in and out of the bath tub. If the mechanical tub-lift was on the 3rd floor when needed the resident might be given a choice if there were sufficient PSWs working to take the extra time required for a bath. The residents' calls for help or assistance were regularly ignored.

For example, my field notes below demonstrate this point well. Field notes from July 2008:

> *A resident constantly yells when he was in his room with nothing to do. The staff would go in and place his wheel chair facing a blank wall. When I inquired about the situation, the staff were quick to tell me that this was a behaviour as if there was no intervention, again reinforcing the idea that the residents on the third floor have been written off as hopeless cases with no interventions. This resident repeatedly yelled throughout the day repeating similar phrases such as: Nurse, nurse, nurse or Jane, Jane, Jane or its 3:15; its 4:20; its 5:25 (Field notes 12-7-2008).*

The residents on the 3rd floor stayed on that floor because there was no way to get outside except through one elevator which required a key to use. This elevator was the primary source of transportation for the residents on the 2nd floor to get to and from the 1st floor for meals, activities and outside. The two stairwells had key pads that required a code to enter or exit. On the 3rd floor, the residents' views were rarely taken into account. The residents were not consulted about their care preferences, clothing, activity interests, and dining schedules. South Park Manor has tried to give the residents a choice of food by preparing two "show plates" with different foods, covered with plastic wrap so they could make choices. The process was very confusing for the residents on the 3rd floor because they thought the food was being offered to them, not a choice. When observing the show plate

process, the residents would grab at the plate, as if it was being offered. When the show plate was taken away most residents became very agitated until their plate was given to them.

> *There are some bad policies that are not really a reflection of care*
>
> *because we are doing what they say (C #2).*

To add to the confusion, there were two separate servings for meals because there was not room for all of residents on the 3rd floor to eat at one time. As part of the dining process (even those on the 2nd floor) residents were provided with bibs. Once the residents were 'bibbed' up a process described by Gubrium, (1997:134) then eating would begin.

When I enquired about a resident going outside on a nice day several PSWs responded in unison 'like we have time'? There were windows at the end of each hallway where the residents who wanted to go outside, would sit. The PSWs did open the windows at the end of the halls on nice days so the residents could get a breath of fresh air. Otherwise, the residents on the 3rd floor rarely went outside.

At South Park Manor the PSWs complained most about a regulation on briefs or continent products. The briefs were provided by the government yet the PSWs were only allocated four briefs a day per resident. This regulation was documented throughout the literature (Armstrong et al. 2011; Banerjee et al. 2012; Daly and Szebehely 2012). I did observe the brief allocation process and the PSWs bargaining for extra briefs when a resident had been

incontinent. The PSWs were not supposed to change a brief until it was 80 percent wet. An image on the front of the brief was visible that changed colours to indicate the level of saturation. Some PSWs said they would add water if needed but did not understand this regulation reflected by the following quotes:

The briefs – you only get one for the eight hour shift. The rule says you have to be literally dripping and changed colour. Some of the residents don't want this. They want it off. Sometimes we do violate the rule (C #1).

I don't agree with the 80 percent rule. I wouldn't do that to my grandparents, why should we do that to them? It causes harm. I change them more often. Don't use my name for that – I'll get fired (C #11).

The PSWs realised that once a resident was checked, if the brief was 50 percent wet, by the time the next shift checked on the residents, the brief would exceed the limit. In an attempt to save money on briefs, the process was costing valuable staff time and extra laundry. Therefore, the PSWs openly said they would violate the rule to reduce time, dignity and avoid an agitated resident.

Scotland: Shady Pines – working by unwritten rules

At Shady Pines, the matron said that all of the residents except 7 had some form of dementia and they did not separate residents according to their diagnosis or cognitive levels. The residents who were severely cognitively impaired were placed in a separate room out of view of the public or visitors. Any separation according to the matron was for dignity so that when the residents were 'assisted with feeding' others would not see. Later, I was told the separation was to avoid over-stimulation. The room was generally very quiet and where the most of the easily agitated and confused residents spent their days, away from the flow of activity and other people. Unfortunately for these residents, being placed in this room was where they spent *all* day, in one chair, and without any special programming except soft classical music played in the background.

The residents were not given a choice about where they sat or that they remained in that room all day. Meals were served in this room on trays and the residents were assisted with eating by CAs. The residents had no choice in the food selections for each meal. The meals were prepared in the kitchen and brought to the room covered on trays. The residents were provided with bibs or clothing protectors for meals. On a regular basis one resident would slowly manage to work his way out of his chair (on a low angled square frame) even with an additional restraint tied around his waist and chair. Then, he would scoot or shuffle on his bum across the corridor into the living room. The staff and other residents would walk around him as if he was invisible. This was a classic example of Kitwood's (1997) malignant social psychology and objectifying behaviours that ignore a person's presence.

The residents at Shady Pines did not have a choice about staying in bed during the day at any time, unless they were very ill. It was openly discussed that residents admitted to Shady Pines in a bed-bound condition would be rehabilitated to be able to sit-up in a chair during the day, dressed smartly and look good. The resident's labelled by the matron as late stage dementia were required to be up, dressed, out of their room and sitting in chairs ready for what Goffman (1959) called public presentation. Likewise Lee-Treweek (1994:2) defined this notion as 'lounge standard bodies'. Consistent with Lee-Treweek (1994:4) the matron agreed that care was judged by the state of the patient's body. The perception was: if the residents were all out and looked good then the care was good. This was an excellent example of impression management (Goffman, 1963) because so much emphasis was placed on appearances at Shady Pines, regardless of choice or comfort.

The layout of the building at Shady Pines was choppy as highlighted in chapter 6 and it was easier for staff to keep a watchful eye on residents if they were all in common spaces during the day and not in bed. Getting all of the residents up, cleaned, dressed, looking good, out of their rooms and transported to the main floor took a great deal of effort and time. Many of the staff (and me included) thought this was a great idea to have the residents out of their room. The resident's did look nice and appeared to be taken care of well. However, the residents had no choice in when they went to the toilet, when they drank tea, the clothing they wore or if it was comfortable and they were cosy. Most CAs viewed this policy as positive as indicated below:

In other places they [the residents] are put in bed and eventually

don't get up. If they are stuck in their rooms their brain deteriorates.

I like that they are up and out of their rooms all day (S #7).

However, after a while I began to wonder if some of the residents might prefer to be in bed, especially those who screamed out from time to time or those who seemed very agitated. Several residents would sleep in their chairs for extended periods of time throughout the day. These residents looked very uncomfortable and were not given a choice to go back to bed to rest. A residents' daughter started visiting daily and told me that her father was not doing well. The next night he died. Looking back on this experience, he probably would have been more comfortable in bed at least a few days before dying, had he been given a choice.

The USA: Wisteria Lane – working by unwritten rules

At Wisteria Lane the residents with dementia were separated from the remaining residents and located a good distance away from the main entrance. The Terrace was designated for long stay residents. These residents did not have a choice in the selection of their clothing and furthermore, they were viewed as sick. This was reflected in their appearances that were discussed in-depth in chapter 6. The residents' appearances in general were not considered important nor were their dignity or comfort. This point was articulated well by these CNAs:

I see my resident's as a bunch of sick kids that I have to take care of.

I have to change their diapers and take extra care if they are sick

(USA #2).

They are like children and forget to go to the bathroom (USA# 25).

The last quote was from a young CNA, who had a small child. Her quote depicts the view of the resident's as infantilised or attributed child-like qualities (Bennett et al. 1997). The CNAs personal circumstances were similar to the recent findings of Dill et al. (2013) that was characteristic of a young, single, mother, with a chaotic life and few positive life experiences. This CNA was very proud of her skills and how she was able to relate providing care for the residents like children.

The morning care was rushed and there were more tasks to complete to get all of the residents up, dressed and to the proper locations for dining in the mornings. Several CNAs reported that it was easier to just do the work on their own and not rely on others. An inter-personal skills intervention by Stone (2003) in the literature review highlighted CNAs cynicism and using caution about sharing personal information. This had a negative impact on team and group work and was evident by this CNA:

I immediately start getting everyone ready for breakfast. There are

lots of people to get up, dressed, and clean. It takes too long to find

someone to help and ask if you need help so it's easier if you just do

it by yourself (USA #2).

The only people who ate in the main dining room and benefitted from the interactions were those not so confused. The other residents were taken to several designated locations for meals depending on the amount of assistance they required. The CNAs would prepare the food that was delivered on a cart with covered trays to the area with little input into the residents' preferences including the amount of seasonings such as salt, pepper and sugar. When the residents had their bibs on, then they would start eating. When the residents were through with breakfast the morning care that was not completed earlier would continue.

I can only do half my job because there is not enough time (USA

#24).

Most of the residents spent the rest of their day in common spaces, especially if they were non-ambulatory. Not only were the residents with dementia separated, they were also placed in chairs as a form of restraints. Throughout the day it was common to see residents wearing night clothes or hospital gowns and several residents who only had one sock on or none at all. Catheter bags were simply hung from the chairs on the side by the wheels and visible, with no regard to the exposure of the resident's urine output. For those without

catheters and not in briefs, toileting schedules occupied a great deal of time. Otherwise the residents would be taken back to their rooms throughout the day to manage and clean their clothes and change their briefs.

Most of them [the residents] don't remember. We need more time

and more staff because they need more care. I don't have time – I be

rippin and runnin (USA #6).

The mornings were full of care activities so programming for people with dementia really did not matter to the care staff. If it was exceptionally quiet you could hear the social service director playing the grand piano in the entry for the other residents after breakfast. Getting the confused residents transported to that area was not possible because the CNAs were busy providing physical care tasks. There was no special programming or activities during the afternoon for those with dementia. The majority of the residents sat in their wheelchairs or large reclining chairs on wheels and slept. The TV on the wall was considered the afternoon programming. However, many residents sat in their chairs directly below this huge loud TV mounted on the wall and slept. The TV was watched by the staff but not the residents. If the residents wanted to watch TV they would do so in their room.

When I asked why the residents were not taken back to their rooms the staff reported that as soon as they put the residents to bed they 'wake-up' and were at risk for falling. It was also easier to watch over all of the residents if they were in the common areas. The

residents were not able to go outside freely because the doors had an automated system that locked the door when the residents were in close proximity. The residents who wanted to be outside would resort to sitting by large windows and look outside for hours. On special occasions some of the residents would be taken outside to a courtyard for short periods of time. Unfortunately for the residents, it took a lot of time and staff and was not a common event. These examples of care were often the outcome of insufficient time, resources, and specifically the understanding of dementia which contributed to a loss of dignity for so many residents.

Chapter 7 summary

The nursing homes in this research were institutionalised, dominated by for-profit ownership, and the resident populations had high cognitive and physical needs. Together these features established the bases of many negative aspects of care scrutinised throughout this thesis. The care workers' accounts constructed legitimate examples that demonstrate circumstances that underscored the barriers to establishing relational features critical for intimate personal care.

Daily routines were framed around care tasks that frequently ignored significant interactions and special programming. The care workers expressed difficulties in efficiently performing basic tasks within the specified parameters allotted. The lack of information on the residents' preferences and time impeded the level of care that was possible. Without sufficient time only physical care could be managed leaving many emotional, social, and spiritual aspects of care often partially met or unmet altogether. In rushed care routines and personal preferences were frequently ignored. Other tasks that were required by the care workers took away from the limited time to provide basic care. As a result, social care was first activity to vanish as basic physical care was most often the immediate need. The care workers repeatedly said they longed for more time for social care, leaving social care as a luxury.

Institutionalised nursing homes that strive for efficiency led to the establishment of unwritten rules. These rules were designed to make care practices more efficient which

regrettably resulted in the loss of dignity and increased the objectification of the residents. The care workers across the countries continually complained about the inability to meet the residents' needs. The end result was a devalued workforce blamed for the failure to meet the relevant care standards specified for the residents. Although the care workers as a workforce were aware of the difficult conditions they were unable to identify or articulate the wider social structures that were responsible for the inability to meet the residents' care needs.

Exploring working by unwritten rules emphasised common practices across the fieldwork sites such as separating the residents with dementia and placing them out of the view of the public eye. These practices did not support the residents' choice, dignity, preference or comfort. Furthermore, the care workers were forced to comply and work under such conditions according to the relevant rules. Working by unwritten rules highlighted several significant examples across the settings that stressed negative outcomes for care workers that featured the lack of resources to do their job and enough time to complete their work.

In next chapter the demands and definitions of care are explored to showcase the similarities and differences of the care workers across the countries. The care workers' descriptions of care to focused on the rewarding interpersonal aspects of care, although many features are involved in care work. The skills that care workers bring from home to work are then examined. Finally, this comparative research, documents similar findings that are presented to underscore the common links identified among care workers across the three countries.

Chapter 8: The Demands and Descriptions of Care

The formal rules and regulations that were meant to be helpful while caring for people with dementia, frequently contributed to difficult and stressful conditions without reference to those who provide direct care. Under such a regime the critical time needed to develop and nurture relationships essential to providing intimate and personal care was not available. Regrettably, the relational aspects of care were often in contradiction to the goals of efficiency because fostering relationships takes up time that must be sacrificed in the cause for efficiency. This chapter explores three specific research questions: 1) what are the care workers' experiences and perspectives of the care; 2) how do the care workers define the concept of care and make distinctions of care; 3) and how are reflexive practices used by care workers in each country?

Goffman (1961) argued that institutions established formalised rules and predetermined responsibilities within routines. As previously discussed in chapter 3, nursing homes provide an institutional structure while the process of delivering care offered a place for this activity to occur. The qualitative ethnographic methods allowed me to observe the everyday mundane activities that were rich in symbolic meanings and revealed valuable insights.

The Symbolic Self in Institutional Living

As highlighted in chapter 3, negative images in the media dominate the nursing home industry although there are some excellent nursing homes that provide high quality standards of care (Kelly, 2013). The move to a nursing home and process of becoming a resident for a person living independently in the community is intended to be one of choice and not a forced decision out of desperation (WHO, 2002:9). Tellis-Nayak (1988:158) reminds us that people often go to the nursing home as a last resort, but that is not always the case. For some, the outcome of moving to a nursing home is positive. Perhaps those individuals are better at adapting to institutional life. However many of the characteristics of total institutions outlined by Goffman's (1961) discussed throughout still apply to the institutionalised nursing homes.

Most people that delayed institutional living leave their homes in frail bodies, with lifelong memories and accomplishments. Life in the nursing home quickly changes as the new residents are reduced to sharing a room, often with a total stranger. The greatest hope for this novel situation is that the care workers responsible for providing very personal care take the time to be kind and courteous (Tellis-Nayak and Tellis-Nayak, 1989:307). In the nursing home the admission process can slowly or radically strip their symbolic status, control and previous perceptions as active productive participants in their communities. The residents are confronted with new routines, rules and regulations. There are new faces, different people and unknown providers for personal intimate care. These residents are metaphorically transplanted to unknown territory and are now on unfamiliar schedules that were designed to accommodate many people rather than just one. Under the best of

circumstances the idea of being prompt and timely can no longer be realistic expectations. These are now simply words from their past along with individuality, autonomy and personal preferences. They are now one of many residents in need of continual care and assistance from a limited number of care workers whose job is to provide care for several residents.

Bourgeault et al. (2009:107) found concerns primarily over living in nursing homes around the inflexibility and accommodations in institutions including small rooms and being restricted from going outside. The work conditions and low staffing levels can leave care workers with bad attitudes or few incentives to be cheerful as they rush through care. This care worker acknowledges these issues and makes a valid point:

> *You have to want to do this work and you have a choice but so many of them [the care workers] here don't want to be and shouldn't be here. I feel bad for their residents (Female, married, mother of 2 children; age 37) (D) (USA #20).* [15]

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[15] The quotes in this chapter are presented in fieldwork order rather than alphabetical order. The quotes contain additional details of care workers such as: gender; relationship status; if they have children or are taking care of other children; if these children live at home; the age of the care worker and their location on the continuum. The additional information is included to illuminate the variations among care workers between the countries. The quotes in the text do not contain the additional information for anonymity reasons.

Nursing home life for residents in late old age who are fragile and vulnerable can be seen as the space people occupy between life and death (Nicholson and Hockley, 2011:103). In the previous chapter I described how the residents experience shrinking social worlds in the nursing home. The care workers become the resident's primary social world consistent with the findings of Henderson (1995) and Tinney (2008), and from my observations. This leaves little time for positive interactions between the residents and care workers that are essential for their well-being.

Care Workers' Conceptualisations of Care

How the care workers conceptualise care influenced their interpretations of meaning from the interactions with the residents through the care process. It also provided meanings of care from their individual perspectives. Throughout the research literature care was discussed from multiple perspectives, viewed as ambiguous and often associated with perceptions based on positive qualities. Bourgeault et al. (2009:108-110) reported a remarkable likeness in what makes a good carer from the perspective of both the care workers and residents. The two key components stressed were: one must love working with the elderly and being willing to take the time to talk and listen (Bourgeault et al. 2009:108-110). Examples of characteristics identified as what makes a good carer included patience, compassion, understanding and responding to needs. Tellis-Nayak and Tellis-Nayak (1989:307) claimed that what the residents valued the most in care workers providing care in the most intimate ways i.e. ADL care were those willing to be helpful and good to you while training and skills were at the bottom of the list for the residents.

These frail residents treasured the 'human qualities' of their helpers such as, when staff were polite, friendly, cheerful, and pleasant. The residents appreciated being treated with patience, dignity and respect, especially when the care workers took the time to listen and show respect, for both frailty and dignity in old age (Tellis-Nayak and Tellis-Nayak, 1989:307-313).

The care workers descriptions of care

Given that the primary responsibility of care workers was to provide resident care, I asked the care workers to define care but did not ask for resident or work specific definitions. The subsequent care workers' descriptions included family features or symbolic metaphors even though they acknowledge the residents were not their family. The care workers' descriptions of care were the gold standard of care under ideal circumstances. The first group of descriptions were from care workers that had previously been identified as engaged or 'being with' the residents based on their observations of interactions with the residents during a meal.

How engaged care workers define care?

Wisteria Lane: USA

> *There shouldn't be a limit on care. I treat them like they [the residents] are my own family, if I can help you … why not (Female, single, mother of 1 child; age 21) (E) (USA #21)?*

> *Care is giving all your love, your heart, you know…. showers, hair, linens, tidy up their [the residents] room, make sure they have the right meal and fluids, …taking care of them and meetin' their needs (Female, married, mother of 2 grown children; age 44) (E) (USA #2).*

Shady Pines: Scotland

> *In terms of my Mum, making sure she was clean, happy, groomed well, out in contact with other people her own age group (Female, married, mother of 3 grown children; age 54) (E) (Scotland #9).*

> *It is when you give all that you've got. You've got to be patient, love the residents and the job as well. It is the small things that make the most difference (Female, with a partner, 1 small child; age 24) (E) (Scotland #2).*

South Park Manor: Canada

> *Care is making sure their [the residents] needs are all met. Top to bottom – physical, emotional and mental. It's not easy for someone to be here. I care for them deeply, like my parents or grandparents (Female, divorced, mother of 2 grown children; age 48) (E) (Canada #6).*

> *Doing things for people [the residents] that they can't do for themselves. Physical, emotional, you cry with them when they cry, hug them when they need a hug and kiss them on the forehead..... Oh geeze!..... I love 'em' (Female, separated, mother of 3 grown children; age 56) (E) (Canada # 15).*

When asked to define care in general the descriptions above were given as if the question had been specific for an ideal or family relationship. Twigg (2000a:393) maintains that care has a warm and loving quality to it that was difficult separate or detach from the 'halo effect'. The care workers described care for the residents using family terms under idyllic circumstances. These care workers' descriptions of care in general for the residents had references that emulated family relationships and highlighted some of the most rewarding aspects of care. The care workers above used endearing terms or symbolic metaphors to refer to care for the residents. Lee-Treweek (1996:122) described these features as 'embellishing resident's care' and mimicking family ties from their own relationships.

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Care for these workers was regarded as rewarding and recounted experiences learned in their own families, and this offered a view of the source for their reflexive practices. For example:

I use my own self experience as a tool (USA #24).

This perspective was consistent with Willcocks et al. (1987), Tellis-Nayak and Tellis-Nayak (1989), Diamond (1995), Foner (1995b), Henderson and Vesperi (1995), Lee-Treweek (1996), Berdes and Eckert (2007), Pfefferle and Weinberg (2008) and Kontos et al. (2010) explored in chapter 2. These authors discussed how different aspects of care were based on the care workers personal experiences and provided a rich resource of knowledge. Moreover, these terms echoed those used to denote care in their own family. However, Bishop et al. (2009) and the participants in this study agreed that reflexive practices from experiences within their own families were not acknowledged or rewarded at work by their superiors, yet they were commonly used while providing care at work. The quotes underscored the positive, loving and rewarding features or the gold standard of care and underplayed the dirty features of care work. This care worker mentioned both aspects of care:

You have a niche for it. You have to have patience and understanding and you're not afraid to get your hands dirty. Love and affection doesn't cost anything (Female, partner, mother of 1 child; age 35) (E) (Scotland #1).

As Twigg (2000b:395) points out, care work was about dealing with human wastes and involved managing dirt and disgust. Only one care worker out of fifty-nine cited both the rewarding qualities along with the dirty work of care recognising that they go hand-in-hand. Most care workers were inclined to stress the enjoyable elements of work that were personally gratifying and minimise the dirty characteristics of care work. The following care workers had very different responses when asked the same question. Consistent with the first group, these care workers responses to the same question remained focused on residents' care.

How disengaged workers defined care?

Wisteria Lane: USA

> *Care.... care for you family is different. We caint take the place of family (Female, married, mother of 5 grown children, assisting with 9 grandchildren; age 49) (D) (USA #1).*

> *When you go in and give total care from head to toe and you don't smell them when you're through. That's how you know when you have done your job (Female, married, mother of 2 children; age 37) (D) (USA #20).*

Shady Pines: Scotland

Doing it your way whether they want it or not – just doing it (Female, single, no children, age 22) (D) (Scotland #11).

Making sure your residents are washed, well dressed and have appropriate creams on (Female, partner, no children; age 17) (D) (Scotland #14).

South Park Manor: Canada

Going above and beyond the bare minimum to make someone's day go a little easier, none of them up here want to be here (Male, married, father of three children; age 29) (D) (Canada #10).

I deeply care for my residents but I love my family (Female, separated, mother of 4 children; age 33) (D) (Canada #12).

The care workers above were previously identified as disengaged or 'doing to' the residents based on their observations of interactions with the residents during a meal. Their accounts were not intended to imply or present negative implications for the care workers. However, any mention of family or kinship was neutral or negative. Furthermore, these illustrations of care were absent of positive endearing relational terms. When asked to

define care the disengaged care workers gave examples of care that focused on the differences in comparison with their families. Rather, the definitions highlighted the differences in the care workers interpretations and meanings of care for the residents. These descriptions demonstrated the distinctions between the two groups.

In contrast, when asked the same question, the first group of engaged care workers provided loving descriptions that focused on the similarities between the residents and their own families. More often than not, care consisted of the gold standard of care that these workers had hoped to deliver but was in contradiction under the circumstances. In the absence of time and resources, the ideal level of care according to the engaged care workers was obstructed and they were often reduced to simply doing their best.

Care Practices by Country

To move beyond the illustrations of care in general and to understand how care workers make distinctions and interpretations of care I asked, w*hat do you think the difference is between the following: good care, okay care and bad care*[16]? All of the care workers, regardless of the setting were able to make distinctions between the three categories without hesitation. The quote below provided insight that not only acknowledged the different categories of care, but defined them as well. This care worker remarked:

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[16] In my interviews, the terms 'good care', 'okay care', and 'bad care' were used when asking for distinctions of care. Therefore, in this section I will use the terms above to accurately reflect my fieldwork interviews, otherwise the term 'care practices' will be used.

Good care is what you should be giving, okay care is what you have

the time to give and bad care is what you could get in trouble for

(Female, married, mother of 2 children; age 40) (D) (Canada #13).

The demarcations of bad care given by the care workers fell into separate but definable categories within each country. With the exception of two definitions (one at Shady Pines and the other at South Park Manor), all of the descriptions of bad care focused on apparent physical characteristics. The subsequent explanations were given by the majority of the care workers and placed in rank order with the most common responses listed first.

Wisteria Lane: USA

The CNAs indicators of bad care included:

- Finding brown rings around the resident's bed pads;
- Residents with dried faeces underneath their fingernails;
- When a CNA bathed and dressed a resident on Friday and returned to work on Monday to find the resident in the same clothes.

Brown rings around the bed pad suggest that urine had soaked through the incontinent product, saturated the clothes, wet the bed pad under the resident, and then dried. The outer edge of a light coloured bed pad with dried urine forms brown rings. This was a common portrayal:

When you leave them [the residents] dirty all day and find rings
around the bed pad and you know they haven't been checked on. I
only cut corners if I have to (Female, single, raising 2 nieces; age
47) (D) (USA #13).

Neglect, bedsores, dehydration, leaving them [the residents] wet,
not checking on them, and not caring sometimes it's a lot of different
reasons (Female, single, no children; age) (E) (USA #15).

Both descriptions above were common and referenced not checking on the residents which
allowed enough time to pass for the urine to dry in rings around the bed pad. The second
most common responses were finding dried faeces underneath the residents' fingernails.
The point that the faeces had 'dried' was stressed. In this situation the residents had to soil
themselves, and attempted to remove the faeces. The descriptions included:

Neglecting the residents, like leaving them wet or faeces under their
fingernails or not answering the call lights (Female, separated,
mother of 3 grown children; age 56) (E) (USA #14).

Neglect, finding dried faeces under their fingernails and leaving
them dirty and they stink (Female, separated, mother of 3 children;
age 33) (D) (USA #19).

It has been discussed throughout the analysis that working without sufficient staff was a common occurrence. Specific to the day shift workers, was the observation that residents would often have worn the same clothes for a number of days.

> *I dressed you [the residents] in the morning and come back after being off for the weekend and they are in the same clothes (Female, separated, mother of 5 children, none live at home; age 41) (E) (USA #10).*

The detailed depictions of bad care at Wisteria Lane were graphic and illustrated practices that were physically harmful for the residents. Similar responses were given by all of the CNAs regardless of whether they had been identified as engaged or disengaged.

Shady Pines: Scotland

The CAs used the following signs as bad care that had broader implications.

- Being there for a job, a cheque and/or experience to get into the university;
- Neglect, ignoring or not listening to the residents;
- Leaving the residents wet, dehydrated or being aggressive to them.

The first definition for bad care was one of the exceptions mentioned in the beginning of this discussion that had no apparent physical features. Being there for a job, cheque, or

experience to get into the university was reflective of the younger CAs needing a job on the way to something better (this will be explored further in chapter 9). Common responses from the CAs were:

To get qualifications and experience for uni. [University](Female, partner, no children; age 17) (D) (Scotland #14).

A cheque (Female, partner, no children; age 18) (D) (Scotland #6).

One of the younger CAs who originally wanted to work with children but did not qualify, reluctantly settled for work in the nursing home. Several CAs openly referred to these workers as 'nursery nurse rejects'. This CAs revealed:

On my first day I vomited and had to leave. It took a week to come back but I'm still here (Female, single, no children; age 22) (E) (Scotland #12).

The second most common description given by the CAs highlighted practices that could cause actual harm. The manner in which some of the CAs gave these descriptions echoed on what they had recently been trained. These CAs stated:

When you don't communicate with the residents and you ignore them. They pick up on that and then they feel bad as well (Female, partner, mother of 1 child; age 24) (E) (Scotland #2).

The residents are getting neglected. The carers aren't maintaining the standards (Female, single, no children; age 31) (D) (Scotland #7).

The last delineation included obvious physical characteristics that were harmful for the residents, such as:

Transferring the residents from a chair to a wheel chair and you find them [the residents] soaking, so you know they have been sitting there for a while (Female, partner, no children; age 18) (D) (Scotland #6).

Bad care, emphasised by the participants, occurred during situational episodes when someone was having a bad day, feeling ill or they were working without sufficiently skilled CAs.

Neglect happens if we are short staffed (Female, widowed, mother of 1 child; age 42) (E) (Scotland #3).

Many of the CAs stressed that bad care was not intentional, and like the CNAs at Wisteria Lane, they felt bad when it did happen.

South Park Manor: Canada

The definitions of bad were consistently defined as:

- Finding the residents with a clean brief and wet clothes;

- Not being able to change a brief until it is 80 percent wet;

- Ignoring or neglecting the residents.

All of the examples of bad care at South Park Manor were deleterious and could cause significant physical harm to the residents. The second definition was a regulation discussed in the previous chapter. In chapter 6, Banerjee et al. (2012:395) argued that insufficient staffing was a standard practice in Canada. Furthermore, according to Armstrong et al. (2009:138) the official data on staffing levels indicate that Canada does not meet the standards established by experts. When South Park Manor was fully staffed, according to the nursing home standards and not the provincial standards, there were never enough PSWs to provide basic resident care. *Low staffing levels mean workers have no time to care* (Armstrong et al. 2011:127).

The following quotes clearly articulate examples of bad care given by the PSWs:

> *Ignorance, avoidance, lack of attention…. like the residents' not dressed properly or the residents' constantly yelling or crying and them being ignored. Soiled clothes and depends….. we have to wait until they are 80 percent wet before we can change them. We wouldn't leave a kid wet. Their skin breaks down (Female, single, no children; age 27) (E) (Canada #14).*

> *Neglect for example. They [the residents] are allotted 1 brief per shift. They say if they are not 80 percent wet leave them for the next shift (Male, married, father of 3 children; age 29) (D) (Canada #10).*

> *Spit-polish…. a wet nighty and clean brief or faeces that has been there for a while (Female, separated, mother of 4 children; age 33) (D) (Canada #12).*

The staffing ratios in chapter 6 revealed that there was not always time to change the residents beyond their brief. Therefore, finding residents wearing wet clothes and a dry brief implied the residents had their brief changed but not their wet clothes. On the night shift only one PSW was responsible for 29 residents. By the early hours in the morning the

PSW knew the morning shift would be in soon and they would shower the residents and get them into dry clean clothes and fresh bedding. This PSW noted:

Time is the difference (Female, separated, mother of 1 child; age

36) (E) (Canada #5).

The PSWs felt bad for the residents but the working conditions were not going to change and they knew that. One PSW said the first thing she does when finding bad care was to apologise to the resident. Several PSWs said they spent the first hour of each shift just cleaning and taking care of bad care from the previous shift because there were not enough PSWs to provide better resident care. For example this PSW adamantly stated:

Clean, you don't report it at all, you take care of it. It's your job. We

spend the first 45 minutes cleaning up bad care when we come on

shift (Female, single, no children; age 49) (E) (Canada #9).

The PSWs explained that even if they had adequate staff (in an ideal situation) the extra tasks, lack of supplies and equipment shortages took away from time to provide proper resident care. If a shift was fully staffed the organisational mandates beyond their control never permitted enough staff or time to provide the level of care the residents needed. These were identified as extra tasks that provided protective barriers under certain situations for the care workers discussed in the previous chapter.

Discussion of Care Practices

The majority of care workers emphasised that bad care was not intentional and stressed that they felt bad when it did happen, although it happened everywhere. To survive the negative work circumstances many care workers had to develop coping strategies. Echoing Twigg's (2000a:393) contentions the care workers highlighted the positive aspects of care and underplayed the negatives. Across the three settings, the managers chose not to hire agency or bank staff to cover shifts when they did not meet the staffing regulations. In the USA, Wisteria Lane had extremely high CNA turnover that resulted in a revolving door (discussed further in chapter 9). In Scotland, at Shady Pines there were high numbers of young CAs and a small core group of senior care workers who had worked there for years. High turnover of the younger staff generated resource spending in recruiting and training new hires. In Canada at South Park Manor, the union benefits compensated for many of the negative circumstances.

Years ago, Glendenning (1993:20) identified finding residents in soiled clothes or linens as an indicator of poor care practice. Such indicators still persist in the current literature, and were given as examples by care workers at each fieldwork settings. One insightful young CNA reported:

> *You can tell if the care workers are providing good care if you just sit and listen (Female, single, mother of 1 child; age 21) (E) (USA #21).*

This CNA placed emphasis on listening. The research of Cohen et al. (2010:1037) reported that care workers may yield a more accurate view of care practices taking place in nursing homes. Towards the end of the long interview (See Appendix C) I candidly asked each participant, "Do you think bad care happens here even if it is unintentional"? Out of a total of fifty-nine care workers fifty-three said bad care happens here where they work. At Wisteria Lane 23 out of 27 CNAs or all but 4 CNAs said bad care happens; at Shady Pines 13 out of 15 CAs said bad care happens; every PSW or 17 out of 17 PSWs at South Park Manor said bad care happens where they work. The 6 care workers that said bad care did not happen were lead or senior care workers and it would have reflected poorly on them. However, in Canada the PSWs unanimously said bad care happens there.

Violation of Human Rights

Human rights have been called the first universal ideology and are those rights that preserve each person's integrity, moral autonomy and dignity (Emmel, 2012:xi-xii). According to the WHO (2002:9-10) "*where institutional care is perceived as a desperate measure, it tends to be stigmatized and shortchanged on resources and caring staff, heightening the vulnerability of the person needing care".* These circumstances established conditions that placed the level of care the residents need as unattainable for the care workers for reasons beyond their control. The care workers must follow the rules of care under such regimes that are considered less traditional places of detention and are not linked to the justice system (Emmel, 2012). Therefore, I argue that the care workers are included with the residents in nursing homes and are susceptible to the violation of human

rights as well. While Kelly and Innes (2012:62) accurately refer to the guidelines for the UK Human Rights Act making the main Articles from the European Convention on Human Rights (ECHR) enforceable, Canada and the USA are not under the jurisdiction of the ECHR. However, important similarities exist between the WHO (2002) for institutional care. Kelly and Innes (2012:66) assert *"that people with dementia in institutional care are less protected by law and therefore more at risk of their rights being violated"*. The issue of concern is the violation of human rights within institutional care (nursing homes) and from my observations this includes residents with high levels of care needs and those providing their care. Kelly and Innes (2012:63) suggest that it was the impact that matters and this might be more severe if it affects someone who was cognitively or physically frail.

In Canada, Armstrong et al. (2011:120) and Banerjee et al. (2012:395) reported that residents were put in briefs because of inadequate staffing. Then, strict limits were placed on incontinent products preventing the PSWs from providing the resident's with better physical care. These practices were harmful for both the care workers and residents and violated their human rights. CAs at Shady Pines in Scotland gave examples of unavoidable neglect as frequently ignoring the residents' requests to use the toilet while being transported in a wheelchair because of the rules on efficiency. The result of inadequate staff, time, equipment and rushed routines regularly caused unintentional neglect. Moreover, in the USA Weiner and Kayser-Jones (1990:89) described how families viewed the residents becoming incontinent because their requests to use the toilet were unheeded. In each case, regardless of the intent, these examples of care practices have been well documented. Emmel (2012) asserts:

Fortunately, two of the most powerful human rights tools don't require enormous resources: they are questions and memory – asking about people who are vulnerable, and remembering people who might have been forgotten (Emmel, 2012:220).

Ho (2007) challenges conventional thinking and the concern for the violation of human rights regarding poor work conditions. To demonstrate, Ho (2007:5) used poverty and power structures as examples. The care workers in nursing homes were more likely to suffer due to the poor work conditions without adequate resources while providing resident care. Yet, their suffering was less likely to be noticed, especially in more unequal societies, which was consistent with Wilkinson and Pickett (2009). Without the necessary resources, the poor work conditions obstructed the delivery of care for the residents guaranteed by the standards in each country. It was at this point when the issues became obvious violations of human rights. Wider structural causes were ultimately responsible for not allowing care workers the time and resources to give adequate resident care although the care workers were most frequently blamed. According to Emmel, (2012:220) the worst human rights violations occur when the perpetrators assume no one was watching. The definitions of care given by the workers clearly demonstrate the most vulnerable people in each society suffered when adequate resources necessary for caring were denied. These resources included more than material resources and equipment but also sufficient care workers with the skills to provide care according to the care standards or regulations. In these situations, the absence of necessary care workers was harmful to the care workers and residents as

well. As Vladeck (1980:20) previously stated, the care workers had to work harder but were also very aware of how little they were doing for the residents, and how inadequate their services were and then demoralization frequently follows.

> *Underpinning the social responsibility for care is the recognition that no activity occurs in isolation; rather, everything affects a larger network (WHO, 2002:5).*

While the violation of human rights begins with exclusion, according to Emmel (2012:210) human rights promotion can take place at every level of society. The examples above reaffirm the recent work of Kelly and Innes (2012) and were consistent with the findings of this research. According to Daly and Szebehely (2012) from a human rights perspective it was the organisation's responsibility to provide care workers with good working conditions and sufficient resources to adequately care for the residents according to the standards of care in each country. The examples of bad care given by the care workers across my fieldwork settings all included leaving incontinent residents wet, consistent with the findings of Kelly and Innes (2012:63) and constitutes a breach of their human rights.

Conclusions

This chapter began by pulling together various aspects of a resident's journey from an active participant in the community to living in a nursing home. Residents experience a symbolic transformation from an independent person in the community to a nursing home resident in need of continual care. The characteristic valued by both the care workers and residents were outlined to emphasise the common features and to underscore the importance that dignity and respect have on the care experience. Care workers bring their experiences from home to work with them. The reflexive practices were based on their experiences or mother's wit explored in chapter 2. In the absence of information about the residents, communication difficulties, the lack of time and resources, care workers frequently relied on reflexive practices to provide care for the residents in institutionalised organisations of efficiency.

Nursing homes are difficult and demanding work environments. How the workers conceptualise care influences their interpretations and meaning of the interactions with the residents. The descriptions and distinctions of care provided by the care workers were multi-faceted and complex. The illustrations of care provided by the care workers classified as engaged or 'being with' the residents highlighted the positive features. Their descriptions of care focused on similarities of ideal family relationships and referenced symbolic metaphors and endearing terms. The care workers classified as disengaged or 'doing to' the residents focused on the differences between their own families and the

residents and provided depictions of care absent of positive relational terms and kinship metaphors for residents. The dirty work of care was not brought up until my participants were asked to make a distinction between good care, okay care, and bad care. These descriptions of care were explored by country to demonstrate the differences. Recent research has revealed that care workers' reports may be more accurate reflections of care practices in nursing homes. This was fundamental for this research as the definitions of bad care clustered into categories that predominantly focused on obvious physical characteristics.

Out of fifty-nine care workers fifty-three said bad care happens where they work. These practices were frequently the result of the lack of resources and time to provide better care and were violations of human rights for the residents and the care workers. The residents would frequently become incontinent as their requests to use the toilet were regularly ignored in efficient routines. The poor working conditions for the care workers do not allow adequate resources to provide the level of care the resident need and know is possible given better circumstances. The availability of these critical features was traced to wider social structures and the broader implications that these had on the direct care provided by the care workers for the residents.

The consistent findings across the three countries in this thesis emphasise the need to re-evaluate the expectations for care workers to provide proper resident care in the absence of sufficient time and resources. Care provided according to the standards must be supported with the resources to provide such care. Care workers need the resources to do their job

and enough time to complete their work. Without adequate resources, the care standards become un-met expectations and the realities of care practice a de-facto violation of human rights.

The last analysis chapter will explore the feature that varied the most across the countries in this comparative research: the care workers characteristics. This has been pointed out throughout this thesis and was briefly noted in chapter 6 however that will be the central aim of the subsequent chapter.

Chapter 9: The Differences That Matter

Comparative research has the ability to identify significant features among and between countries. Until now, this comparative thesis has focused on care workers and their experiences of care within the wider context of the work settings and work related issues across these three countries. Similarities and differences have been highlighted throughout along with key findings and culturally specific characteristics. Throughout the process of answering my research questions, I discovered that the care workers varied the most, as a workforce, in each country, compared with any other features explored. Therefore, the goal of the remaining chapter is to systematically outline the differences between the care workers identified in the literature review, fieldwork, and the data reported by the care workers. Then I will demonstrate how the care workers as a workforce in each country vary and link that information with the findings and research of Wilkinson and Pickett (2009) discussed at the beginning of chapter 4 on Table 2. In the absence of time, resources, knowledge of resident preferences and other valuable information, the care workers used their reflexive practices discussed in chapter 2 to make care decisions and provide proper resident care. These reflexive practices or insightful skills were not included in the training across the settings but were relied upon when care worker's job responsibilities placed them in situations that they were not prepared to manage. These reflexive practices were based on their past experiences underscoring the importance of exploring care worker characteristics to contextualise the findings from this research. This chapter contributes to a gap in the cross-national comparative research literature on the

care workers' experiences. Furthermore this research provides insights on how the care worker characteristics vary and the significance of these features across these countries.

The four key elements of institutionalisation outlined by Goffman (1961) were identified at the beginning of chapter 3. The influence of institutionalisation and the powerful significance of institutionally directed care were seen as preventing the care workers from doing their job. The concepts of total institutions (Goffman, 1961) were pinpointed throughout this thesis and discussed within the various contexts. Although the goals of the nursing home differ from other institutions, the consequences that these institutionalised nursing homes had on the care workers and residents were immense. According to Goffman (1961:6) total institutions breakdown the barriers that typically separate the three spheres of life as each phase of a person's daily activity is carried out in the immediate company of a large batch of other members, who are all treated alike and required to do the same thing together. Batch living is in contradiction to the notion of autonomy and choice for the residents. The implications of rushed routines leave little time for positive and meaningful interactions as demonstrated by the care workers. The care workers provided clear examples in their interviews of how the rigid, inflexible routines, especially in the mornings frequently led to the loss of dignity for the residents. Furthermore, incontinence was unintentionally promoted by not allowing residents to stop and use the toilet upon request while being transported for breakfast, as there was no time. The loss of choice and dignity for the residents was frustrating for the care workers as well because they were not provided with the time and resources to do their jobs. In the end this was demoralising for the care workers since they knew better care was possible under different circumstances

within the binary management. The residents in general assumed the inmate role for numerous reasons emphasised beyond those such as basic survival, powerlessness, isolation, and segregation. The institutional perspective brings these four concepts of total institutions to close in a full circle identified as institutionalisation. Institutionalisation was not the organisation's choice or intention of nursing homes caring for residents with high levels of cognitive and physical needs: it was the outcome or consequence instead.

It has been established thus far that the work conditions, routines, organisation of care, and the care practices in nursing homes for the most vulnerable population in each society share strong resemblances across the countries. Three primary significant similarities that applied in each country compromised of the institutionalisation of the nursing homes that were dominated by for-profit ownership, and provided care for a similar resident population with high levels of cognitive and physical needs. These features contributed to multiple forms of stigma outlined in chapter 3. Significant differences in the care worker circumstances that have been discussed throughout this thesis involve staffing ratios, training required and pay. However, other distinct characteristic about these care workers varied that were outlined in chapter 6 regarding their physical appearances. The features that contributed to the differences in physical characteristics that varied the most across the countries included the mode of dress or clothing, piercings, tattoos, fingernails, wrist watches and general appearances. Some of the features that contributed to the differences in the care workers will now be discussed.

The country of employment played a significant role in the differences for the workforce and determined many of the aspects for the workers such as pay, benefits, holidays, and training. There were similarities and differences but each workforce group could be defined as representing low status groups although their income stratification varied. Reid (1998) implied that stratification suggests an arrangement of separation between the layers in society. The separation between the layers in each society was identified as social differentiation by country and that implied ranking order within that society.

In a post script Wilkinson and Pickett (2010:275-276) maintained that when people in the same social class, at the same level of income or education, were compared across countries, those in more equal societies do better. The importance of inequities in relation to this chapter was recognising that people under chronic stress such as care workers, experience psychological factors that were extremely difficult, especially for those at the bottom of social differences. Wilkinson (1992:168) revealed that relative poverty was especially important as it excludes people, socially and materially, from ordinary participation and life in society. The social consequences of an individual's varying circumstances in terms of stress, self-esteem, and social relations may now be one of the most important influences on health. Wilkinson and Pickett's (2009:497) index of Health and Social problems in relation to income inequality in rich countries presented as Table 2 in chapter 4 included all of the countries in this study with the exception of Scotland which was depicted as the entire UK.

Wilkinson and Pickett (2009) explored stratification or unequal positions individuals occupy in a society in terms of wealth, property, and access to material goods and products. Chapter 4 pinpointed social problems exploring Wilkinson and Pickett's (2009) study and it was determined that these features were more common in unequal societies. Moreover, Wilkinson and Pickett (2009) summarised these illuminating characteristics and underscore a link between these factors:

> *... these relationships are likely to reflect a sensitivity of health and social problems to the scale of social stratification and status competition, underpinned by societal differences in material inequity (Wilkinson and Pickett, 2009:493).*

For example, exploring income distribution and life expectancy Canada had the highest life expectancy presented in on Table 3 in chapter 4. In a recent document: *What makes Canadians Healthy or unhealthy? Underlying Premise and Evidence Table*:

> *.... studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned by society members. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole (Public Health Agency of Canada, 2013).*

The remaining sections in this chapter will examine significant differences among the care workers as a workforce in each country and make links to the index of inequalities of Wilkinson and Pickett (2009) using the literature, data from my participants, and fieldwork.

The Differences of the Care Workers as a Workforce by Country

Canada: South Park Manor

In Canada, the PSWs receive standard government benefits for being citizens and employed in a social democratic country that places value on citizens that can work and do. South Park Manor in Canada was the only nursing home in my research that was unionised. Once the PSWs were offered a contract, their union and work benefits began and these were in addition to the existing government benefits. The PSWs repeatedly stated that union membership provided job stability discussed in chapter 6 setting the scene. Daly and Szebehely (2012) reported that union membership has resulted in more PSWs that had worked at one nursing home for over a decade. Consistent with those findings most PSWs had worked at South Park Manor for over a decade and two PSWs had worked there for over 30 years. Zuberi (2006) disclosed that the Canadian unionised workforce has steadily increased after 1970. The majority of nursing homes in Canada belong to home unions and those provided additional benefits i.e. seniority, retirement, wage increases, delineated in chapter 4 (NUPGE, 2007). All PSWs were required to belong to the home union and for those employed at another nursing home with a different

home union it was compulsory to belong to that union also. Furthermore a collective bargaining agreement has reduced the management's discretion over many organisational features (Brannon et al. 2002:167; NUPGE, 2007).

These Canadian PSW jobs were paraprofessional positions that required almost one year of college. The training requirements for PSWs were equivalent to those of a barber or beautician in the USA according to Braun et al. (2005) noted in chapter 1 and required approximately 1500 hours of training. The value of care work was reflected in the amount of training required for the position presented in chapter 4 on Table 7 and the higher average pay. The PSWs in Canada were the highest wage earners in my research. Lindsey and Almey (2006:134) with Statistics Canada reported that women in Canada between 35 and 54 years old earned the highest average income compared with women in other age group. Most PSWs in my research were single, again consistent with Lindsey and Almey (2006:134) and Statistics Canada, which reported that single women between 35 and 54 years of age earned approximately $40,100.00 CAD per year.

At South Park Manor, many of the PWSs had formed close friendships with their co-workers and spent time socially together outside of work discoursed in chapter 6 which was an additional benefit. In the break room the PSWs would coordinate trips for grocery shopping and rides if anyone needed help with transportation. This group was more willing to work an extra shift, come in early or stay late to help out a fellow co-worker compared with the two other groups in my research. Kontos et al. (2010:10) described this as establishing an 'espirit de corp' based on occupational knowledge and strengthened by

their group solidarity and humour. These close bonds of friendships were supported by my participants and the literature and were culturally specific to South Park Manor. Casper and O'Rourke (2008) reported the care and respect from these nurtured relationships provided a sense of support that appeared to act as a protective buffer in poor working conditions that have been considered throughout this thesis.

These PSWs were on average aged 44 years old. Casper and O'Rourke (2008) indicate the average aged in their research was 43 years, while Banerjee et al. (2012) reported the average aged in their study was 45 years old for PSWs in Canada. The ranges in ages were not as extreme as my other research sites and more than half of my Canadian participants were in their forty's and fifty's. The majority of the PSWs had grown children who no longer lived at home with a few exceptions.

Stone and Harahan (2010:113) affirmed, *A high-quality workforce depends, in large part, on the investments that society makes in education and on-going training of new and experienced personnel*. Although the statement was written by Americans directed at the USA, Canada made education a priority and was committed years ago to provide education for all citizens. Educational opportunities at various levels were available for most occupations which allowed all Canadians the chance to learn a trade, set of skills, or knowledge for employment (Zuberi, 2006). The training curriculums for care workers were not standardised across any country in this research. However, the minimum standards for Canada's PSW training exceeded that required throughout the different regions in Scotland and the USA (see Table 7 in chapter 4).

Canada's extensive network of public colleges, private career colleges, and training centres explored in chapter 4 were established to provide skills for multiple occupations. Gainful employment was highly valued. According to Zuberi (2006) Canada offered the highest levels of education, training and benefits to all citizens to gain qualifications to earn a steady income. This was reflected in the overall population achievements demarcated by social differentiation. Almost all of the PSWs at South Park Manor were home owners and vehicle owners (one PSW owned two homes but no car) which were symbols of middle-class success according to Zuberi (2006:140). These PSWs received paid holidays and took planned, destination holidays. The following excerpt was from my field notes:

> *Registered Education Savings Plan (RESR) is a college savings plan for parents to use for their children's education. If you save $3,000 or $30,000 the government will match it, there is no limit. There is a $500 signup fee and the children have to go to some school for at least 12 weeks. Even if someone went for lawn mowing or some kind of yard (garden) maintenance then the remaining money could be used to purchase the equipment needed to start a business. If this money is not used by the children it can be rolled over into a Registered Retirement Savings Plan (RRSP) for the employee (Field notes: 13-7-2008).*

These stable PSW positions were able to provide workers with a steady income that allowed them the benefits of middle-class life and resources. They also ranked as the highest wage earners of the countries compared in this research (Zuberi, 2006). Wilkinson and Pickett's index (2009) demonstrated that health and social problems correlated with income inequality. The country out of those in my research with the fewest problems was Canada. The principal of universality noted in chapter 4, where services were provided for all classes of society along with the high number of unionised employees offered the PSWs more opportunities for a stable work force in Canada. This links back to the WHOs (1947) definition of health in chapter 4 from a preventative perspective with the goal of eradicating all inequities. Canada was the first country in this study to adopt the WHO (1947) definition of health. As a result, the achievements made in reducing inequities were reflected in Wilkinson and Pickett's (2009) index discussed in chapter 4. Moreover, the benefits were reflective of more than just value. The PSWs at South Park Manor *did not* have to manage care worker turnover in comparison with Scotland and the USA. Yet, these highly rewarded Canadians worked with the lowest staffing levels outlined in chapter 6, in the worst physical building layout, institutionalised and extremely stigmatised work settings. The other organisational barriers such as management turnover, size and for-profit ownership discussed in chapter 3. However, all of these factors combined contributed to little or no turnover for the PSWs at South Park Manor.

Scotland: Shady Pines

In Scotland, at Shady Pines the CAs were entitled to standard benefits simply for being citizens of Scotland regardless of employment status. The benefits in the social democratic country of Scotland were very complex. Wages earned could jeopardise the citizens' benefits resulting in reduced overall income compared to those not employed. Unfortunately, people found they were worse off financially in low paying jobs, which provided few incentives for being employed in low paid positions, such as care work. A new CA could be offered a contract once their three month probationary period was over and then the work place benefits would begin. Shady Pines was the only nursing home in my study that offered meals for CAs at a reduced rate.

In chapter 8, I explored the demands and descriptions care for care workers'. The CAs at Shady Pines were the only group who gave a definition for bad care that had no apparent physical characteristics. These CAs suggested having an 'instrumental attitude' as a form of bad care and described being there for a job, a cheque, or experience to get into the university as bad care. Training at Shady Pines delineated in chapter 4 on Table 7 was the only fieldwork site that provided on-site staff training to meet the regulation requirements. These CAs earned a little over minimum wage which reduced the possibility of securing capital in society and reinforced the marginal stigmatised role of care workers. Twigg (2000a:124) affirmed that: *"Careworkers are predominantly drawn from working class women"*. Furthermore, Twigg (2000a:125) argues that care work was seen as reasonably accessible for young women who were culturally prepared for care work in their working

class families (Twigg, 2000a; Colley, 2003). Most recently Twigg et al. (2011:178) maintained that the current responsibility of caring for the body, including the elderly was highly dependent on classed groups and this reinforced the stigma that serving the body carries. The notion that care workers were drawn from the working class in Scotland has been well documented in the research literature by Reid (1998), Twigg (2000a), and Colley (2003) and was reflected by their level of stratification defined earlier.

Shady Pines had the widest range or most extreme ages among CAs. There was a wide range in ages with a significant difference between the very young and middle aged CAs. There was a small number of stable senior care workers who had worked there for several years who were in their 50's, very few in-between and the remaining were either in their 20s or teenagers. A report from the Official Statistics Publication (2012) on care workers explained the two peaks in age distribution. However, these two age peaks represented groups for CAs around their late 20's and the other near their late 40's or less extreme than my sample (Official Statistics Publication, 2012:38). The large group of younger care workers brought the average aged down to the lowest in this study. The overall average age of my participants was 29 years old which was extremely close to the findings of Hughes et al. (2008) who reported that two-fifths of the dementia CAs in Scotland were 30 years old or younger. Most of the older senior care workers were married because the low pay typically required two incomes. This CA demonstrates -that notion well maintaining she could not live on her own with the low pay of care work:

I had to get married before I could be a carer otherwise I couldn't

afford to work here (Female, married, no children; age 42) (E)

(Scotland #10).

Many of the younger CAs emphasised that they were working in the nursing home for qualifications and experience to get into the university for nursing. To better understand this group I used the continuum as an analysis tool. The CAs group that were classified as engaged in providing resident care was identified as Group A and the disengaged as Group B. Group A was slightly larger and all had reported in their interviews that 'yes' being a CA does help define who they were, and 'yes' they did consider care work as their career. Those CAs were classified as having 'role and career' continuity. The CAs in Group A on average were 35 years old. Several of the younger CAs in Group A adamantly maintained this was their career, yet they wanted to go to university. However, the older senior care workers in Group A reported this was their career, but they had no desire to go to university. To better understand these CAs responses I separated those in Group A between the care workers that said they 'did' and 'did not' have plans to go back to school. Looking at my data and exploring these responses provided insightful information. The CAs that reported they 'did not' have plans to go to university were on average 45 years old. The CAs in Group A that said they 'did' have plans for further education were on average 23 years old. This pinpointed a large gap in ages consistent with the age peaks identified by (Official Statistics Publication, 2012) within Group A among those who 'did' and 'did not' have plans to go to university. The CAs in Group A that were identified as

engaged and had role and career continuity. Therefore, they identified with the role internally and this was reflected in their observations of interactions with the residents during a meal compared with Group B.

Investigating the same questions from my participants categorised as disengaged or 'doing to' on the continuum (See Table 8 in chapter 5) in Group B, all had reported on their interviews that 'yes' being a CA does help define who they were but 'no' they did not consider care work as their career. Therefore they did not have role and career continuity. These CAs all wanted to go to university irrespective of age. Many of these CAs viewed work in a nursing home as a stepping stone to attain requirements for university. The average aged age- of participants in Group B was 21 years old and most of the CAs still lived at home with their parents. These CAs stressed they were working in the nursing home for the following:

> *I need the experience to get into the uni. [university](Female, single, no children; age 22) (D) (Scotland #11).*

> *The uni. [university] looks for experience if you have been in this line of work (Female, single, no children; age 17) (D) (Scotland #4).*
> *I need money before I go to the uni. [university](Female, single, no children; age 20) (D) (Scotland #13).*

The CAs in Group B did not identify with the role and were just putting in their time for experience and qualifications and this was reflected during their observations. Furthermore, Group B consisted of much younger CAs overall compared with Group A. Therefore, regardless of the whether or not being a care worker helped to define their role, the younger CAs did have plans to the university for nursing. These CAs had completed their standard exams and needed qualifications to get into the university. The CAs qualified after 1 ½ years of experience and qualifications of SVQ level 2 before they could apply to the university. One care assistant revealed:

Went to college and I applied to nursing, but didn't get in because I needed 1 ½ years' experience to get in because my grades weren't good enough (Female, single, no children; age 20) (E) (Scotland #13).

Almost all of the younger CAs said they saw working in the nursing home as a step to a better career. The senior nurse at Shady Pines had worked in nursing homes at an early age and successfully gained her qualifications to get into the university. She completed her nursing degree and encouraged the younger CAs wanting to go to the university to follow the same path. These CAs viewed the career path that was encouraged by the matron and senior nurse. A young, but experienced CA expressed this point well:

If a young girl can work in a nursing home she can definitely be a nurse (Female, single, no children; age 18) (E) (Scotland #15).

Exploring education as an inspiration revealed a reasonable explanation for the high number of younger CAs at Shady Pines. The group distinction between those who wanted to go to the university was supported in my analysis by using the continuum which validated the differences in the groups. More important, care work in a nursing home was recognised as a formal route to get into the university for nursing, according to the matron, nurse and my participants. Shady Pines was my only fieldwork site that offered this extensive career laddering that had been a successful path for several other CAs and this was openly discussed. Shady Pines was also the only nursing home in my research that employed a full-time training coordinator to ensure that the CAs all had the experience and appropriate qualifications. All of this combined was significant in offering an explanation for the high number of young CAs working at Shady Pines. It also helped to explain the high turnover. Once most CAs completed their requirements they would go on to the university for nursing which was their original goal.

According to the senior care workers, the high number of young CAs in addition to fewer life experiences and knowledge often left a gap in past experiences to draw from for care practices. Reflexive practices were previously defined in this research as applying insightful, perceptive or instinctual knowledge learned from previous experiences. The young CAs that had exceptional reflexive practices were intuitive workers based on their responses from the interviews and observations and had worked at Shady Pines for a year or longer. A couple of the young CAs were able to identify resident needs that the residents were unable to articulate. However, on average, most of the very young teen-age girls that still lived at home and had never lived on their own were working at Shady Pines for

qualifications and experience to get into the university for nursing. These CAs did not exhibit reflexive practices in their interviews, especially on the hypothetical questions in comparison with the experienced or older senior care workers. Based on my observations, the care workers who were engaged or being with the residents (explained in chapter 5 and highlighted throughout the analysis chapters) appeared to be more reflexive and intuitive workers in their accounts in comparison to the disengaged or less experienced CAs.

As previously discussed in setting the scene the matron chose not to hire bank or agency staff to fill-in when needed. A young (18 ½ year old) but very experienced CA who had worked at Shady Pines for over a year commented that:

> *Even if we are fully staffed it is not always enough because of the skill mix. If there are a lot of inexperienced[17] carers on it puts more pressure on the experienced care workers (Female, single, no children; age 18 ½) (E) (Scotland #15).*

Two senior care workers added:

> *If you're on with younger (inexperienced) carers you will be doing all the work (Female, married, no children; age 42) (E) (Scotland #10).*

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[17] In a discussion about the complexities surrounding the lack of staff, a young but experienced CA refers to other young CAs as inexperienced. However, the senior care workers refer to all of the young workers as inexperienced. There is a distinction to be noted between the young CAs that are experienced and those who are inexperienced.

If you are working with a young (inexperienced) person you do more

of the physical work. If you're on with young ones it can go haywire

(Female, widowed, 1 child; age 42) (E) (Scotland S #3).

Therefore, at Shady Pines, having sufficient CAs to provide proper care was affected by skill level and mix on a shift, as well as experience and knowledge. This added to the existing complexities on staffing and offers an explanation for the high turnover from the CAs perspective. The extreme differences in ages and experience also contributed to the absence of close bonds of friendship among CAs that were an added benefit in Canada.

The USA: Wisteria Lane

At Wisteria Lane the CNAs were drawn from the working poor in America. Yamada (2002), Montgomery et al. (2005), Squillace et al. (2009) and most recently Dill et al. (2013) all reported a substantial number of CNAs were at or below the poverty level that allowed them to qualify for government benefits. CNAs were the lowest paid health care workers. The few benefits available were only offered after full-time employment for one year. There were only two CNAs at Wisteria Lane that qualified and purchased the costly health insurance. This was consistent with the findings of Bishop et al. (2009) who highlighted that most CNAs could not afford insurance. Therefore, it was easier for the CNAs to let their hours decrease which allowed them to qualify for the highly stigmatised, Medicaid or means-tested welfare as their primary health care provider (Montgomery et al. 2005). Squillace et al. (2009) found that most CNAs already received some means-tested

government subsidy. The lack of benefits for CNAs was culturally specific to the USA. Furthermore, the CNAs stratified at the lowest level according to this research. In fact, it was noted in the literature that "*care workers are expendable*" (Tellis-Nayak and Tellis-Nayak, 1989:312). Stigmatised work, low pay, few benefits, all contributed to the on-going turnover and revolving door. If a CNA was in good standing i.e. certified, had no violations, and was current on training, there were always places hiring. It was not uncommon for a CNA to quit and take a new job down the road that paid slightly more or had a starting bonus.

Dill et al. (2013) recently identified some unique circumstances for this large portion of low-waged health care workers. The CNAs were the primary source of income, were predominantly single females, and responsible for several young or school age children in need of childcare. The comparative research of Zuberi (2006) discussed throughout this research explored social policy and the working poor in the USA and Canada. The absence of a social policy safety-net for the working poor in the USA leaves this group struggling to break the cycle of poverty (Schwarz, 1996; Zuberi, 2006; Dill et al. 2013). For example:

> *'Contingency factors' include both financial and personal circumstances, reflecting the vulnerability of low-waged workers to personal and family issues for which they have no cushion of wealth, insurance or safety net protection (Dill et al. 2013:223).*

Limited financial, personal, and job related resources explored in chapter 2, leave CNAs with less financial discretion to act on their preferences. Dill et al. (2013) borrowed the term 'shocks' from poverty research and identified them as unpredictable stressful events for low-waged workers. A variety of shocks that triggered turnover included inconsistent child care, personal or family injury or health issues, irregular working hours, and economic pressures such as money to keep the car running. The recurrent outcome of shocks was for the CNAs to quit work at their current nursing home which resulted in increased turnover (Dill et al. 2013).

The average age of my CNA sample was 37 years old and matched the national average and the research literature (Yeatts and Cready, 2007; Morgan and Konrad, 2008; Squillace et al. 2009; Dill et al. 2013). The number of CNAs employed in the nursing home significantly decreased as their age increased by the decade. Collectively the nursing home as an industry has not presented CNA employment as desirable, leaving other health care settings more appealing. This has contributed to attracting a different type of worker in comparison with Canada and Scotland (Brannon et al. 2002; Dobbs et al. 2008; Karantzas et al. 2012).

Reflecting back on not using the lockers in the break room at Wisteria Lane and the absence of enforced breaks and mealtimes created an atmosphere of 'sneaking' around to take care of ones' self as an employee. The sneaking distrustful atmosphere contributed to an environment of mistrust. This was consistent with the findings of Dodson and Schmalzbauer (2005) and Secrest et al. (2005:93) who described this behaviour as

producing a 'pervasive undercurrent of suspiciousness'. Adding to this notion, the manager stressed to me on several occasions to never leave anything in the break room and made it very clear that the workers in general were not to be trusted. Eaton (2000) echoed these sentiments, recounting that managers do not trust their workers in the USA. This links back to a series of interventions on interpersonal skills and empathy training discussed in chapter 2 (Stone, 2003). The goal was to reduce turnover by encouraging camaraderie, cooperation and team work, similar to the experiences of PSWs in Canada. Regrettably the summary report revealed a sense of cynicism characteristic of those who have experienced many hard times and disappointments in life. Similar results suggest a lack of trust as motives common throughout other research in the USA, especially when obtained from those in poverty such as the CNAs (Stone, 2003).

Pfefferle and Weinberg (2008:954) and Dill et al. (2013) explain the difficult work experiences and chaotic lives that CNAs manage on a daily basis. Many of these workers could not deal with additional undesirable experience and found it easier to simply not call in or show-up for work to avoid another negative put-down. The sensitivity and importance of this issue was reflected in this CNAs definition of care:

> *Being there on time, havin' passion and a lot of love, meetin' their*
> *[the residents] needs, ADLs, emotional needs (Female, divorced,*
> *mother of 1 grown child, raising 2 nieces; age 48) (USA #24).*

The example above exemplifies the research of Dodson and Schmalzbauer (2005:949) on poverty in response to stigma and punitive authority, and Zuberi's (2006) depiction of the marginalised working poor in the USA. Zuberi (2006) corroborated that if you were not allowed sick days why would these workers bother to call in sick? The CNAs were penalized for calling-in sick or if they were going to be late, making punctuality important. This was culturally specific for the USA.

Dodson and Schmalzbauer (2005:950) point out how women in poverty use extreme caution when speaking about their lives in response to punitive authority. Reporting bad care goes against how the CNAs had been taught and socialised and was touched upon in chapter 6. Goffman (1963:13) described the 'othered' people's notion or the efforts to manage stigmatization through impression management. Likewise, Secrest et al. (2005:93) underscore the pervasive undercurrent of concern and suspicion of being 'told on', regardless of whether it was justified or not, as part of the stigmatised role of CNAs in modern America. The amalgamation of undesirable circumstances created an atmosphere of 'sneaking' for a smoke or a sit to get off of your feet. This ethos encouraged an atmosphere of sneaking, stealing and thievery pointed out in chapter 6 and links back to the residents' appearances of no one wearing expensive jewellery, their original wedding rings or bringing valuable items to nursing home.

Dodson and Schmalzbauer's (2005) research helped to explain many of the issues I encountered in the field. Recognising the situation from the symbolic interaction approach, Bishop et al. (2009:616) reported that CNAs with family care giving responsibilities

especially those with children may experience more stress on the job. This information was significant and contributed to the grim picture from the literature for these workers. The following sentiments were repeated frequently during fieldwork at Wisteria Lane. From my field notes:

On several occasions I observed the shuffling of children on the double weekend (16 hour) shift. Children were dropped off and picked up at the nursing home frequently. On one weekend two children under the age of three were dropped off. The CNAs were not expecting this because they were scheduled to work and were working. On one occasion a Dad wanted to 'go out' so he just dropped off the child. It was close to the CNAs shift to be over so the supervisor let her go home early. The other instance on the weekend the CNA made a phone call (which was against the rules while working) and made the Dad take the child back to his Mom's house to get the child's remaining clothes before another relative would be called to come and pick the child up. Earlier that week all of the CNAs signed an agreement that they would not use mobile phones on the floor while working and if they were caught they would be terminated immediately. This lead CNA simply stepped into the shower room to make her call as if all of the other staff and I were totally invisible (Field notes: 21-1-2008).

Survival in America for poor families often becomes reliant on the mother's ability to be creative. Therefore, they do not disclose income from bartering, swapping and selling of informal labour to make ends meet such as child care or doing hair mentioned both by Foner, (1995b:104) and Dodson and Schmalzbauer, (2005). These CNAs were typical of the working poor in America where acknowledging gifts or additional income often resulted in losing means-tested government benefits (Zuberi 2006). Consistent with McNamara and Williamson (2013) the USA has high levels of income inequality and this was reflected with fewer financial resources for these low-waged workers (explored in chapter 4). Brannon et al. (2007:827) noted that compared with their Canadian counter parts, the team spirit or value placed on co-worker relationships was unlikely with the CNAs. These sentiments were repeated by Wilkinson and Pickett (2009:505) who underscore that low social status, difficult family responsibilities and weak friendship networks are all sources of chronic stress which were characteristic of the CNAs.

The Implications of the Differences in the Care Workers as a Workforce

The goal of this chapter was to utilise comparative research to emphasise unique aspects of care worker characteristics and to explain some of the significant features identified throughout this thesis. The aim was to demonstrate links between the literature, and data from my participants. The care workers as a workforce by country were linked to when the WHO (1947) adopted the new definition of health and the index of Wilkinson and Pickett's (2009) index of health and social problems in relation to income inequality on Table 2 in chapter 4. Furthermore links were made with the life expectancies within each

country which were consistent with Wilkinson and Pickett (2010). Wilkinson and Pickett (2009) provided insight and explanations for my findings on care workers in nursing homes. As each country embraced the definition of health from a preventative perspective by the WHO (1947) and tried to reduce inequities through health and social care policy priorities, each country's health and social problems also decreased. The country in this study with the lowest income inequality, the largest middle class, and situated in the centre on the index was Canada. The UK followed Canada and off in the far right corner representing the country with the most extreme income inequality was the USA.

This chapter has pointed out the differences in care workers identified throughout this research. Care workers were expected to provide proper resident care under difficult conditions without sufficient resources. Some groups were better equipped at coping with the poor work conditions as a result of their level in society and access to available benefits. For example, much of the research literature in Canada did not cite many of the same problematic issues as in Scotland and the USA. In Canada, the high number of unionised nursing homes, higher pay and benefits placed them in a different situation. However, the Canadian workers did have their issues too, such as lack of resources, and low staffing levels that placed any care other than basic physical needs beyond consideration.

The Canadian care workers were on average older with years of experiences as a knowledge base for their reflexive practices. They were required to belong to the home union which existed within the broader social structure. These PSWs represented middle-

class in Canada, were highly rewarded for the work they provided and this contributed to high number of years of employment and the lowest turnover among my participants. Moreover, this group of workers required the most training of all of my research sites. These workers were still required to provide care in institutionalised, for-profit organisations under difficult conditions although a combination of benefits helped to compensate for many of the negative features in the stressful work conditions. Furthermore, the PSWs placed high esteem on their co-workers from the close bonds of friendship, and this made some of the less desirable characteristics more tolerable.

In Scotland the largest gap identified existed in ages for these workers and that depended on whether or not the CAs planned to go back to college or university. Most of the younger CAs viewed work in the nursing home as a stepping stone or educational inspiration. Shady Pines employed a full-time training coordinator to help the new hires reach their qualifications. The ultimate goal for the younger CAs was to gain experience and qualifications so they could go to the university for nursing. The registered nurse had achieved experience and qualifications through work in a nursing home for acceptance to university for her degree in nursing through this career path. Therefore, the registered nurse encouraged these young CAs to follow the same way. This Scottish group as a whole were drawn from the working class reflected in the literature and supported by my research participants.

The USA care workers were drawn from the working poor (Loprest et al. 2009; Dill et al. 2013). The CNAs worked under especially difficult circumstances in an atmosphere of distrust, suspicion and thievery. Most of these single females had small or school age children which made life in general more chaotic and stressful. The lack of resources for these CNAs such as work-place benefits and support was one of the greatest differences between countries. The lack of various support had significant negative implications highlighted in this research. The absence of a social safety net for those in poverty, the lack of a career ladder, and low pay meant that even those working full-time were below the poverty level and relied on means-tested government subsidies. The cycle of poverty for these CNAs has continued without recognition of need, or policies aimed to support working their way out of poverty to become equal active participants in society. Furthermore, low education, access to support services and resources for these single mothers in poverty, and often poor health placed these workers at risk for social detachment. Wilkinson and Pickett's (2009) descriptions appropriately described the CNAs in the USA. The more unequal a rich country was the worse off the performance was likely to be across a wide range of variables. Moreover, the poor working conditions have gone un-noticed and therefore not addressed while inadequate resident care has repeatedly been blamed on the CNAs.

The care workers as a workforce varied by characteristics that included government and union benefits, turnover, staffing levels, training required, pay and benefits, average ages, and compliance with phone rules while working. The rules and regulations on physical

appearances for the workers providing care for residents with high levels of cognitive and physical needs varied tremendously by country. These differences were brought to light by this cross-national comparative research that aimed to explore dementia care worker's experiences in nursing homes across the countries studied.

Chapter 10: Conclusions

The aim of this thesis was to understand the work experiences of dementia care workers in nursing homes in three countries. A comparative framework was used to analyse data collected from ethnographic methods to explore concepts central to care, the training required, and to gain knowledge from the care workers' perspectives. The comparative and ethnographic nature of this study offered insights into the similarities and differences of the following: care workers, residents, work settings and environments, care practices, the organisation of care, training requirements, staffing, reflexive practices, and the lived experiences of dementia care workers. In this last chapter I will revisit my research questions to discuss the knowledge gained from this exploratory comparative research. This final chapter will highlight the key conclusions from chapter's six to nine in the analysis. I will then consider the contributions this research has made to the understanding of work experiences of dementia care workers across the three settings. The last section in this chapter will consider the limitations of this study and then reflections. Incorporating cross-national comparisons at the macro level on secondary data allowed me to determine features to explore with ethnographic methods. The comparisons of ethnographic data at the micro level identified key information on dementia care workers in nursing homes that will contribute to the existing knowledge. This comparative approach underscores the insights of the care workers experiences within the context of symbolic interaction. Symbolic interaction facilitated the organisation of descriptions and guided interpretations. These dual perspectives helped me to understand how shared meanings were ascribed to interpretations of interactions to construct the accounts of dementia care workers. The

comparative methods at macro and micro levels also contributed to understanding the work experiences of care workers within the wider social context. This study has shed new light on the similar work conditions and environments and the significant differences between the care workers as a workforce in nursing homes in Canada, Scotland and the USA.

Key Findings for Practice

Cross-national comparative research has the potential to identify results that can reveal patterns, similarities and differences among and between the countries. This research has identified important features that were consistent across the countries yet varied within the countries and vice versa. The findings from this study call for new directions for investigating the underlying causes to understand the stressful work conditions and resultant care issues in the nursing home. The following key results were identified from this comparative research that contributed to the knowledge and fill existing gaps in the research literature.

1) The consistent findings across these three countries in this thesis underscore the need to re-evaluate the expectations for care workers to provide proper resident care in the absence of sufficient staff, time and resources. Care workers need sufficient resources in order to do their job and adequate time to complete their work.

2) Care provided by the care workers according to the guaranteed care standards in each country must be supported with sufficient staff, time and resources to provide such care. As demonstrated, without adequate resources, the care standards often become unrealistic expectations for the care workers and residents and result in the violation of human rights.

3) The poor work conditions and absence of adequate resources left the care workers unable to provide the level of care they knew was possible under better circumstances. As a result of this inability to provide the level of care the residents needed, the care workers were more likely to suffer psychological harm.

Contributions to Knowledge

This study established that care workers require adequate resources to do their job and sufficient time to complete their work. The care workers in nursing homes in this study had to follow the rules of care under such regimes that were considered as less traditional places of detention and not linked to the justice system (Emmel, 2012). The circumstances above, established conditions that placed the level of care the residents needed as unattainable for the care workers for reasons beyond their control. The care workers suffering was less likely to be noticed, especially in more unequal societies (Wilkinson and Pickett, 2009). In the absence of adequate resources, the care workers were unable to meet the care standards guaranteed by the government. These un-met needs were a violation of human rights in accordance with the WHO's (2002) overview of human rights on ethical choices in long-term care. Wider structural causes were ultimately responsible for not

allowing the care workers adequate staff, time, and resources to deliver proper resident care although the care workers were most frequently blamed (Tellis-Nayak and Tellis-Nayak, 1989; Comondore et al. 2009). This research identified causes for the residents un-met needs and care workers poor work conditions throughout that were consistently linked with institutionalisation by Goffman (1961). Moreover, beyond institutionally directed care Armstrong et al. (2011:125) suggest that the broader structural forces for-profit ownership often excluded the necessary resources for care. Emmel (2012:220) asserts that the worst human rights violations occur when the perpetrator assumes no one is watching. The unwritten rules identified across the fieldwork sites encouraged the separation of residents with dementia and provided an excellent example of Emmel's (2012) claims. This practice was consistent with the 'corruption of care' which allowed the separation of people with dementia out of view of the public according to Wardhaugh and Wilding (1993:27).

This research also identified a link between the work conditions for care workers and care for the residents. Each of the subsequent authors reported results similar to - good working conditions which promote good resident care; or improving the work conditions for the care workers in turn supports better outcomes for the residents. Eaton (2000:11) found "*the care environment is equal to resident's quality of care*" while Tellis-Nayak, (1988:158) established that "g*ood spirits, optimism and happy residents are also related to better physical health*". The findings of Armstrong et al. (2009:13) report that "g*ood work conditions are related to better care for residents*". All of the citations listed below contained a similar quote (Innes et al. 2006:47-57; Casper and O'Rourke 2008:S256; Banerjee et al. 2012:390; Bourgeault et al. 2009:119; Bishop et al. 2009:621; Daly and

Szebehely 2012:140; Lupton and Croft-White, 2013b:8). These authors all recognised the importance of good work conditions for the care workers and how those conditions influenced the experiences and perceptions of care. The abundant research confirms that the work experiences of care workers have been explored from various perspectives. However, the similar resultant findings had not been compared across these three countries for cross-national comparisons in order to provide significant outcomes.

Three key features were consistently identified across the countries in the literature review and supported by my participants, fieldwork experiences and data, and the nursing homes. First, the nursing homes in this research were identified as institutionalised according to Goffman (1961) (previously defined in chapter 3, i.e. batch living, binary management, inmate role, the institutional perspective). Second, the nursing homes were dominated by for-profit ownership and influences of broader social structures. Berta et al. (2004); Pollock et al. (2005); Kash et al. (2006); and Armstrong et al. (2009) implied that care under those circumstances often becomes secondary to business goals. Third, care workers provided care for residents that consistently represented the most dependent vulnerable, frail, oldest people in each society primarily those with dementia, who can no longer care for themselves or live independently (He et al. 2005; Caron et al. 2006; Innes, 2009).

Care worker differences

The greatest differences found in this research were the care workers as a workforce or group in each country. While the care workers as a workforce varied the most between the countries the overall resident populations, care needs, care practices, and the organisation of care across the settings were very similar.

The care workers that had maintained the longest employment with the least amount of turnover were in Canada. This group of workers were highly rewarded which encouraged these workers to maintain steady employment longer in comparison with those in Scotland and the USA. However, these Canadian PSWs had the lowest staffing levels and delivered care under the most difficult work conditions across the settings. All three fieldwork sites had to manage care with inadequate staffing levels or staff without sufficient knowledge or skills but the turnover levels in the USA were much higher in comparison with Scotland. In Scotland the nursing home was identified as a stepping stone or educational inspiration to acquire qualifications and experience for university. The primary goal for the youngest group of care workers was to gain requirements to go on to university for nursing. This highlighted noteworthy information for Scotland as two age peaks were identified by the Official Statistics Publication (2012) and the younger CAs identified the nursing home as a career ladder. In the USA, the valuable knowledge learned from the comparisons of the other two countries in regard to retention, support, and rewards to develop a dedicated stable work force was significant because neither existed. This may be discouraging to the nursing home industry in the USA. However, in comparison to the money spent on new

hires it might be time to consider alternatives. Salary, benefits, and staff support do affect

turnover rates and were also incentives to remain employed at the same nursing home for a

longer period of time.

Answering My Research Questions

To answer my five research questions outlined in chapter one, the key findings from

chapter's six to nine in the analysis will now be linked back and supported by the research

literature discussed in chapters two to four, and the theoretical perspectives outlined in

chapter five. The dual theoretical perspectives of symbolic interaction and cross-national

comparisons added context to the findings that contributed to the body of knowledge

central to the work experiences of care workers in nursing homes. The complementary

comparative framework enabled me to compare the care workers using the same approach

and research tools across the settings that revealed remarkable similarities and differences.

Experiences of care

What are the care workers' experiences and perceptions of care?

Across the three countries the care workers' experiences and perceptions shared strong

similarities. The care workers had little contact with the managers and felt their needs and

concerns were frequently dismissed. The daily routines in the nursing homes were framed

around task oriented care within strict time frames consistent with the research literature

presented in chapter 2. Although the workers responsibilities centred on a whole person,

they were only delegated enough time to care for part of the person (Wolkowitz, 2006). This left many resident care needs guaranteed by the care standards, omitted or only partially fulfilled. Basic ADL care was priority leaving simple daily pleasures that were rewarding for the care workers and residents absent from their experiences. Consistent with Daly and Szebehely (2012) the care workers in this study expressed distress with the inability to adequately meet the residents' needs. Both Armstrong et al. (2009) and Banerjee et al. (2012) documented that not only were the care workers unable to complete physical care, social care was often ignored. The absence of sufficient domestic, incontinent supplies and equipment that included wheelchairs for transportation, lifts for the bath tub and elevators, was common in all of the settings. My findings suggest that the absence of these essential items for care created frustrating and helpless work experiences. The care workers repeatedly questioned why there was not more time or staff and felt bad for the residents but knew that they could not change the situation.

Relational aspects of care were frequently ignored because they were in contradiction to the goals of efficiency. The care workers repeatedly expressed the desire to spend more time with the residents, particularly if they were agitated. The intimate nature of care work was extremely difficult for the care workers especially without the knowledge of the residents' preferences. Jonas-Simpson et al. (2006), Brannon et al. (2007) and Tinney (2008) report that absence of these significant aspects of care were distressing for the care worker's well-being and were reflected in their narratives of care for the residents.

The nursing homes were stigmatised from multiple dimensions discussed in-depth in chapter 3 where stigma was conceptualised as traversing boundaries from the location as a site to work or live, to the person who provides or receives care services. Too add the nursing homes were associated with places for people with dementia, illness and death (Gustafson, 1972; Gamliel and Hazan, 2006; Whitaker, 2010). All of these factors combined resulted in multiple forms of stigma. The care workers recognised the stigma of working in a nursing home, yet several demonstrated how they refused to allow the degrading work affect them.

Training requirements

What are the care workers' training requirements in each country?

The training requirements for care workers were summarised on Table 7 in chapter 4 and highlight the significant differences that exist in the required training for a care worker in these three nations. There were unique approaches to acquiring qualifications with considerable extremes: from the number of hours or units required for training to the manner in which the requirements were to be achieved. These differences included competency based assessment to an exam and from the classroom to on the job training and varied in location. A background check was required before anyone could be hired yet no standardised regulations were applicable for all of the workers and no previous experience was required for any workers.

The PSWs in Canada required the highest numbers of hours of training out of the three fieldwork sites. The training required almost a year in a community college setting (Health Canada, 2012). The training and clinical practicum in a nursing home allowed the students the opportunity to apply their new knowledge and skills under supervision with support. Upon completion of the practicums in two settings, a double matching process was implemented for future employment. The majority of the nursing homes were unionised which provided benefits in addition to the government, such as collective bargaining, seniority, retirement pension, and better wages with regular increases. This has reduced turnover in care workers and was reflected by two PSWs that had maintained employment at Shady Pines for over 30 years. The union encourages on-going training and PSWs who wanted to pursue further education were encouraged to do so. The decision to increase education and move vertically within the care sector helped to prevent the loss of PSWs to other settings. Several of the registered practical nurses started as PSWs and had worked their way up. The PSWs were adamant about the need for even more extensive training. On several occasions the PSWs expressed that, the more training they had, the more they recognised the need for additional training. This group of workers was the most stable, on average the oldest in my research and had witnessed the resident's physical and cognitive care needs escalate over the years.

At Shady Pines in Scotland, the senior care workers and CAs consisted of two distinct groups in regard to their length of training and age (Official Statistics Publication, 2012). First, the senior care workers who had been employed for many years expressed concerns over the need for more training. Like the Canadian PSWs these senior care workers had

also observed an increase in the resident's care needs over the years. Shady Pines employed the only full-time training coordinator to ensure the new hires were meeting their competency based qualifications that could be acquired on the job. The second group of workers were primarily younger CAs who openly stated their goal of working in the nursing home was to gain qualifications and 1 ½ years of experience to meet the requirements for admission to university. These CAs expressed a desire to go on to university for nursing. This was encouraged by the registered nurse who had worked in a nursing home at an early age. The matron also encouraged this path as it provided the CAs with hands-on experience. The senior care workers voiced concerns over the skill levels of the younger CAs, especially those who were new to care work in nursing homes. Although the role of the senior care workers was to support and train the new CAs, they did express some resentment in their narratives about working with those CAs without any work experience. The senior care workers expressed on those occasions they would be providing the bulk of care.

Turnover for the CAs was high but not for the senior care workers. My findings support an educational inspiration or career ladder for the CAs who did not have the qualifications or experience for acceptance at university. The process of gaining qualifications and experience in addition to the high turnover resulted in a gap in knowledge of the resident preferences that were essential to support choice and dignity.

Wisteria Lane in the USA required the least amount of training out of my three fieldwork sites. The USA was the only country that had an established mandatory registry. Once the

minimal training of 75 hours was achieved and the basic requirements were met, a certificate to practice was granted. To be in good standing on the registry, the CNAs had to be employed and complete a one hour compulsory training session each month (Office of Inspector General, 2002). The training was provided by the nursing home and predetermined topics were required to be covered within a year but it was essentially left to the discretion of the manager or a nurse. In the USA CNA turnover was so high that at Wisteria Lane only a few CNAs had worked there for more than a year. The high turnover was a major concern and magnified the absence in knowledge of resident preferences. Perhaps because this stigmatised workforce was viewed so poorly by society that over the years the job was referred in the research literature as 'something any warm body can do' by Vladeck (1980), Stone (2001:50), and Kane and West (2005). This perception along with the low wages and scarce benefits until their one year employment anniversary, left few reasons for any long-term commitment from these CNAs. Furthermore, it was established by Eaton (2000) and echoed to me by the manager during fieldwork that these workers were not to be trusted. The absence of concern for these CNAs in society or their location in regard to access to resources or support contributed to the high turnover and not reporting to work when scheduled. Recently Dill et al. (2013) affirmed these sentiments maintaining that without the needed supports in place for the CNAs, it was easier to not show up for work to avoid another negative experience. The CNA certification was easy to obtain and there were always nursing homes looking for new hires.

Organisational characteristic

How do organisational characteristics influence the delivery of care in the settings?

The similar categories of ownership as for-profit, voluntary and government, with for-profit ownership dominating the nursing home industry were considerable for this research. The organisational characteristics for the nursing home industry across the nations was summarised on Table 1 in chapter 3. The consistency of these categories across all three countries allowed for more accurate comparisons based on these specific organisational characteristics (Berta et al. 2006; CDC:NNHS, 2006; Scottish Executive, 2006). Tellis-Nayak and Tellis-Nayak (1989) and Armstrong et al. (2011) implied that the practices had shifted from nursing home care viewed as a public good to the commercialisation seen in the for-profit sector.

Mercer et al (1993) and McGregor et al. (2005) suggest that for-profit nursing homes were less likely to spend money on extra staff, supplies and equipment. The additional time and work that the care workers were required to spend to provide resident care without sufficient resources and adequate time was more costly in the end. Throughout my fieldwork the care workers constantly questioned the lack of resources but had accepted that care work was not going to change. It was consistently noted in the research that reducing staff levels was one of the best options to increase profits (McGregor et al. 2005). However, the choice to eliminate a care worker position on paper when reviewing the operating budget had consequences in practice that impacted almost every aspect of work for the care workers and residents alike.

Descriptions and distinctions of care

How do care workers define the concept of care and make distinctions of care?

The demands and descriptions of care were scrutinised to underscore the differences in the care workers' perspectives in each setting. The descriptions of care featured positive relational family metaphors that would have typically been provided under ideal circumstances. The portrayals depicted the gold standard of care until the care workers were asked to make a distinction between good care, ok care and bad care. The descriptions of bad care divided into three primary categories for each country and represented the care workers interpretations of care practices. In the descriptions of care, each country had at least one category of bad care that included the residents sitting in wet or soiled clothing which was discussed in chapter 8 by Glendenning (1993:20) as an indicator of poor care practices. In the absence of staff, time, skill level and resources the care workers were unable to provide better care for the residents. The care workers were aware of the stressful work conditions yet often felt powerless and were unable to articulate the cause.

The demarcations of bad care given by the care workers with the exception of two categories all had examples that focused on apparent physical characteristics. One definition from Scotland had no apparent physical features and included working there for a job, cheque or experience, all to get into university. The other example in Canada was a regulation implemented by the Ministry of Health and LTC, (2006) that did not allow changing a brief until it reached the 80 percent wet mark indicated by a tab. The care

workers knew that when a resident was at 50 percent wet they would exceed the limit by the next shift. Then the process of cleaning would require a shower or a bath for the resident, changing their clothes and bedding which was more costly and time consuming in the end. This highlights other examples where bad care was also the result of factors beyond the care workers control.

Reflexive practice

How are reflexive (insightful; perceptive; instinctual) practices used by care workers in each country?

Reflexive practices for care workers were defined as applying insightful, perceptive or instinctual knowledge learned from prior experiences. Care workers frequently drew on previous experiences from their own family. The care workers used reflexive practices to make decisions for the residents in the absence of time, information and resident preferences. These reflexive or intuitive practices were not included in training but were utilised when care responsibilities placed the care workers in situations that they were not prepared to manage. Willcocks et al. (1987:63) state that "*care workers approach tasks of residential care from a background of common sense caring and experiences practised in the domestic setting*". Furthermore, Kontos et al. (2010:356-357) demonstrate that in providing care the workers drew heavily on their personal experiences. The prior research acknowledges that care workers bring their experiences from home to work. However, as previously emphasised the care workers varied the most as a workforce between countries. Therefore, the experiences and skills that the care workers brought from home to work also varied by country.

In summary, the requirements to be a care worker varied extremely by country, province, local authority and state, although the care provided appeared to be similar ADL care regardless of the location. The training was not standardised in any of the countries nor were the staffing ratios. At each field work site different obstacles prevented the care workers from providing the level of care they knew the residents needed but they were unable to give under such circumstances. In the end, the resident's care needs were often not met according to the guaranteed standards of care and the care workers were most frequently blamed. This contributed to frustrated and helpless work experiences for the care workers that were beyond their control. The wider structural forces beyond the nursing home, government regulations or the lack of regulations prevented the care workers from providing the level of care they wanted to give and knew the residents needed. The inability to deliver care to residents with high levels of cognitive and physical care needs was often a violation of human rights for both the care workers and residents across these nations. This cross-national comparative research concludes with suggesting that future researchers go beyond the care workers and individual nursing homes and explore broader institutional and social forces for the responsibility of providing care according to the standards. Good working conditions for care workers are precursors to good care for the residents.

Exploring the work experiences and perceptions of dementia care workers revealed new understandings of care work in nursing homes. This research identified key features that significantly impeded the care workers abilities to provide proper care for residents. Although there were high expectations for the care workers to provide compassionate,

supportive care, there were considerable structural forces that obstructed such care (Foner, 1995b:1; Bourgeault et al. 2009; Armstrong et al. 2009; 2011). The absence of time and resources created difficult work conditions and experiences for the care workers. The outcome was the inability to deliver relevant care guaranteed to the residents according to the government standards in each country. In conclusion, this exploratory comparative thesis has identified and contributed to three gaps in knowledge and three key findings for practice. Moreover, throughout this thesis, culturally specific practices were also identified in the text that related to work experiences of care workers in nursing homes in Canada, Scotland, and the USA. The exploration of concepts central to care, the training required, and the lived experience of dementia care workers highlighted the salience of work conditions and environments. Utilizing a comparative framework at the macro and micro levels, and ethnographic methods provided valuable information about the work experiences across three settings.

Practice, Research, and Policy Implications

Practice implications

This comparative research revealed new understandings on dementia care workers in nursing homes. The feature that varied the most throughout this research was the care workers as a workforce in each country. Care workers were expected to provide proper resident care under difficult conditions without sufficient resources. Some groups were better equipped at coping with the poor work conditions as a result of their level in society and access to available benefits (Wilkinson and Pickett, 2009). The current care practices

placed the care workers in a position for negative interactions with the residents in task oriented routines framed around physical care. Without significant time and resources the care workers struggled to complete physical care ignoring other aspects of care (Armstrong et al. 2009).

In the absence of dementia knowledge, time and resources, the residents with dementia were separated out of view of the public eye. The residents were not allowed to move around the nursing home freely. There was no encouragement, access, or assistance for these residents to interact with the wider community or simply go outside. Across the fieldwork sites the nursing homes were working by unwritten rules. These similar policies, rules and regulations were developed with good intentions but in the absence of dementia knowledge and understanding the care practices did not allow dignity and choice for the residents. Regulations or standards of this nature developed without dialogue from those who provide dementia care set the care workers up for negative interactions. The consequences of rules and regulations implemented with the lack of dementia awareness from policy makers, resulted in care practices that were counter-productive when put into practice. These practices were intended to be helpful in everyday practice but often augmented the negative circumstances. In the absence of resident preferences or knowledge the care workers relied on reflexive practices to make care decisions for the residents. This was a critical aspect for practice when the care needs exceeded the skill level of the care workers. This research suggests that the care workers bring their experiences from home to work and were utilised as reflective practices.

Research implications

The findings throughout this thesis underscore the significance of cross-national comparative research. Multi-country data such as the results from this study can help to inform researchers, governments and policy makers to better understand the broader implications and consequences of aging societies and the services in the LTC continuum, specifically the nursing home and the care workers providing such care. The knowledge learned from other countries, including those with different health care systems, could facilitate the crafting of more appropriate policies and research agendas.

Eaton (2000) linked human resource management and patient care quality in nursing homes. In her conclusions she recommends "*International comparisons of care for elders and disabled under other regulatory regimes would be valuable, particularly where more coordinated and alternative services are provided than in the US*" Eaton (2000:611). This study has provided evidence demonstrating that international comparisons reveal valuable information.

Policy implications

This comparative research has identified relevant findings critical for policy makers to engage with dementia care providers. The current care provisions create situations that place care for the residents unattainable for the care workers for reasons beyond their control. Care workers must follow the rules of care in nursing homes considered less

traditional places of detention and not linked to the justice system (Emmel, 2012). Furthermore, Kelly and Innes (2012:66) assert that people with dementia in institutional care were less protected by law and therefore more at risk of their rights being violated. The current care practices were identified as violations of human rights for the care workers and residents according to the WHO (2002) collection on long-term care.

Too often low standards of care in nursing homes emphasise the problems as stressful stigmatised work places, the lack of training, ageist attitudes and ignore the wider structural and organisational contexts where the problems have their origins (Tellis-Nayak and Tellis-Nayak, 1989). Care for frail residents with high levels of cognitive and physical needs, calls for a change in the provision of resources to support the care worker workforce. Initiatives need to go beyond the goals for improving quality care for residents and include the work conditions and environments for care workers. The invisibility of care workers as a workforce in each country has made it difficult to develop policy initiatives targeted for this population.

Limitations of This Study

This research was an exploratory study of dementia care workers in three nursing homes in three different countries. The magnitude of this study was over ambitious for a PhD thesis and there were several significant consequences as a result. The ambitious scale of this work prevented the further exploration and thorough discussion of all of the data collected such as interviews with the managers and nurses. This information was rather extensive

and could have provided explanations for some of the unknown questions in the end. Furthermore, the impact and concerns around training were only partially explored as a result of the scale of the work and the lack of standardised training. The results of this study are not generalizable due to the small sample. Moreover, the small number of nursing homes in this research could lead to conclusions that were more speculative. Given a narrower focus perhaps some of the general unanswered questions could be more fully explored.

The need to address certain questions from the data such as the impact of nursing homes that were operated as for-profit versus non-for-profit left many unanswered questions. There was not sufficient time to tease apart issues that were influenced by larger social structures and how those impacted institutionalization and/or for-profit ownership. The lack of adequate resources, staff and time that was needed to provide the level of care the residents required existed regardless of whether the outcome was the result of ownership, institutionally directed care or both.

Reflections

I was extremely fortunate to have the opportunity to conduct a research project of this magnitude as a PhD student. With that said, there were many drawbacks to managing a study of this size. Comparing three countries was extremely ambitious and should be left for large cross-national, well-funded projects. I would not recommend a PhD student to conduct comparative research in three countries. In fact, I would not replicate this study

myself without a large group of support staff and an endless supply of money. This was a self-funded PhD as an international student. This meant that fieldwork was very expensive, and transportation and accommodations alone were astronomical. I could not have survived without the many acts of kindness that were gifted to me in several ways. I thank you all anonymously.

This research was emotionally distressing at times to see care workers ignore residents or interact in ways that were not beneficial to either. During my fieldwork at least two or more residents died at each nursing home. It was touching to watch some of these care workers carry out their work responsibilities over several weeks. Their struggles broke my heart while their strength amazed me. Their openness to share their stories, hopes and fears was heart-warming. They taught me a lot.

Appendices

Appendix A - Observation check list

The observations will take place in the areas in the nursing home where the residents eat, are fed, or are assisted while eating. These observations will be focused on the interactions between the care worker and the residents during mealtimes.

1. Is the CW making eye contact with the resident(s)? **Yes** _____ **No** _____

2. Are they sitting at eye level with the resident? **Yes** _____ **No** _____

3. Do the expressions on the CW face show emotions? **Yes** _____ **No** _____
    (positive affect: pleasure, interest, contentment)(negative affect:sadness,anxiety/worry,anger)

4. Do the expressions on the CWs face look concerned? **Yes** _____ **No** _____

5. Do the expressions on the CWs face look bored? **Yes** _____ **No** _____
    (uninterested or dull)   *(circle relevant ones)*

6. Is the CW talking to other staff about **work, personal issues** or **other**?(circle one)**No** __

7. Is the CW talking on their phone or texting while feeding? **Yes** _____ **No** _____

8. Is the CW talking to the resident(s) being fed? **Yes** _____ **No** _____

9. Is the CW talking to other resident(s)? **Yes** _____ **No** _____

10. Does their body language look like they are interested in what they are doing? **Yes   No**

11. Does their body language look like they are bored? **Yes** _____ **No** _____

12. Does their body language look like they are in a hurry? **Yes** _____ **No** _____

13. Does it look like they are paying attention to the resident(s)?**Yes** _____ **No** _____

14. Are the CWs looking around at something else? **Yes** _____ **No** _____

15. Does it look like they are focused on just the task? **Yes** _____ **No** _____

16. Does it look like they are interested in what they are doing?**Yes** _____ **No** _____

17. Does it look like they are paying attention to the resident's body language? **Yes__ No__**

18. If so, are they responding to the resident(s)? **Yes** _____ **No** _____

Appendix B - Structured interview questions

Care Workers

1. What is your job title? _____

2. Are you a certified, registered or hold a permit to practice from passing a written or demonstration exam or to get your job title?   **Yes** _____   **No** _____

3. Did you have to pay for your training?   **Yes** _____   **No** _____

4. How long have you worked here? _____

5. Have you worked in a care home before?   **Yes** _____   **No** _____

6. If so, how long have you worked in care homes?

   _____

   _____

7. Have you ever worked in any other type of aging service such as *home care*, *hospital*, *assisted living*, *sheltered housing*, *hospice* or any other service that provides care for the elderly?   If yes, circle service.   **Yes** _____   **No** _____

8. Where did you get your training to be able to do your job,

   _____ a. in a school classroom

   _____ b. in a care home with a class room

   _____ c. or on the job training

   _____ d. taking care of a family member

   _____ e. other?

9. Please explain

   _____

10. About how many residents do you take care of on a shift? _____

    _____

11. Do you like your job?   **Yes** _____   **No** _____

12. Is it difficult to take care of the residents and then take care of yourself and your family?

                   Yes _____   **No** _____

13. Please explain

_____

_____

14. Is your job more **physically**, **mentally** or **emotionally** challenging? (circle one)

15. (Choice is selected -) How do you cope with that? _____

_____

16.   Are you **single**, **married, partner, separated, divorced or widowed**? (circle one)

17.   Do you have children? **Yes** _____   **No** _____ How many? _____

If yes the following questions:

18. How many of your children live at home with you?

_____

19. Is child care an issue or problem for you?   **Yes** _____   **No** _____

20. Who keeps your children while you work? _____

21. How many adult relatives live with you? _____

22. How many people **other than family members** live with you? _____

_____

23. What is their relationship to you (roommate, partner, boyfriend, etc.)?

_____

24. Do you consider yourself to be a religious person? _____

25. If so, did that motivate you do choose your career? _____

26. Did your religious beliefs have anything to do with you choosing this job? _____

27. Are you currently going to school or taking courses for something other than care worker?

                                        Yes _____   **No** _____

28. If so what? _____

_____

29. Is transportation to and from work an issue for you?   **Yes** _____   **No** _____

30. Do you own a car?   **Yes** _____   **No** _____

31. Do you drive yourself to and from work?   **Yes** _____   **No** _____

32. Do you use public transportation?   **Yes** _____   **No** _____

33. If so, is it reliable?   **Yes** _____   **No** _____

34. Please explain _____

Appendix C - Unstructured interviews

Care Worker

1. How would you describe a typical day? You get to work, clock in and how does your day go from there?

   _____

   _____

   _____

2. Are you happy with your work routine?   **Yes** _____ **No** _____
3. Would you recommend the type of work you do?   **Yes** _____ **No** _____
4. Do you think **anyone** can do this type of work?   **Yes** _____ **No** _____
5. What are the top 3 reasons you are here?   1._____

   2._____

   3. _____

6. How would **you** define your role as a Care Worker? _____

   _____

7. How do you think the nurses view your role as a Care Worker? _____

   _____

8. Do you see your job as *a labour of love* where you get something from caring for the residents?   **Yes** _____ **No** _____
9. Are you getting '**emotional currency**' for caregiving instead of money? **Yes** ___ N**o**__
10. Does your role as a Care Worker help define who you are? **Yes** _____ **No** _____
11. In terms of your career, what are your plans for the future? _____

   _____

12. Do you plan to go back to school for something in the nursing field? **Yes** _____ **No** __
13. If so, why? _____

   _____

14. Did you get your **high school diploma** or **GED; standard** or **higher exams**?

                                   (circle one)

15. Do you consider being a Care Worker as your career?   **Yes** _____ **No** _____

   _____

16. If so, why did you choose this career? _____

_____

17. Have you ever worked with residents who are confused?   **Yes** _____ **No** _____

18. Was the topic confusion covered in **training** or something you **learned on the job**?

19. (Either choice) Approximately how much time did you spend learning about how to
    communicating with confused residents? _____

_____

20. Do you feel like you had enough training to do your job? **Yes** _____ **No** _____

21. Can you tell me what dementia is?   **Yes** _____ **No** _____

22. How would you define dementia? _____

_____

23. I am going to give you some hypothetical work situations. Please tell me how would you
    respond under the following circumstances?

    If Mr. Smith has asked you 5 times in the past 10 minutes where his wife is and you know
    she is deceased, how will you respond?_____

_____

    If Ms. Jones asks you 5 times in the past 10 minutes when will her son be here to take her
    home and you know he just left, how will you respond?_____

_____

24. Why did you get a job in a care home? _____

_____

25. Do you feel like you have the time to give the care you want?   **Yes** _____ **No** _____
    Please explain_____

_____

26. Do you think the staff to resident ratios meet the regulations?   **Yes** _____ **No** _____

27. Do you think there is enough staff to meet the residents' needs? **Yes** _____ **No** _____

28. Why? _____

_____

29. If not, what do you think the staff to resident ratios would need to be to provide the care
    you would feel good about giving? _____

_____

30. Do you think Care Work is **positive** or **negativ**e? Please explain. _____

_____

31. When you first started working as a Care Worker did you feel like there was a negotiation
    phase where you were assigned more tasks than you could do until they figured out what
    you were **able** to do kind of like a 'hazing' or initiation faze so to speak?

    Yes___ No ___

32. How do you define care? _____

_____

_____

33. What do you think is the difference between the following:

    Good care? _____

    Okay care? _____

    Bad care? _____

34. Do you think bad care happens here even if it is unintentional? **Yes _____ No _____**

35. If so, how do you deal with bad care when you find it? _____

_____

36. Do you think Care Workers change the way they provide care and act when the inspectors
    are around? _____**Yes ____ No ____**

37. What about when families, the Matron or Nurse Manager is around? **Yes ____ No_____**

38. Do you feel more comfortable <u>doing work on your own without anyone watching</u>?

    It doesn't matter either way _____   **Yes ____ No ____**

39. Please explain_____

40. Does this type of work give you more personal freedom?   **Yes _____ No ____**

41. Are you self-conscious about working with other Care Workers?   **Yes _____ No ____**

42. Do you consider yourself to be shy?   **Yes _____ No ____**

43. Have you ever been called shy before?   **Yes _____ No ____**

44. If I define mothering or daughtering skills as: the way you learned to nurture your children
    or mother, do you think those skills have anything to do with how you do your job?

_____

_____

45. Was there a grandparent or older person or mentor that touched your heart or influenced your decision to work in the nursing home? **Yes** _____ **No** ____

46. Do you or did you have a close relationship with an elderly person growing up?

Yes _____ **No** _____

47. Who was this person? _____

_____

48. Did they live in the same house? **Yes** _____ **No** _____

49. Do you use family terms or metaphors for the residents that you are close to? **Yes** _No_

50. Do you ever fear or think about catching some illness or disease working in the nursing home?   _____**Yes** _____ **No** _____

_____

51. What is your: Age _____   Sex _____   Race _____

52. Did you choose working here because of the following? Please answer **yes** or **no**:

_____   it fits your schedule?

_____   you like working with older people?

_____   you like giving care?

_____   the location?

_____   a friend or relative works here?

_____   it was recommended?

53. What would you change about the work for Care Workers in the ***care home industry in general***, if anything?

_____

_____

54. Is there anything else that you would like to tell me?

_____

_____

_____

Appendix D - Interview questions - Manager/Matron

1. How long have you worked in LTC? _____

2. Have you worked in other LTC services such as **assisted living**, **home care**, or other?
   Other _____   **Yes** _____ **No** _____

3. How long have you been employed in your current position? _____

4. Is there a certification or license that is required for your job? **Yes** _____ **No** _____

5. If so, what? _____

6. Were you required to get special training to do your job?   **Yes** _____ **No** _____

7. If so, did any of that training cover working with the elderly? _____

8. What percentage of your residents would you estimate are confused? _____

9. How many resident's do you currently have (current census)? _____

10. How many places do you have licensed for long-stay? _____
    Private? _____

11. Are any places designated for short-stay or respite?   **Yes** _____ **No** _____

12. How long has your care home been in operation? _____

13. How long have you been in this building? _____

14. Is your care home owned by a **chain, group** or **individual?** _____

15. If it is owned by a **chain** or **group**, how many other care homes do they own?
    _____

16. Approximately how many total employees do you have? _____

17. What is your nursing staff composition? For example how many:

    Nurses   _____
    Licensed Vocational   _____
    Medication Assistants   _____
    Care Workers   _____

18. What is your average staff to resident ratio _____

    6:00 am to 2:00 pm   _____
    2:00 pm to 10:00 pm   _____
    10:00pm to 6:00 am   _____

19. What is the starting pay per hour for a Care Worker? _____

20. Do the care workers get any benefits with their job, and if so when do they start –
    immediately, on their one-year anniversary, etc.? _____

    _____

21. Do you personally provide any training for:

    Your administrative staff   **Yes _____ No _____**
    Nurses   **Yes _____ No _____**
    Care workers   **Yes _____ No _____**
    Other staff (who) _____   **Yes _____ No _____**

22. Are you happy or content with the way the LTC industry as a whole is set up and operates
                                    Yes _____ No _____

23. If you could change anything about the industry or system what would you change?
    _____

    _____

24. Can I have a copy of you floor plans of the building or lay out so I can become as familiar
    as possible with where the majority of the staff will be?

25. Is there anything I need to know for safety precautions such as fire exits; evacuation
    locations; and/or contamination procedures?   **Yes ____ No ____**

    If so, what? _____

Appendix E - Interview questions Nursing Manager

1. How long have you been employed here? _____

2. How long have you been a nurse? _____

3. Have you worked in a care home before? _____

4. Have you worked in other areas of LTC with the elderly before such as:

   Home health, assisted living, hospital, hospice, or other? _____

5. Do you have any special gerontology education that makes this job especially suited for you to do your job? _____

6. How many levels of staff do you manage? _____

7. What is you nursing staff composition? For example how many:

Nurses	_____
Licensed Vocational Nurses	_____
Medication Assistants	_____
Care Workers	_____

8. Are these their correct titles?   **Yes _____ No _____**

9. What is your average staff to resident ratio? _____

   6:00 am to 2:00 pm   _____
   2:00 pm to 10:00 pm   _____
   10:00pm to 6:00 am   _____

10. Is there any nursing staff that you do not oversee?   **Yes _____ No _____**

11. Which staff members are specifically designated to give the residents their medications?
    _____

12. Is there a special designation for one of your nursing staff to carry out physician ordered medical treatments for the residents?   **Yes _____ No _____**

13. If so who?
    _____

14. Did this person receive special training to perform these specialized tasks?

Yes _____ **No** _____

15. Do you do IV therapy here?   **Yes** _____ **No** _____

16. If so, who on your staff does that? _____

17. How are your monthly in-service training coordinated? _____

_____

18. Is there a designated person to coordinate these?   **Yes** _____ **No** _____

19. How many years has the longest employed Care Worker been here? _____

20. How many years has the longest employed person in any department been here?

_____

21. What would you estimate your annual staff turnover to be? _____

22. What would you attribute to as the major cause of turnover? _____

_____

23. What is the most difficult aspect of your job? _____

_____

24. Do you provide much **resident care** or is your job primarily **administrative**?

25. If you do provide resident care, approx. how many hours per day? _____

26. Are you happy with the way the *care home industry* in general is organised?

_____

_____

27. If you could change anything in the long-term care system, what would it be?

_____

Appendix F - General information sheet

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A Cross-national Comparison of the Dementia Care Workers in Nursing/Care Homes in Canada, Scotland, and the United States

Researcher: Roxann Johnson

Thank you for taking the time to read this information sheet. This is a cross-national study and different terms are used in each country. The following is a guide to clarify the terms listed alphabetically by country: Canada, Scotland and the United States.

Nursing Home (NH) = Care Home

Executive Director/Manager or Matron/Administrator = The person that manages or runs a care home.

Care Coordinator/Nurse Manager/Director of Nursing = The head nurse in charge of resident care and over all front-line workers.

Care Worker = Personal Support Worker/**Care Worker**/Certified Nurse's Aide (The staff that provide the majority of the hands-on care for the residents).

What is the purpose of this study?
The aim of this study is two-fold. First, I would like to explore the training of care workers in care homes. I want to gain insight from the *care worker's perspective*. I am interested in learning if they feel as if they were properly trained to do their job and if so, where did they get this knowledge. Second, I want to explore whether or not the care workers put this knowledge into practice as reflexive practitioners.

What does this study require?
I would like to interview the Manager/Matron and the Nurse Manager. I would also like to interview the care workers using interview questions; an open-ended set of questions; and then observe their interactions as they work with the residents. I will only ask you to do any of these if you feel comfortable in participating.

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What will happen if I choose to participate in this study?
I would like to spend three to four weeks in your care home. During the first week I would like to conduct a short interview and then a longer interview with open-ended questions. Then, I would like to observe the care workers as they carry out their work and make some notes about their interactions with the residents. I do not plan to interfere in your work or cause any discomfort or potential harm.

What is the purpose of the observation element?
The goal of the observation element in this study is to observe the care workers while they carry out their work to explore the interactions with the residents. I will not participate in work activities but I will assist as a visitor by holding an item, opening a door, etc.

Do I have to participate in this study?
Your participation is strictly voluntary and you do not have to participate in this study. If you decide that you are willing to participate in any part of this research, I will give you this information sheet to keep and ask you to sign a consent form. You are free to withdraw consent at any time and without giving a reason. Your decision will not affect your work in any way.

What are the possible disadvantages and risks of taking part?
It is possible that you or a resident will be distracted by my presence. If this is upsetting I will stop my interviewing or observation. I do not for see any other risks.

What are the possible benefits of participating in this study?
There will be no immediate benefit to participating in this study. However, the information learned by your participation will help answer my research questions and contribute to this cross-national study. It will also provide a better understanding of your job and needs.

Will all information be kept confidential?
All information collected during this study will be kept strictly confidential. Any information that leaves the care home that has your name or country on it will be removed so that you will not be recognised or identified from it. When writing up my results, I will make sure that the details are changed so that no one will be identified.

What will happen to the results of this study?
The results of this study will be published as my PhD thesis in 2008/2009. If you like, I can send you a shortened report.

If you have any questions about this study, please contact Dr. Xxxxx at www.stir.ac.uk or me at www.stir.ac.uk.

Sincerely,
Roxann Johnson, MS, CTRS

Appendix G - Information sheet Manager/Matron or Nurse Manager

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A Cross-national Comparison of the Dementia Care Workers in Nursing/Care Homes in Canada, Scotland, and the United States

Researcher: Roxann Johnson

Thank you for taking the time to read this information sheet. I am a PhD student at the University of Stirling in Scotland where I am conducting a cross-national study comparing the long-term care systems in Canada, Scotland and the US. I am interested in the training of care workers and my aim is to compare the results from each country looking for similarities, differences and patterns. I have worked in different nursing homes in the US for over the past 20 years in various positions such as a care worker, activity director, and social service director.

I would like to explore the training provided to care workers who work in care homes. I want to gain insight from the *care workers worker's perspective*. I am interested in learning if they feel as if they were adequately trained to do their job and if so, where did they get this knowledge. I also want to explore whether or not the care workers put this knowledge into practice as reflexive practitioners.

I would like to seek your consent to spend three to four weeks in your care home. During the first week I would like to interview the Manager/Matron and the Nurses in various positions. I would also like to interview the care workers and then ask them some open-ended questions about hypothetical care situations. The second to third week, I would like to observe your care workers as they carry out their daily responsibilities and make some notes about their interactions with the residents.

I feel that it is important that you know that my goal is to answer my research questions, not judge your care practices or staff. I am following the statement of ethical practice for the British Sociological Association http://www.sociology.org.uk/as4bsoce.pdf . I would like to reassure you that no one except me and maybe my supervisors will know the

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information in my field notes. All information will remain confidential. I would also like to ask your permission to use any relevant quotes in my PhD thesis and any subsequent publications/reports. I will make sure that all personal details are altered so that no one will be recognised. I will be happy to show you any quotes I plan to use. If you do not want me to use the specific quotes I will respect your wishes. If you do not want me to use quotes at all, just leave the box blank on the consent form.

Please feel free to email or call me if you have any questions or concerns. I can be reached at www.stir.ac.uk.

Sincerely,

Roxann Johnson, MS, CTRS.

Appendix H - Information sheet - care workers

UNIVERSITY OF STIRLING

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A Cross-national Comparison of the Dementia Care Workers in Nursing/Care Homes in Canada, Scotland, and the United States

Thank you for taking the time to read this information sheet.

I am a PhD student at the University of Stirling in Scotland. I have worked in several care homes over the past 20 years in different positions. I have worked as a certified nurse aide in the US (which is the same as a care worker) and understand some of the difficulties of your job. I am now conducting this cross-national research study and my aim is to compare the results of each country looking for similarities, differences and patterns.

I would like to explore the training provided to care workers who work in care homes to gain insight from *your* perspective. I want to know if you feel as if you were properly trained to do your job and if so, where did you get your training. I also want to see if the training prepared you with dementia knowledge and then to find out if this information is used on a daily basis while working with the residents.

First, I would like to spend the first part of week one interviewing you with a short interview and then with a second interview and ask some questions about possible work situations. Then, I would like to spend some time observing you as you carry out your daily responsibilities and make some notes about your interactions with the residents. I will be writing down what I observe in a notebook. I will be very sensitive to the location of the observation and I will not observe during personal care such as bathing, dressing, or toileting or if a resident or a care worker feels uncomfortable with my presence. You can choose at any time not to participate in the observation or any part of this study. My goal is to answer my research questions and not judge your work or harm you as a person.

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I would like to invite you to participate in this study. Before you make a decision, it is very important for you to understand why the research is being conducted and what it will involve. For the observation component I am only interested in the interactions that take place on a daily basis between you and the residents. No one except me and maybe my supervisors will know the information in my field notes and all information will remain confidential.

If you are willing to participate I will ask you to sign a consent form. I would also like your permission to use any relevant quotes in my PhD thesis and any subsequent publications/reports. I will make sure that all personal details are altered so that no one will be recognised. If you do not wish to participate in any part of this study, simply leave the box blank on the consent form.

If you have any questions about this study, please contact Dr. Xxxxx at www.stir.ac.uk or please feel free to contact me if there is anything that is not clear. I can be reached at www.stir.ac.uk

Sincerely,

Roxann Johnson, MS, CTRS.

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