A critical examination of how Ontario's home care system policy affects PSW-provided home care and client risk

by

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Author Declaration

This thesis consists of material all of which I authored or co-authored: see *Statement of Contributions* included in this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Statement of Contributions

Research presented in Chapters 1, 3 and 5

Pamela Hopwood was the sole author for Chapters 1, 3, and 5 which were written under the supervision of Dr. Ellen MacEachen and were not written for publication. This thesis consists in part of two manuscripts written for publication. Exceptions to sole authorship of material are as follows:

Research presented in Chapter 2

Hopwood, P. and MacEachen, E. (2021). Policy and Practice Note: Policy, Safety, and Regulation with Regard to Ontario Home Care Clients and Personal Support Workers. Canadian Journal on Aging / La Revue Canadienne Du Vieillissement, 1-9. doi:10.1017/S0714980821000209

This research was conducted at the University of Waterloo by Pamela Hopwood under the supervision of Dr. Ellen MacEachen. Pamela Hopwood was responsible for designing this study, recruitment, data collection and analysis, drafting and submitting manuscripts. Co-author Dr. Ellen MacEachen provided guidance during each step of the research and provided feedback on draft manuscripts.

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This research was conducted at the University of Waterloo by Pamela Hopwood under the supervision of Dr. Ellen MacEachen. Pamela Hopwood was responsible for designing this study, recruitment, data collection and analysis, drafting and submitting manuscripts. Co-author Dr. Ellen MacEachen provided guidance during each step of the research and provided feedback on draft manuscripts. Co-authors McAiney and Tong provided feedback on the draft manuscript.

Abstract

The demand for home care is increasing as aging populations grow in Canada and internationally. Personal Support Workers (PSWs) provide the majority of the direct home care in Ontario, yet there are longstanding *and* acute shortages of these workers. Home care client safety is of concern given complex client needs, the unregulated status of the workforce, and the home care setting.

This thesis aimed to identify policy gaps related to PSW work, and the resultant risks for home care clients. Investigating policy relevant to PSW work, home care, and client safety created opportunity for a contextually informed examination and interpretive analysis of policy gaps and intersecting aspects of PSW-provided home care that may increase client risk.

For the purposes of this thesis, client risk describes potential harm (physical and psychological) stemming from policy governing PSW-provided home care. This meaning of client risk has been used elsewhere to define potential harms to patients in a PSW-occupation risk assessment (Professional Standards Authority, 2016)

This study was conducted with qualitative research methods and tools from Yanow's Interpretive Policy Analysis (IPA). Drawing on the case of Ontario, policies related to PSWs in the home care context were examined (manuscript, Chapter 2). Interviews were conducted with 16 key informants (KIs) experienced in core areas of PSW work, home care, policy, and safety.

This study highlighted safety concerns with PSW education, recruitment, hiring, complex care tasks, and supervision. PSW shortages during COVID-19 were found to prompt policy measures such as accelerated, condensed education and rapid recruitment and hiring, further elevating pre-existing worker and client risks.

This thesis examines how policy that is contextually situated in PSW-provided home care in Ontario affects client risk, adding a policy-prioritised lens to other research that considers home care workers, client risk or client safety, and worker-client interrelatedness.

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Table of Contents

List of Figures

List of Abbreviations

ADL	***Activities of Daily Living***
CCAC	*Community Care Access Centre*
HCCSS	*Home and Community Care Support Services*
IPA	*Interpretive Policy Analysi*
LHIN	*Local Health Integration Network*
OH	*Ontario Health*
OHT	*Ontario Health Team*
PSW	*Personal Support Worker*
QIP	*Quality Improvement Plan*
RN	Registered Nurse
RPN	Registered Practical Nurse
SOP	*Standard Operating Procedure*. Not to be confused with *Scope of Practice*.

“The conditions of work are the conditions of care. Addressing the quality of care requires addressing the quality of the conditions under which care is provided”

~ Armstrong & Cohen, 2020, p.8

“While care for the patients should be the primary concern, such care cannot be provided if the workforce’s own safety and health is not considered simultaneously”

~ Denton et al., 2018, p.9

Chapter 1: Introduction

1.1. Problem Context: Policy, PSWs and client risk in Ontario home care

Home care in Ontario is provided by many contracted and sub-contracted organisations that employ home care workers *including PSWs*. This fragmented/disjointed structure, and the fact that most workers providing personal support services are unregulated, prompted exploration of any checks and balances that exist in policy to ensure client safety. This is of growing importance due to limited health care resources already stretched to meet the needs of our current population, and the rapidly-increasing proportion of ageing Canadians (Nuernberger et al., 2018). For the purposes of this thesis, policy is used to refer to formal documents (including law) which outline processes, procedures, or practices.

Home is the first location most older people prefer to live: A July 2020 poll reported that 91% of adults over 55 would prefer to age at home for as long as possible (Home Care Ontario, 2020). Older people make up a considerable proportion of home care clients: Adults 65 and older accounted for 60% of 650,000 (approximately 390,000) Ontarians who received a total 28.7 million hours of personal support and homemaking services in 2015 (Ministry of Health and Long-Term Care, 2016).

Personal support workers (PSWs) are a critical part of meeting home care needs and avoiding premature long-term care admission for the growing population of older individuals (Nuernberger et al., 2018). Despite their key role in providing care, PSWs are not recognized in Ontario's Regulated Health Professions Act, 1991 (1991), the law that sets out regulatory colleges for health professions, and includes a procedural code outlining rule surrounding registration, complaint investigation and discipline.

Without regulation or another form of organisation to work towards consistent standards in the occupation, Ontario's PSWs have heterogenous education and experience. A minimum

education standard for PSWs was introduced in 2014 (Kelly & Bourgeault, 2015a; Kelly & Bourgeault, 2015b) although education programs vary in length and format despite this minimum standard (Kelly, 2017). However, of more concern is that, in the home care sector, there has been no legal requirement[1] for workers to have graduated from any PSW training program; rather, the SPOs who are contracted by the Ontario government to provide home care have been contractually obliged to assign "home support workers" deemed qualified in light of: the client's care plan, in consideration of law, and according to college regulations when applicable (Ontario Ministry of Health, 2014). In contrast, in Long-term Care, (LTC) since January 1, 2016, every person hired to provide personal support services must have completed a PSW program meeting the 2014 Ministry of Colleges and Universities' PSW program standard, and provided proof of graduation (Long-Term Care Homes Act, 2007, Reg 79/10, s. 47).

Home care PSWs are primarily 'lone workers' who are usually unsupervised (Afzal et al., 2018; Saari, Patterson et al., 2018; Zeytinoglu & Denton, 2006). These unregulated workers go to clients who live in their own homes, and provide personal, often intimate, care depending on clients' individual care plans. Many clients are vulnerable due to health challenges with physical or cognitive ability (e.g., dementia), magnifying the risk of neglect or other abuse by caregivers (Frank, 2020; Yon et al., 2017). Abuse, including neglect, is a potential harm that has been considered as part of risk assessment for the PSW occupation (Professional Standard Authority, 2016). A paucity of information about risk associated with the PSW workforce in Ontario led the Professional Standards Authority to advise the Ontario government this risk could not be quantified:

> "We understand that to date no risk assessment has been carried out for the PSW workforce in Ontario, and a rapid review of published material suggests that little

[1] While this thesis was being finalised (June 2021), The Supportive Care Providers Oversight Authority Act (S.0. 2021,c.17) was passed. However, this law has not been enforced. Furthermore, it does not mandate all home care workers enroll once PSW work becomes a regulated profession.

> work has been carried out on this topic elsewhere. Quantification of the risks will therefore not be possible for this review" (Professional Standards Authority, 2016, p.36).

Despite a scarcity of research studies focused on client abuse by unregulated care providers, there is some evidence of client abuse by Ontario PSWs in media coverage, which provided examples such as verbal and sexual abuse (Baxter, 2018; Rinaldo, 2018). We also note that in a review of the PSW occupation, Ontario's professional regulatory body found that abuse and misconduct occur, although prevalence is unknown and incidents are likely underreported (Health Professions Regulatory Advisory Council, 2006).

Fear of repercussions and power imbalance (e.g., losing services allotted by government agencies or retaliation by care providers) have been identified as barriers to client reporting of poor or abusive care (Frank, 2020; Patient Ombudsman, 2017). Client satisfaction is difficult to measure and indicators of the quality of care do not account for external conditions (e.g., consistency of providers fails to account for staff turnover) (Steele Gray et al., 2014). The methodology, validity and reliability of some quality indicators have also been described as weak or lacking sufficient evidence for home care application (Steele Gray, Berta et al., 2014; Wagner et al., 2020).

Although home care is publicly funded (albeit via for-profit organisations in many cases) and provided under government-defined parameters, there has been scarce oversight by the provincial government aimed at meaningfully ensuring that quality care is provided by PSWs (Afzal et al, 2018). As a result, there are multiple gaps exposing vulnerable populations to potential harms. This study considers the potential that unsafe, low-quality care may be a 'hidden' problem in clients' homes (Hopwood & MacEachen, 2021).

1.2 Purpose

The purpose of this thesis is to critically examine policy in Ontario's home care system that pertains to home care PSWs, and identify gaps that could compromise client safety and particularly, increase risk of abuse including neglect.

This topic transverses public governance (e.g., Ministry of Health, Ministry of Training, Colleges and Universities, Crown agencies) as well as non-governmental organisations, health worker employment conditions, and client safety. Investigation at the confluence of often-separate topics (e.g., PSWs and client safety) provides the opportunity to precisely identify public policy gaps in PSW-provided home care that increase risk for clients. The objective of identifying policy gaps in this target area is achieved by drawing on principles of Interpretive Policy Analysis, which involves going beyond consideration of policy itself to analyse related texts and actors' interpretations as well as descriptions of enacting policy (Yanow, 2011). The student researchers' experiences with clients who had been neglected provided the initial impetus for examining the topic of how this could occur and what contributes to the potential occurrence of client abuse by paid care providers. (Researcher positionality is an important consideration in interpretivist research. This is discussed further in *Methods*, Chpt.3).

1.3. Literature review

The literature review for this thesis begins with describing governance and policy background that shaped the home care policy landscape as it exists today. This section examines contextualizing aspects of the home care system, and particularly, decentralisation as it impacts the organisation of home care in Ontario. A brief discussion regarding home care legislation introduced during the period of this thesis research is also included.

Chapter two is the core element of this literature review. This manuscript (Hopwood & MacEachen, 2021) about policy and practices influencing the PSW occupation in Ontario's

home care settings identifies policy factors relevant to home care PSWs' unregulated status and implications for client safety.

1.3.1 Background: The home care landscape

Health system reform in Ontario over the last 30 years has left a wake of changes due to regularly-shifting policy and organisational factors affecting home care landscape. This has influenced *who* current stakeholders are, with a shift to fewer non-profit organisations. In addition, 'evergreen' (i.e., perpetually-renewed without competitive bidding) contracts have contributed to solidifying service providers' share of publicly-funded services as well as establishing their places in the market as employers.

The value Canadians ascribe to publicly-funded health care is often considered a core part of Canadian identity, and a key political concern (Soroka et al., 2013). Publicly-funded health services are primarily within provincial or territorial jurisdiction in Canada, with administration and delivery falling almost exclusively under the provincial umbrella[2]. Within provinces, health care planning often follows election cycles, leading to politicized prioritising and policy, which in turn influences the form and function of health care. For instance, a June 2020 health services analysis published in the Canadian Medical Association Journal highlights how this short-term approach impairs improvement and sustainability for the long term:

> The decision horizon of many politicians is the time until the next election, which can sometimes lead to the deferral of substantial capital investments to future electoral cycles in order to avoid an increase in deficits in the current electoral cycle or in hope of greater future tax revenue. Capital investment, however, requires long-term planning and commitment, with time horizons of 20 years and longer" (Teja et al., 2020, p.E680)

Political cycles and resultant health policy change have been found to follow patterns that transition similarly to economies- between expansion and contraction (Teja et al., 2020). This

[2] The Federal Government provides funding via transfer payments to provinces, sets standards in the Canada Health Act (1985), and funds care for some groups such as First Nations and Inuit people, serving Canadian Forces members, and some veterans. https://www.canada.ca/en/health-canada/services/canada-health-care-system.html

sort of volatility, which lacks long-term foresight and planning, is part of the historical foundation underlying today's health care systems.

1970s - 2006

Ontario's home care system, formally established in the 1970s, was funded by the province, with most services administered by Public Health Departments and some administered by public hospitals and the Victorian Order of Nurses (Ontario Home Care Association, 2008). Over the years as more services were required, more providers stepped in. In 1996, 42 Community Care Access Centres (CCACs) were set up, initially for connecting people to care; however, from 2006 – 2017 CCACs also acted as corporations that contracted service providers and reported to Local Health Integration Networks (LHINs) (Ontario Home Care Association, 2008). To facilitate CCAC and LHIN communication, the number of CCACs was reduced to 14 in 2006, in alignment with the LHIN geographical boundaries (Ontario Home Care Association, 2008). The 14 LHINs introduced in 2006 acted as an administrative layer to oversee the CCACs (Ontario Home Care Association, 2008).

In addition to organisational structure reform, funding and paying for home care has undergone change. Marketised home care introduced in the late 1990s resulted in Service Provider Organisations (SPOs) bidding for home care contracts; however, the competitive bidding component was later removed as the loss of contracts created unpredictability for SPOs and caused instability in health workforces (Denton et al., 2006; England et al., 2007). This operational instability and the resultant discontinuity of care providers and precarity for the workforce have been investigated in previous literature (Aronson et al., 2004; Aronson & Neysmith, 2006).

2006 - 2019

In 2008, the Ontario Home Care Association highlighted the "local" and "integrated" features of LHINs, and noted the Ministry of Health and Long Term Care (MOHLTC) was less involved in health care service delivery:

> In today's home care scene, the MOHLTC is now a steward, not a manager, of the health system and local health services are planned, integrated, and funded by new structures called Local Health Integration Networks (LHINs) (Ontario Home Care Association, 2008).

The CCACs were found to have a number of excess expenditure issues, and particularly a concerning proportion of spending on administration versus care provision (Office of the Auditor General of Ontario, 2015).The Auditor General also found systemic inequity for clients due to differing costs for services and regional variation in availability of services (Office of the Auditor General of Ontario, 2015). The administrative structures of the 14 CCACs were abolished, while their contracts with service providers and CCAC staff were transferred to 14 LHINs with the same regional boundaries (Ontario Ministry of Health, 2017). If or how effectively this reorganisation addressed issues identified by the Auditor General is unclear, as some things were renamed or moved under another structure. For instance, contracts with SPOs were amended by replacing occurrences of CCAC with LHIN to transfer[3] responsibility (Ontario Ministry of Health, 2017). Over the past few decades of change to administrative and organisational restructuring, funding models have also shifted. Home care marketisation, then the cessation of competitive bidding and a move to managed competition, combined with downloading of hospital patients and population demographics have made it challenging to

[3] LHINs have recently been re-named Home and Community Care Support Services (HCCSS). LHIN/HCCSS care coordinator Isabel said, "I seriously think though that it's not going to affect us much. It's maybe - we joke around about here that it's probably our I.D. badge will change. That is, it will change the design of our ID badge, but our work will continue to be the same because otherwise like, who will do it?"

evaluate the costs/benefits of change, such as implementing LHINs as regional health authorities (Marchildon, 2015).

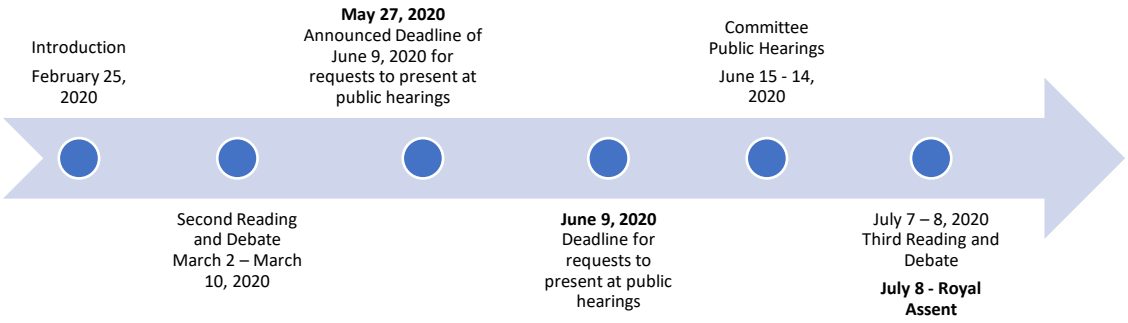
2019-2021

Ontario's health care system was marked for large-scale transformation with the passage of the Connecting Care Act, 2019 (2019). Under the Connecting Care Act, 2019 (2019) the Ontario government brought multiple organisations under a single government agency called Ontario Health, which now includes organisations such as Cancer Care Ontario and Health Quality Ontario. The Connecting Care Act, 2019 (2019) when fully implemented, will position 50 – 70 separate local groups called Ontario Health Teams as responsible for an "integrated" set of health care services (Bell, 2019). With this model, Ontario Health Teams will become responsible for health outcomes for specific populations, and will integrate previously-siloed services (Connecting Care Act, 2019). Although Ontario Health and Ontario Health Teams are not operational yet, responsibility for home care was moved from LHINs to a new transitional agency[4] called Home and Community Care Support Services (HCCSS) on April 1, 2021 (Ontario Ministry of Health, 2021).

In February 2020, the province moved forward with Bill 175, an act that will repeal the Home Care and Community Services Act (1994) and, when enforced, will reform home care as part of an integrated set of services provided by Ontario Health Teams.

[4] https://www.ontario.ca/page/ontario-health-agency#section-1

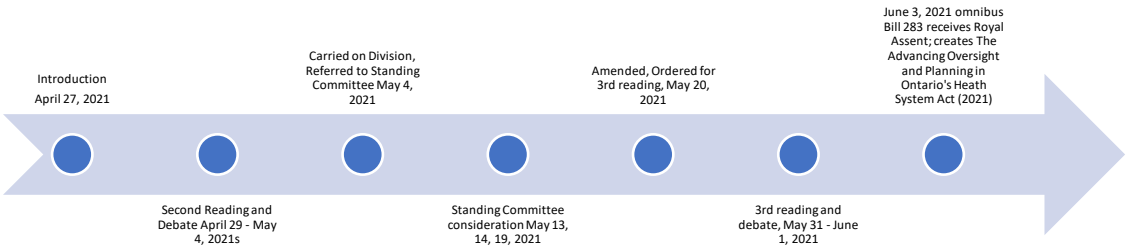
Figure 1: Bill 175 timeline



The Connecting People to Home and Community Care Act (2020) received Royal Assent in July 2020. As of the time of writing (July 2021), the Act has not yet come into enforcement.

On April 27, 2021 following data collection and as this thesis was being prepared, an omnibus bill incorporating multiple proposed Acts was brought forward in parliament: Bill-283[5], An Act to Amend and Enact Various Acts with Respect to the Health System, included the proposed legislation for the Health and Supportive Care Providers Oversight Authority Act (2021). The timeline of Bill 283, which received Royal Assent on June 3, 2021, is represented below *(figure 2)*.

Figure 2: Bill 283 timeline



[5] The Advancing Oversight and Planning in Ontario's Health System Act, SO 2021, c 27 - Bill 283 was an omnibus bill, meaning it contained multiple acts within. The contained Health and Supportive Care Providers Oversight Authority Act, 2021, (chapter 27, schedule 2 of Bill 283, the Advancing Oversight and Planning in Ontario's Health System Act, 2021) will be enacted on a date to be announced by the Lieutenant Governor. https://www.ola.org/sites/default/files/node-files/bill/document/pdf/2021/2021-06/b283ra_e.pdf

One of the Acts included in the Health and Supportive Care Providers Oversight Authority Act (2021) was the Advancing Oversight and Planning in Ontario's Health System Act (2021). This law creates a framework for registering PSWs. The new law, however, appears to have one major weakness in that not all care providers are required to be registered:

> "Part II establishes the Health and Supportive Care Providers Oversight Authority (the "Authority") […] Persons who choose not to register with the Authority are not prohibited from providing health services or supportive care services, but they cannot hold themselves out as a registrant with the Authority or use any visual mark or other identifier established by the Authority for registrants" (Advancing Oversight and Planning in Ontario's Health System Act, SO 2021, c 27, s.2 – Bill 283: Health and Supportive Care Providers Oversight Authority Act, 2021).

This Act addresses a number of the concerns reviewed in this thesis. The dynamic policy environment preceding the passage of this Act is the arena for this research study, which is identifying policy gaps related to home care PSW work as it affects client safety.

1.3.2. What's missing?

As will be discussed further in chapters two and three, data about home care (e.g., interRAI) is often aimed at valuable system-level measurements; however, this poses challenges for wholly understanding PSW-provided home care and client risk.

One area where data collection and analysis seem to miss capturing information regarding home care is within home care quality. The first issue, reflected within the description of *Home Care Patient Satisfaction* itself, is that satisfaction with service providers is conflated with care coordination: Ontario reported the percentage of clients and caregivers who rated home care "…coordination *and* service providers…" as a measure of home care quality (Health Quality Ontario, n.d). The home care 'patient satisfaction' data for the period 2018-2019 was reported as: 41.6% as "Excellent"; 32.2% as "Very Good"; 17.5% as "Good"; 6.3 as "Fair"; and 2.4% as "Poor" (Health Quality Ontario, 2021). Conflating the metrics for very different components – care coordination provided through a government agency (LHIN/HCCSS), and

direct service provided by contracted SPOs – undoubtedly obscures satisfaction rates for each component separately. In addition to satisfaction as a problematic measure of home care services, limitations with who is surveyed and how satisfaction surveys are administered also exist:

- Only clients who receive certain types of service (e.g., long-term home care) are surveyed in the Client and Care Giver Experience Survey
- Inconsistencies in method of administering survey (mode effects) and respondent type (some family/caregivers, some clients, some cognitively-impaired clients)
- Low response rate
- Response bias due to client fear of reprisals or losing services (Health Quality Ontario, n.d.).

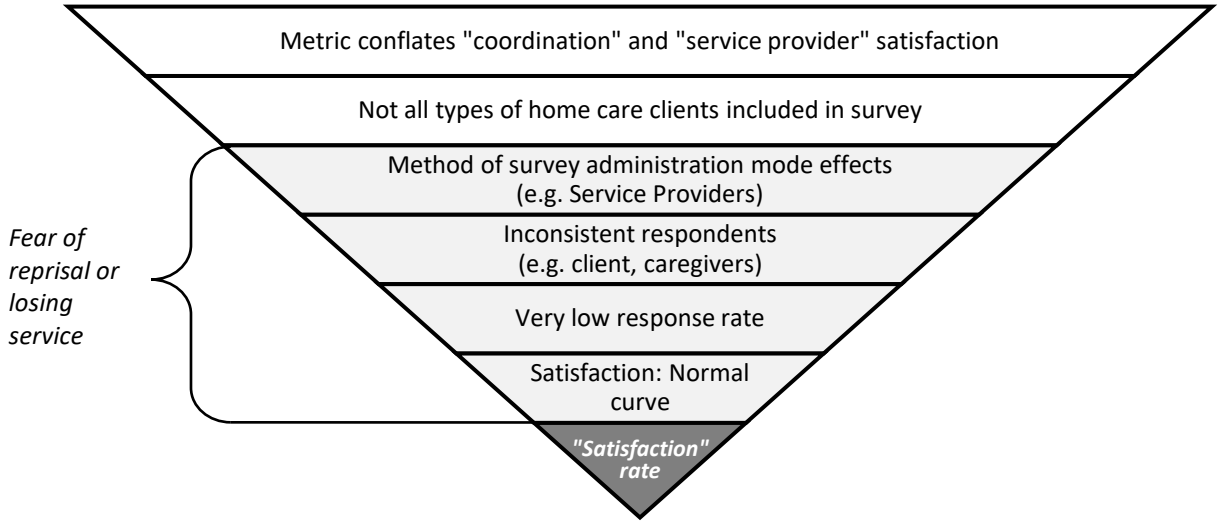
Health Quality Ontario describes a list of caveats and limitations with the quality indicator[6], 'Home care client satisfaction' that purports to measure client and caregivers' satisfaction with '*coordination and* service providers':

> "Several types of home care clients and services are excluded (e.g., end-of-life clients, respite services, nursing clinic services) […] Caregivers were surveyed in place of clients in the event any of the following criteria were met: 1) Client is <19 years of age at time of sample selection 2) Client is identified as cognitively incapable 3) Client is discharged from placement with one of the four discharge dispositions listed under the General Survey Inclusion Criteria[7]. Surveying may be done while a person is still a home care client. They may feel like they cannot respond honestly because of risk to their services. This is mitigated by the survey not being conducted by the provider" (Health Quality Ontario, n.d.).

As a result of these issues, it seems the reported satisfaction rate has *several* limitations overall. These issues funnel down to a publicly-reported satisfaction rate that may be misleading about clients' actual satisfaction (See *figure 3*).

[6] http://indicatorlibrary.hqontario.ca/Indicator/Summary/home-care-client-satisfaction/EN
[7] Admission final; withdrawn, interim became final; withdrawn, placement by other LHIN; refused bed.

Figure 3: Limitations of reported Home Care Satisfaction Rate



As the health quality indicator library description cited above shows, there are issues with the reported "satisfaction rate". This may be a moot point in future, given that the government's health quality website[8] states this indicator will be retired in 2020-2021; however, it appears the "satisfaction rates" are poorly-measured and potentially inaccurate reflections of client and caregiver satisfaction (Health Quality Ontario, n.d.; Steele Gray et al., 2014).

Another problem with the satisfaction rates that Health Quality Ontario reports is that they do not measure client complaints. Clients are instructed to address their concerns with the service providers directly and have little recourse for escalating complaints - particularly as the scope of the Health Services Review Board applies only to eligibility and level of service and does not extend to the actual quality or safety of care. A new Ontario law passed in June 2021, the Advancing Oversight and Planning in Ontario's Health System Act (2021), adds a potential

[8] http://indicatorlibrary.hqontario.ca/Indicator/Detailed/home-care-client-satisfaction/EN

pathway to address some quality-of-care issues, although ongoing evaluation of the efficacy of any new framework for oversight is paramount for future success.

1.3.3. Bringing past and present policy and problems together

With past and current systems, where home care is contracted to dozens of different providers, a number of issues arise related to management and data. A key aspect in this fragmented industry (Martin-Matthews et al., 2012) is the lack of data about the PSW workforce. We found recent literature that cites the number of PSWs in Ontario as approximately 100,000 (Kelly, 2017) based on a 2014 Ministry of Finance news release[9]. Lack of data and the inability to track a worker's background are key problems relevant to client safety and underlie some of the key findings of this paper. In other Canadian jurisdictions, workforce data may be available through worker registries. For instance, The *BC Care Aide & Community Health Worker Registry* covers credentialed workers, and it is mandatory for everyone who wants to work for publicly-funded organisations to apply (The BC Care Aide & Community Health Worker Registry, 2013).

As evidenced during the COVID-19 pandemic and discussed in the findings paper (see Chapter 4, p. 76) having Non-Governmental Organisations and different health sectors working independently does not encourage a care focus that is oriented around clients' best interest. This sort of sectored care can position parts of the health system against one another:

> Silos give an incentive for cost shifting. No organization has full responsibility, or accountability, for the health of a population. Issues arise across sectors, as well as across geographical boundaries. […] service-based funding gives incentives to: increase volume, decrease length of stay, and shift costs to other silos (which may be confused with cost saving if decision makers do not look at these other budgets) (Dayan et al., 2009, p. 32).

[9] https://news.ontario.ca/en/release/29418/improving-home-and-community-care-for-ontario-seniors

The current transitional period is the means towards the goal of an integrated system; however, how this will play out, and the impact, remain to be seen.

Chapter 2: Policy and Practice Note: Policy, safety, and regulation with regard to Ontario home care clients and Personal Support Workers

Status: Published

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Abstract

In light of COVID-19 and elevated concerns for the health of older Canadians receiving care, this Policy and Practice Note explores the confluence of the current home care policy landscape and the organisation of personal support worker (PSW) work, and highlights the need to consider governance of PSW work generally, and in home and community care especially. PSWs are currently not professionally regulated, nor is there a central site documenting location, education, or any form of verification of the PSW workforce. Home care PSWs often provide physical care in isolated settings with no in-person supervision. In home and community health care, complaints about PSWs can be scattered among different service providers or client files not linked to or searchable by PSW name. This policy note explores how these factors and the currently-unregulated status of PSWs affect home care safety in general as well as in the context of COVID-19, Ontario's decentralised home care system, and efforts towards professional regulation.

Résumé

À la lumière du COVID-19 et des préoccupations élevées pour la santé des Canadiens âgés qui reçoivent des soins, cette 'Note sur les politiques et les pratiques' explore la confluence du paysage actuel des politiques de soins à domicile et de l'organisation du travail des préposés aux services de soutien à la personne (PSW), et souligne la nécessité de: envisager la gouvernance du travail des PSW en général, et en particulier dans les soins à domicile et en milieu communautaire. Les PSW ne sont actuellement pas réglementés professionnellement, et il n'y a pas non plus de site central pour documenter l'emplacement, l'éducation ou toute forme de vérification du personnel PSW. Soins à domicile Les PSW fournissent souvent des soins physiques dans des milieux isolés sans supervision en personne. Dans les soins de santé à domicile et en milieu communautaire, les plaintes concernant les PSW peuvent être dispersées

entre différents fournisseurs de services ou des dossiers de clients non liés ou consultables par le nom du PSW. Cette note de politique explore comment ces facteurs et le statut actuellement non réglementé des PSW affectent la sécurité des soins à domicile en général ainsi que dans le contexte du COVID-19, le système de soins à domicile décentralisé de l'Ontario, et les efforts visant à réglementer les professionnels.

Introduction

The COVID-19 pandemic has highlighted pre-existing issues in Ontario's LTC and home care sectors. Key safety concerns include multi-site workers, chronic worker shortages, and the interrelatedness of personal support worker (PSW) work and client health and safety (Denton et al., 2018; Gruben & Bélanger-Hardy, 2020; Hignett et al., 2016; Ontario Personal Support Workers Association, 2020a). Providing safe care requires Ontario to have policy that will ensure safe practices. To achieve this, we argue that we must support a PSW workforce in order to be capable of meeting our aging population's demand for care.

Medicare coverage for home care is not federally mandated. With home care excluded from the Canada Health Act, heterogenous home care systems exist across the country (England et al., 2007). In the case of Ontario home care, the policy and practices governing PSWs is fragmented across multiple administrative tiers: provincial funding from the Ministry of Health is administered by Local Health Integration Networks[10] (LHINs), which engage Service Provider Organisations[11] (SPOs) via contracts, which in turn employ PSWs. This decentralisation was

[10] The 14 LHINs across Ontario are crown agencies which essentially coordinate and fund direct service providers. LHINs also employ Case Managers, who work with families and clients to assess and arrange for the appropriate care. All contracts between SPOs and the now-defunct Community Care Access Centres (CCACs) were simply moved over to the LHINs through "Amendment Agreements" under a provincial "Transfer Order" when CCACs were eliminated to reduce excess bureaucratic administration and expense (Health Shared Services, 2017).
[11] SPOs are private agencies (both non-profit and for-profit) which are funded through the LHINs to provide a contractually-agreed-upon quantity of services. Examples of SPOs who employ PSWs to provide home care include Red Cross, Paramed, and Care Partners.

developed alongside "managed competition" and the premise that a market-model approach would help reduce costs and make home care more efficient (England et al., 2007). However, this model has devolved as the competitive component has been nearly eliminated over the last decade (Saari et al., 2017; Saari et al., 2018). Despite this, Ontario's model of home care delivery continues to rely on thousands of contractual agreements where SPOs provide care or services in the home and community sector (Wojtak & Stark, 2016). This government-outsourcing has been criticized as neoliberal privatisation (Yakerson, 2019) with governments transferring a set amount of funding to private agencies (SPOs) which then assume associated risk (Martin-Matthews et al., 2012). One paper referred to the outsourcing of home care services as "Uberizing" home care, noting that meeting targets of service provision has become the focus, and a flat rate per visit detracts from the importance of measures such as effectiveness and service quality (Wojtak & Stark, 2016).

Forty-one different SPOs across Ontario have home care services provided by PSWs (Health Shared Services, O., 2019) although with the inclusion of all services such as meal delivery programs and Adult Day Programs, there are nearly 1,000 agencies engaged in contracts with the 14 local LHINs across the home and community support sector (Wojtak & Stark, 2016). The contracts (and other documents related to the contractual relationship such as memorandums of understanding) between SPOs and LHINs are not publicly available, despite the public source of funding. Legislation introduced in 2020 is expected to move contract management to a more local level[12], creating even more contracts[13] . While SPOs sign contracts and agreements with

[12] Ontario Health Teams take various forms and involve different types of health care providers such as Family Health Teams, hospitals, LTC and Home and Community Care providers

[13] https://www.ola.org/sites/default/files/node-files/hansard/document/pdf/2020/2020-08/16-JUN-2020_M013.pdf

LHINs, each SPO presumably creates their own standards for managing their employees, such as PSWs providing homecare.

With the majority of direct care being provided by PSWs, it is critical to examine how workers in this unregulated profession are situated and managed in Ontario's health care sector, particularly as care provision has become an elevated concern during the COVID-19 pandemic (Gruben & Bélanger-Hardy, 2020). However, original data about the Ontario PSW workforce is limited with multiple papers frequently sharing the same sources. For instance, a 2009 survey of Ontario PSWs (Lum et al., 2010) is cited in multiple papers referenced in this article. The sparse data about Ontario PSWs reflects the lack of system organisation and a dearth of research with these understudied workers (Berta et al., 2018). Any form of regulation may improve access to access to data on PSWs.

PSWs and demand for care

Home care is often credited with providing support that allows clients to remain at home, contributing to reduced strain on hospitals and LTC homes, yet resources to provide home care are not always adequate given estimations that up to one in nine of Ontarians admitted to LTC could remain at home if appropriate support was available (Canadian Institute for Health Information, 2020). An Ontario study also suggests that providing equivalent care at home is estimated at 20 times less expensive than hospital care, although the home care sector receives 5% or less of the total provincial health care budget and thus rations care based on available funding rather than need (Home Care Ontario, 2018). A July 2020 poll reported that 91% of adults over 55 would prefer to age at home for as long as possible (Home Care Ontario, 2020). As such, both economic and person-centered goals support the need to provide adequate PSW support for the safe delivery of home care (Saari, Xiao et al., 2018; Saari et al., 2018; Williams et al., 2009) PSWs are an important part of Ontario's healthcare infrastructure, caring for

vulnerable populations including our growing population of older adults (CIHI, 2017). Despite their key role in providing home care services to older individuals living in the community, PSW work has been regularly and systemically undervalued (Afzal et al., 2018; Zagrodney & Saks, 2017). Home care PSWs (who are disproportionately female, older, racial minorities) work under precarious employment conditions, with low wages, irregular scheduling, part-time positions, and no extended health benefits (Zagrodney & Saks, 2017). Research points to these employment conditions to explain why PSWs leave the workforce (Afzal et al., 2018; Barken et al., 2018; Keefe et al., 2011; Lee & Jang, 2016; Lum et al., 2010; Panagiotoglou et al., 2017; Zagrodney & Saks, 2017; Zeytinoglu & Denton, 2006; Zeytinoglu et al., 2009). In 2014, the Ministry of Health and Long Term Care estimated home care PSW turnover at 60% annually (MINISTRY OF HEALTH AND LONG-TERM CARE, 2014). Home care PSW's work hours vary depending on the needs of clients and can be modified with little notice when client circumstances change (Zeytinoglu et al., 2015). A further aspect of poor PSW working conditions is travel, with unpaid time to and from client homes, no compensation for the cost of operating a vehicle or taking public transit, and no allowance for hazardous weather conditions (Fitzpatrick & Neis, 2015; Lippel & Walters, 2019). Schedules that are disrupted by last-minute cancellations and additions and include large gaps in the middle of a day, together with obligations to keep certain days and times free for potential client need, reduce worker satisfaction (Lum et al., 2010; Panagiotoglou et al., 2017). PSW retention has been evaluated from numerous angles, yet Ontario (as well as other jurisdictions) continues to have an acute shortage of PSWs. Pandemic-era wage increases and bonuses have been introduced by governments and industry in efforts to recruit, retain and re-engage workers; however, these reactionary measures fail to address a myriad of other issues, such as insecure part-time

schedules and unpaid sick time (Fitzpatrick & Neis, 2015; Lippel & Walters, 2019; Standing Committee on the Legislative Assembly, 2020) .

Worker shortages are particularly concerning given that demand for PSWs will only increase as the population ages. By 2030, it is projected that people over age 65 will account for approximately 22% of Canadians, up from 17% in 2018 (Statistics Canada, 2019). Echoing population demographics, home care clientele are also increasingly older. During the 2009-2010 business year, approximately 325,910 Ontarians aged 65 and older made up 54% of all publicly-funded home care service users, increasing to 459,495 or 63% of all publicly-funded home care service users by the end of 2015-2016 (Home Care Ontario, n.d.). Among all Ontario home care clients, an estimated 15% are children, 20% are adults age 18 – 64, and 60% are age 65 and older, with palliative clients comprising the remaining 5% (Home Care Ontario, 2018).

A case for regulation?

PSW work conditions are interwoven with client safety. This has become increasingly evident during the COVID-19 pandemic. Health care workers face challenges such as: insufficient personal protection equipment; increased risk of exposure, illness, and even death; stress and exhaustion; and ongoing violence – conditions described in *The Lancet* prompting authors to state unequivocally, "…healthcare workforce safety is patient safety. One cannot exist without the other" (Shaw et al., 2020, para.8).

Bearing worker and client safety interrelatedness in mind, supporting and protecting the workforce requires a comprehensive understanding of PSW work within the health care system. A lack of data pertaining to PSWs suggests we cannot know what we might (or might not) be missing when it comes to home care client safety and PSW-provided care.

LHIN tracking mechanisms and client-based record keeping miss tracking data as it relates to home care worker presence or involvement in adverse events such as falls, medication

errors and injury (Gillese, 2019; Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018). There is also no aggregate measure or transparent reporting of theft, fraud or other types of incidents involving PSWs providing home care. However, a paucity of information should not be interpreted as reflecting the absence of these issues. The 2015 *National Survey on the Mistreatment of Older Canadians* reported the prevalence of abuse (physical, sexual, emotional, financial and neglect) among older Canadians was 8.2% in the previous year (McDonald, 2018). Paid caregivers were found to be responsible for just 1% of physical abuse incidents, zero instances of sexual, financial, or psychological instances, and 9% of neglect instances (McDonald, 2018). In all types of abuse, these figures were eclipsed by abuse by adult children and grandchildren, spouses, and siblings – (McDonald, 2018) making the role of PSWs and other staff in identification and reporting of suspected abuse a key safety measure. Though these figures reflect well on paid care providers, some differences do exist between the prevalence study sample (age 55 and older and described as 'cognitively intact') and home care clientele, the majority of whom are adults age 65 and older. Response bias (e.g., lower participation in answering phone calls) or other factors may also affect the transferability of the prevalence study data.

Complaint processes and tracking further impede a full understanding of safety and PSW-provided home care. Home care complaints and investigation involving PSWs may be addressed by SPOs, LHINs, the Ministry of Health, the Patient Ombudsman, or Police in the case of criminal investigations. While estimating prevalence of abuse among home care recipients is thus complicated, some additional information contributes to our knowledge:

1. The Ontario Patient Ombudsperson reported 226 complaints in 2018 related to LHIN Home and Community Care, of which 43% related to Personal Support Services; however, the majority of these related to service levels and consistency (Patient

Ombudsman, 2020). For LHIN-coordinated home care, in the recent periods June 2018 - June 2019 and June 2019-June 2020, the Patient Ombudsman received "less than five complaints related to personal security or safety" (G. White, personal communication, September 30, 2020).

2. Clients may turn to legal clinics such as ARCH Disability Law Centre or the Advocacy Centre for the Elderly (ACE). ACE Lawyer Jane Meadus presented the following information at a June 13, 2020 parliamentary committee meeting regarding home care legislation:

> We take over 4,000 calls annually on individual matters on a variety of seniors' issues. We get many calls regarding home care. Examples of those issues would be inaccessibility to home care due to wait-lists, insufficient care, poor quality of care, staff not showing up, inconsistent staffing. (Standing Committee on the Legislative Assembly, 2020, p. M-105).

3. Although not specific to paid caregivers, Statistics Canada reports that older adults (not living in an institution) with a cognitive or mental health disability are as much as four times more likely to have reported abuse by a caregiver (Statistics Canada, 2014).
4. There is no way to assess the amount of alleged or actual health sector crime that occurs, based on what is reported in media (i.e., PSW assault, sexual assault, fraud and theft[14]).

In a decentralised home care system with no tracking mechanism for PSWs and a lack of standard data collection it is difficult to fully assess abuse, neglect or events such as falls or

[14] See for example a) Sexual assault: https://www.yorkregion.com/news-story/7346187-mackenzie-health-psw-accused-of-sexually-assaulting-elderly-patients-evades-conviction/ b) Fraud, theft: https://www.cbc.ca/news/canada/windsor/support-worked-fraud-arrest-victims-1.5043384 c) Fraud: https://quickbitenews.com/article/brampton/brampton-personal-support-worker-charged-with-fraud/ d) Assault https://london.ctvnews.ca/psw-charged-with-assaulting-her-patient-1.5110350

missed visits in PSW-provided home care. This general gap in available information draws attention to the need to better understand the context of PSW-provided home care.

During the COVID-19 pandemic, the plight of precariously employed health workers prominently entered the public sphere of awareness. Issues such as PSWs working for multiple employers and the tension between health care workers' duty to care and their rights to safe work conditions received fresh attention in Canada (Gruben & Bélanger-Hardy, 2020). As unregulated care providers, PSWs do not face the same legal obligations as regulated professionals, such as nurses or physicians, yet are often expected to adhere by the same ethical standards (Gruben & Bélanger-Hardy, 2020). The unregulated status of PSWs has persisted despite years of discussion and debate about personal support work as a profession and types of regulation including the 2006 HPRAC rejection of PSW as a profession (Estabrooks et al., 2015; Saks & Allsop, 2020; Health Professions Regulatory Advisory Council, 2006). The Ontario Personal Support Workers Association (OPSWA), a voluntary PSW association for paying members, has recently been campaigning for self-regulation for PSWs. A July 22, 2020 newsletter from OPSWA states:

> For the last few months, the OPSWA has continued our battle for Self Regulation of the PSWs in Ontario. This battle has been steady and we are happy to inform you all that conversation surrounding Regulation of PSWs have begun (Ontario Personal Support Workers Association, 2020b).

Also, in July 2020, OPSWA published a Call to Action, informing members they were in the *"home stretch for Regulation, Recognition and Professional Respect"* (Ontario Personal Support Workers Association, 2020)para.1). While promoting self-regulation, OPSWA simultaneously provides access to liability insurance and other associated benefits such as annual police checks for its paying members. New sections of the website (https://ontariopswassociation.com/) added between July 22 and Aug 5, 2020 offer different membership types, such as organisation-level

memberships for agencies at the regional, provincial and national levels. The OPSWA website also contains a copy of their bylaws, approved July 30, 2020.

The OPSWA has suggested implementing an oversight body (The Personal Support Workers Institute of Canada) and utilizing their membership body, OPSWA, to facilitate PSW self-regulation. In their proposal for self-regulation (accessed July 22, 2020), the OPSWA stated: "[OPSWA] has established an independent and separate Board of Directors, President and administrative body prepared to monitor complaints and enforce discipline which will be known as The Personal Support Workers Institute of Canada" (OPSWA, n.d.). However, a previously-available page providing details about how OPSWA proposed to handle complaints using a separate board (formerly published at http://www.ontariopswassociation.com/complaints-discipline) was no longer available, at the time of writing (September 11, 2020). According to the Federal Corporation website, The Personal Support Workers Institute of Canada was registered (in the name of Ian DaSilva, OPSWA's Director of Operations) as Corporation #11471422 with Corporations Canada on June 18, 2019 (Federal Corporation,). If and how PSW regulation is constructed will be a key component in safe home care provision – one that health system and policy experts might wish to evaluate, given OPSWA's claim of being in the "home stretch" towards self-regulation (Ontario Personal Support Workers Association, 2020). Although OPSWA has expressed an interest in both the registration and regulatory aspects of self-regulation, greater separation of these roles may be needed to ensure true independence and avoid any conflict of interest, real or perceived.

In lieu of a legally-binding framework , Gruben & Belanger-Hardy (2020) propose guidance for PSWs already occurs in the following four forms:

1. Education standards (e.g., Kelly & Bourgeault, 2015a)

2. Regulated professionals (e.g., nurses) ensuring PSW competency for delegated controlled acts (e.g., Denton et al., 2015; Barken et al., 2015)
3. Supervision through the employer (e.g., Lum et al., 2010; Afzal et al., 2018) and
4. Association (e.g., Ontario Personal Support Workers Association) guidelines or codes of conduct (Gruben & Bélanger-Hardy, 2020).

However, our view is that all the forms of guidance presented by Gruben & Belanger-Hardy (2020) have limitations or caveats, and that some limitations are of elevated concern for home care. Each of these four guidance topics are discussed below.

1. Education: Challenging Verification and No Registration

Gruben and Bélanger-Hardy (2020) propose that a PSW education standard, implemented in 2014 in Ontario (Kelly & Bourgeault, 2015a) can increase client safety. However, this applies only to new PSWs and not those employed prior to the introduction of standardised education (Kelly & Bourgeault, 2015a; Kelly & Bourgeault, 2015b). The number of PSWs currently working in Ontario who graduated since the education standard was implemented is unknown, as there is no central database of currently employed, qualified PSWs. A five year project to create a registry of PSWs in Ontario ended in 2016 without achieving the goal . As well, an Ontario Liberal government plan to unify PSWs under a single provincial agency was dropped in 2018 when the Conservative party formed the subsequent Ontario government (Crawley, 2017). A "pilot project" for a new provincial registry developed by the Ontario government in cooperation with the Michener Institute was completed in 2019; however, plans to implement this or any registry are unclear (Michener Institute, n.d.).

While education may provide a PSW-skills baseline, there is a scarcity of information about their ongoing practises and the effect of education on the quality of home care provided by PSWs.

2. Task-shifting: Delegated but Unsupervised

A key challenge to safety in home care is the need for PSWs to meet increasingly complex client care needs and often perform tasks that are beyond their basic training. Gruben and Bélanger-Hardy (2020) suggest that a safety measure is that they do these tasks under the direction of a licensed practitioner, an approach called "task shifting" (Afzal et al., 2018; Barken et al., 2015; Denton et al.,2015; Saari et al., 2018; Zeytinoglu et al., 2014). However, what tasks are delegated and what approaches exist to educate PSWs to perform such controlled acts varies among SPOs (Afzal et al., 2018; Barken et al., 2015; Denton et al., 2015). How a registered worker, such as a nurse, can follow up or monitor PSWs performing controlled acts in home care is also elusive in policy. One Ontario study found some concern among occupational therapists, nurses and supervisors about home care workers lacking the necessary skill level and assessment abilities important for some complex tasks that were shifted to home care workers (Barken et al., 2015).

3. Employer Supervision: Lip Service Only?

In Ontario's current care system, responsibility for PSWs is considered to be the duty of SPOs who employ them, and the SPOs themselves are contracted by the regional LHINs (Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018). Within this layered system, the onus is on individual SPOs to verify PSW applicants' references and vet their qualifications as this information is not collected in any central location (Michener Institute, n.d.; Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018). The multiple parties involved in home care services (Province of Ontario, LHINs, and SPOs) also lack any common source for documenting worker performance issues or client complaints about specific PSWs (42). For example, in the Southwest LHIN, which uses an "Event Tracking Mechanism System" (ETMS), there is no method for recording information according to which workers are involved

in any reported client complaints or adverse events documented in client files (Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018). The ETMS does, however, incorporate SPO staff or LHIN staff reports of suspected client abuse or neglect – something which frontline staff are trained to recognize and obliged to report (Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018). PSWs often act as advocates for clients and report concerns to supervisors, which is documented at the level of individual client files (Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018).

During the 2018 Long-Term Care Homes Public Inquiry that followed the murder of eight LTC residents in Ontario by nurse Elizabeth Wettlaufer, workers' self-reporting was referenced in the following excerpt from Day 33 of the public hearings:

> Associate Counsel Lara Kinkartz: Is it fair to say that since they're in the home alone, a service provider staff member's failure to report may well go unnoticed unless the patient or someone else there decides to make a report?
> Donna Ladouceur, vice-president of Home and Community Care, Southwest LHIN: *Yes, it could* (Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018, p. 7708.).

Although staff members' failure to report would not be addressed by professional regulation alone, a regulatory body with means to document complaints about workers could contribute to validating workers' past employment records. The LTC inquiry recommends SPOs maintain permanent employee files documenting performance, complaints and concerns (Gillese, 2019). We suggest that this would be most effective on a provincial level so other current and future employers could access information relevant for screening not necessarily captured elsewhere, such as a Police Record check.

Home care settings differ from LTC settings, which are busy environments with family and volunteer visitors, residents, and usually multiple staff, who present a greater likelihood of workers being observed or supervised in LTC than they would be in a private dwelling.

Additionally, LTC facilities (unlike home care settings) are subject to compliance checks and investigations on a regular basis (Gillese, 2019). It is notable that during the COVID-19 crisis beginning in March 2020, LTC homes also drew extensive media attention, while the impact on home care clients receiving PSW-provided care received less public consideration. Lang & Edwards (2006) found home care services lacked measures to address safety issues such as the uncontrolled setting of private residences, especially in comparison to institutionalised settings of LTC and hospitals (Lang & Edwards, 2006). Similarly, Peckham et al. (2018) found the home care system is marginalised and fragmented compared with mainstream "organised and institutionalised" entities such as hospitals (Peckham et al., 2018). This circumstance was aptly described by lawyer David Golden when cross-examining Donna Ladouceur, the vice president of Home and Community Care for the Southwest LHIN during the LTC public inquiry:

> And I'm wondering in that context whether you've participated with anyone from the Ministry in policy discussions over why the group of vulnerable persons that you're serving are primarily protected through contracts, whereas the group of vulnerable people in long-term care have this very detailed, regulatory system? Have you participated in any policy discussions that understand why the two groups of vulnerable persons receiving taxpayer money for healthcare are treated so differently from a legislative perspective? (Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018, p. 7753).

The LTC Homes Public Inquiry, though focused on LTC and registered staff, highlighted multiple weaknesses in home care safety (Gillese, 2019). To date, there has been less attention given to the implications of public inquiry findings relevant for client safety in the context of PSW-provided home care.

The current organisation of home care delivery by PSWs appears to still encompass the same circumstances that allowed nurse Elizabeth Wettlaufer to work in home care, where she stole medication, entered client homes without authorisation, and attempted to kill a client in their own home (Gillese, 2019) . Wettlaufer's home care sector crime has received little attention in light of her serial killings in LTC, yet her activities still illuminate gaps in policy ensuring the safety and security of home care provision. Wettlaufer was, as a nurse, part of a regulated profession. In contrast, PSWs who are not regulated workers and who do not belong to a college or professional body are subject to even less oversight. However, Wettlaufer's crimes, undetected in both LTC and home and community care until her confession, demonstrate that professional regulation is not adequate to compensate for the gaps (or chasms?) between service providers in a fragmented system. The Long-Term Care Home Public Inquiry Hearings Day 33 (Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018)) and the LTC Homes Public Inquiry (Gillese, 2019) made explicit that service providers lack a common source of worker verification, and client complaints about workers are buried within client files kept by a patchwork of SPOs in a network of LHINs.

Ontario's home care system currently relies on client or family/caregiver complaints for ensuring quality of care (Baxter, 2018; Gillese, 2019) . While complaints about eligibility and the amount of time and frequency of care can be escalated to the Health *Services* Appeal and Review Board (HSARB), the narrow mandate of the board renders it unable to respond to any complaints or allegations of abuse (Baxter, 2018; Ontario, Commission for the Long-Term Care Homes Public Inquiry, 2018). A scan of hearing proceedings posted by the Canadian Legal Information Institute (www.canlii.org), shows that HSARB regularly states that complaints about service quality are outside of their jurisdiction according to the Home Care and Community Services Act (1994). The Health *Professionals* Appeals and Review Board (HPARB) *does* deal

with complaints and hearings for the 28 different self-regulated professions, such as Occupational Therapists, dental hygienists, massage therapists and physicians. However, as unregulated health system workers, PSWs are not covered by HPARB (Health Professionals Appeal and Review Board, n.d.).

4. Association guidelines: A presumptive compliance

A fourth method that Gruben & Belanger-Hardy (2020) suggest serves as a form of regulation is the guidance provided to PSWs through membership organisations, such as OPSWA, a voluntary membership organisation with a mandate to support PSWs. However, in the case of Ontario this clearly covers only the voluntary members, meaning the same standards do not apply for all PSWs.

Next steps: Policy & research

As discussed above, education standards, regulated staff delegating controlled acts, supervision through employers, and guidelines created by associations each have limitations, many of which are more apparent in the home care context than in LTC. In light of these limitations, we draw attention to knowledge gaps and explore how policy might address risk and improve safety in home care delivered by PSWs.

There are clear knowledge gaps in what is known about the safety of PSW-provided home care in Ontario. Little research has considered the prevalence of client abuse or neglect by paid home care workers such as PSWs (McDonald, 2018). Studies that consider physical injury (e.g., Doran et al., 2013) do not account for other events that may occur in PSW-provided home care, such as verbal abuse or theft. The taxonomy of safety (such as adverse events) often fails to include aspects such as near misses (Lang & Edwards, 2006). Research about PSWs regularly fails to differentiate between in-home versus institutional workers (e.g., LTC homes), or PSWs versus other in-home workers such as nurses and occupational therapists (e.g., Denton et al.,

2002; Gilmour, 2018; Home Care Sector Study Corporation, 2003). In one paper investigating theories of team-based person-centered care, unregulated home care providers such as PSWs were not considered separately: instead, their role was cited as likely "inherent" to the disciplines who supervised these workers (Giosa et al., 2019). However, PSWs' unregulated status is unique, and regularly mismatched with the level of care these unsupervised workers provide. Regulated professionals (nurses and therapists) in Ontario have described problems with delegating acts or transferring tasks to unregulated care providers, such as training that occurs in usually just one visit, lack of skill to identify changes or assess new issues that arise, and limited opportunity to monitor delegated acts on an ongoing basis (Denton et al., 2015).

PSW care and client safety in research studies seldom go beyond physical outcomes or exploration of events that occur during the provision of care and is remiss to consider how the absence of professional regulation of PSWs may impact research into client safety. Research looking at a single aspect of care provision fails to encompass the risk potential in the "policy-system-worker-client" integrated actuality. Policy-oriented literature in this area also falls short of the mark, often approaching issues from economic or organisational standpoints that miss delving into PSW work and its relation to the safety of home care clients (e.g., Forbes & Edge, 2009; Peckham et al., 2018; Wojtak & Stark, 2016). The accountability of home care structure and delivery is a long-standing concern (e.g., Coyte & McKeever, 2001). One study found that although some accountability existed through regulations such as the Occupational Health and Safety Act, (1990) home and community care organisations were primarily held accountable through limited means such as expenditure tools (Steele Gray et al., 2014). Financial accountability and service quantity targets are priority metrics in SPO contracts, and there were almost no requirements or performance measures in place for the quality of care provided to the vulnerable populations (Steele Gray et al., 2014).

Some portions of the Home Care and Community Services Act (1994), such as the client Bill of Rights (Home Care and Community Services Act, 1994) address home care services yet do not address PSW work specifically. The Home Care and Community Services Act (1994) also outlines certain elements of the Service Agreements between LHINs and SPOs but tends to focus on higher level administrative aspects as opposed to directives about the act of caregiving (Home Care and Community Services Act, 1994). Legislation has also been criticized for failing to deal with funding and capacity of home care services (Sheppard, 2019). How these issues will play out in Ontario's pending Connecting People to Home and Community Care Act (2020) regulation, and the full impact of the recent Connecting Care Act (2019) remain to be seen. Political party mandates after provincial elections or crises may prompt health system change, yet frequent overhaul may unnecessarily increase costs or result in revolving policy modifications. While policy should respond to changing population needs, it is important to balance this with stability in the system and provide some level of security to enable SPOs to plan for ongoing service provision and the necessary resources. This challenge may be addressed through evidence-based, non-partisan research, organisational planning and policy development.

Conclusion

This *Policy and Practice Note* provided an overview of numerous limitations of our current knowledge and policy pertaining to PSW-provided home care and client safety.

We suggest the complexity of home care client safety in Ontario requires research that bridges interrelated domains (such as client safety, occupational health and safety, and health system organisation) to develop policy interfaces that encompass multiple parties, rather than dispersing responsibility but failing to compensate for the resultant fragmentation. To this end, juxtaposing client rights and PSWs' occupational rights as conflicting or sometimes mutually-exclusive is also problematic. Two groups of researchers have approached this issue by

considering multiple parties in conjunction, providing models that might inspire future work. Martin-Matthews, Sims-Gould and Tong (2012) center their inquiry on the experiences of workers, clients and family carers, and managers (Martin-Matthews et al., 2012). Lang and Edwards (2006) developed a patient-safety framework that acknowledged interrelatedness of client, caregiver, and provider safety. Later research citing this framework incorporated a "triad" of participants: care recipient, family or informal caregiver, and paid care providers (Lang et al., 2014). We suggest that home care safety may be best served with this or a similarly-integrated approach that values the safety of all parties. Further research that considers policy, PSW work, and client safety in conjunction, is important for exploring risks in PSW-provided home care and addressing knowledge gaps (e.g., the prevalence of various kinds of abuse and neglect by care providers).

That PSW regulation might improve client safety is something to keep in mind; however, this should be carefully structured. We suggest that if self-regulation of PSWs is implemented, an external regulatory body and legislative change (e.g., Regulated Health Professions Act, 1991) are both needed to ensure that PSWs are regulated fairly and fall under The Health Professionals Appeals and Review Board jurisdiction. Any system introduced should include data about Ontario PSWs working for all types of organisations, including the multiple service providers and home and community sector employers. These employers should also be able to verify workers' qualifications and past performance. As the Wettlaufer crimes demonstrated, registration with the College of Nurses alone failed to protect care recipients. This suggests that alternative solutions or enhancements to a registry or regulatory body may be needed, especially as self-regulating professions are not integrated with the many various private organisations providing care in a decentralised system. To address system-level safety risks, it seems appropriate to consider system-wide safety-related standards as opposed to the current system in

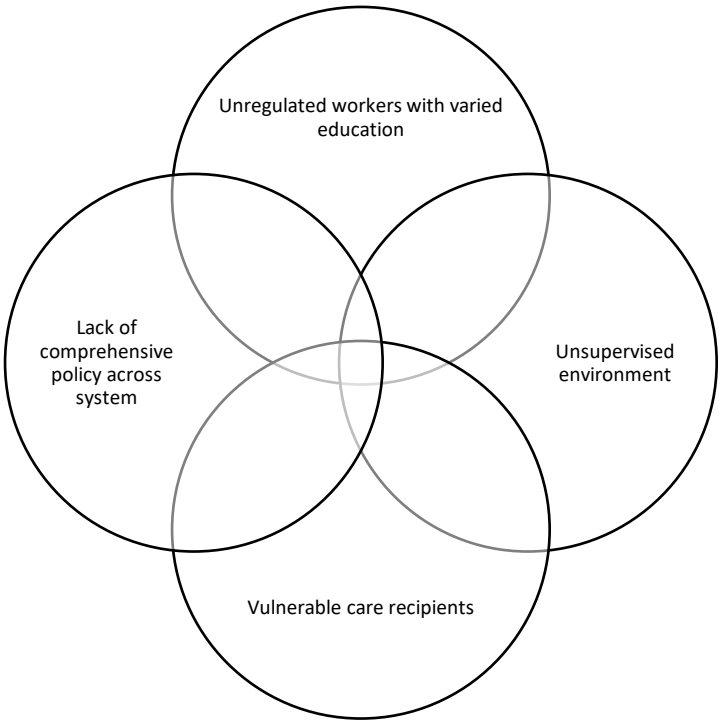
Ontario that has hundreds of separate employers and organisations attempt to develop policies and manage these issues. For example, a complaints-based system that fails to widely track complaints about individual workers (Baxter, 2018; Health Professionals Appeal and Review Board, n.d.) is a system-level problem and therefore calls for a system-level response.

We cannot afford to underestimate the importance of system design: client safety requires policy that recognizes that the roles of multiple parties, and system design itself, contribute to home care safety (Zeytinoglu et al., 2017) and health care safety more broadly. The LTC home inquiry and problems exposed during the COVID-19 pandemic illustrate that current system organisation in Ontario (including the decentralised structure and current accountability mechanisms for non-governmental organisations) do not provide needed safety conditions for care recipients or workers (Gruben & Bélanger-Hardy, 2020). We argue that Ontario requires a robust policy framework that will assure quality and enable our health system to meet increasing demand and sustain *safe* care in emergency circumstances such as pandemics.

Chapter 3: Methods

The aim of this thesis – to examine how system policies shape PSW-provided home care in Ontario, as far as this home care service affects risk of harm to clients– involves a number of actors, processes, and system elements. However, concern for client safety in PSW-provided home care and client risk as described in previous chapters, occurs at the conflux of four components *(figure 4):*

Figure 4: Problem Context



a) PSW-provided home care occurs in non-institutional environments such as individuals' homes or apartments, so is unsupervised

b) PSWs are unregulated care providers with varied educations

c) Many home care clients are part of vulnerable populations. One such group is older adults, a population known to underreport abuse and neglect (Frank, 2020; Yon, 2020) which are considered here as risks for clients' safety. There is limited knowledge of the prevalence of paid caregiver abuse or neglect among home care clientele – a key information gap given the risk inherent in unsupervised, unregulated workers with variable educations.

d) A lack of comprehensive policy – policy that overcomes the structural impediments to safety – transverses each of the other concerns. Prior to the Advancing Oversight and Planning in Ontario's Health System Act (2021), policy failed to consider PSWs in different settings (e.g.,

LTC and home care) and may still neglect privately-hired workers, workers called home support workers, and PSWs who do not sign up for the voluntary registration as proposed in legislation. There is also no policy mandating the frequency or format of supervision of PSWs – something which would need to come from the provincial level to be enforceable and could extend to both government-funded and private home care service providers. Policy to protect populations dependent on care requires further research and is also a concern embedded in each of the other areas.

The complexity of this problem context, and the many various parties involved, contributes to the study design.

Study design

Qualitative research methodology allows selection of appropriate approaches and methods steered by research questions and what is being investigated (Silverman, 2015). Qualitative research was critical for this provincially-located interpretive policy analysis involving multiple home care stakeholders, because it allows for consideration of detailed contextualising factors. Further, qualitative inquiry is useful when flexibility in adapting methods to situations is appropriate – another characteristic key to this study given the policy reforms occurring simultaneously with research.

The intersecting topics and diverse knowledge expertise required for addressing the research questions in this thesis required an approach that considered policy and actors' positions and interpretations, but would also flex in an iterative manner with new information given the changing policy and need to incorporate new information as the study progressed. Thus, we followed an Interpretive Policy Analysis (IPA) approach as this provides the opportunity to explore multiple types of data such as interviews and policy texts and interpret data with consideration of social context (Yanow, 2011). The philosophy that meaning occurs in

interpretations of the many actors involved is very suitable for the complex array of players in home care and their views of policy. As such, IPA provided appropriate methodology to guide this work, as well as analytic tools to draw on during analysis (See *Appendix 3*).

This qualitative study is ontologically rooted in interpretivism, holding that meanings in and of policy *are* interpretations reflective of human understandings (Yanow, 2007; Yanow, 2011, Chpt.1, p.11). In this thesis therefore, policy is understood as expressions of what is interpreted; and how the understandings of actors who read, implement or enact policy and related measures are also acknowledged as arising through interpretation (Yanow, 2011, Chpt.2, p.11). Additional interpretation may also occur, such as in cases where agencies are creating and implementing their own policies according to actors' interpretations of a higher-level policy, leading to re-interpretations another step removed from initial policies.

Theoretical orientation and researcher positionality

Another interpretive level occurs in the researcher's analysis and conveying findings (Yanow, 2001). In qualitative research, it is important researchers acknowledge how their own background and assumptions shape their approach in order to facilitate opportunity for others to critically engage with researchers:

> "From a [Critical Social Sciences Perspective], the point is to render assumptions and ideology explicit. Making them explicit means that they can be contested, and that they can be contested on other grounds than are provided for by the prevailing paradigm. In other words, space is opened up for seeing that things could be otherwise, and for potential change…" (Eakin et al., 1996, p. 158).

To be transparent and open up to this opportunity for critical engagement, I acknowledge that my employment experience (in home care service provision from 2005-2006 and elsewhere in the home and community care sector from 2006-2018) have influenced my framing of this research. Prior work experience provided me with an emic (insider) view of workers' poor employment conditions, as well as examples of policy failures in the 'elbows-deep' reality of home care, and

also influenced my approach to this research. These were also key elements I needed to reflect on while conducting interviews, and during analysis. Obtaining the perspectives of KIs, and the rigorous methods followed while conducting analysis contribute to the reliability of this research; however, as with any research informed by interpretivist ontology and epistemology, others may have interpreted (i.e., *understood as*, and *made meaning from*) data differently.

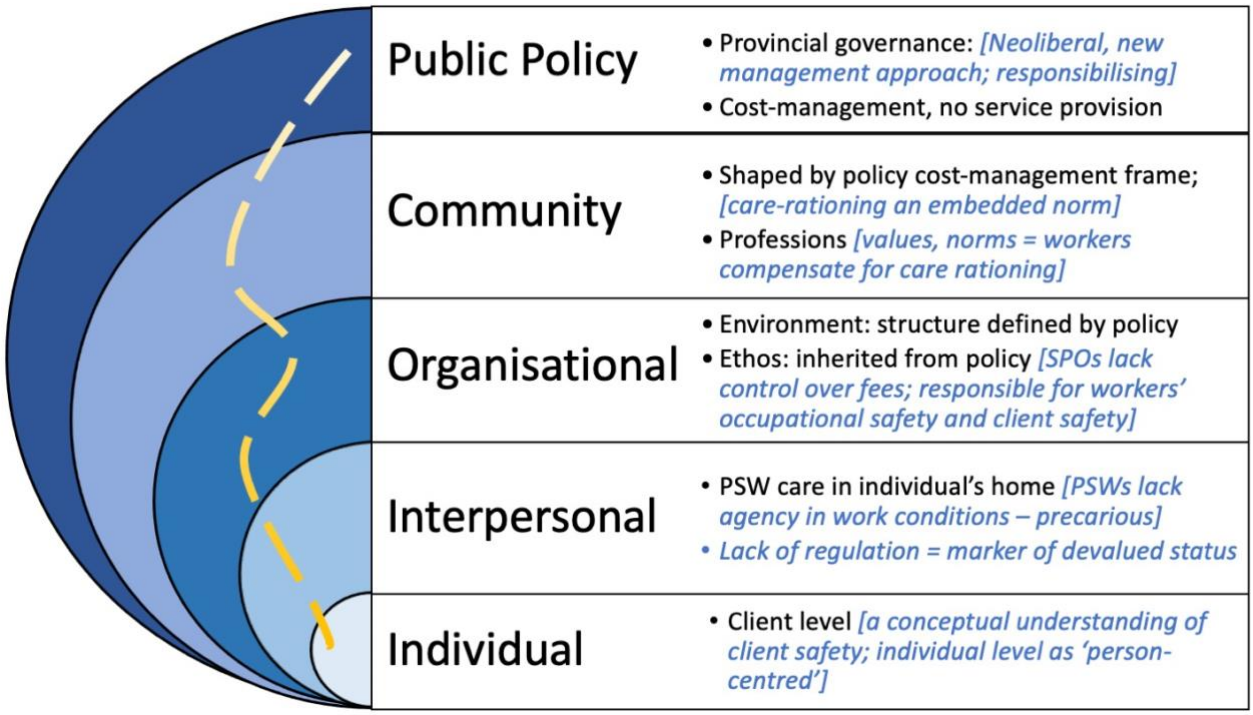
My experience with home and community care influenced my framing of this research and I confronted challenges that arose from re-entry to academe after a 15 year hiatus. Others in similar circumstances have also experienced challenges especially in naming the self with "lived experience" including work experience (Evans, 2000, p 272-273) in disciplines that venerate objectivity - despite the impossibility of purely objective and absolutely unbiased research (Evans, 2000).

The concept of client safety provides an illustrative example of how interpretation can impact meaning. Technocratic measures are commonly used for indicators related to health and systems, including measures related to patient safety. Clinical assessments (e.g. interRAI used across Canada[15]) are immensely valuable for identifying measurable units such as types of adverse events or instances of disease, and are powerful tools for the production of population-level data (e.g., White, 2009). However, these were ill-suited for consideration of the social-contextual aspects of PSW-provided care. InterRAI data is aggregated from standardised client assessments and does not provide information analysed at the worker level, or with consideration of the client-worker intersection within a system shaped by policy. My experience drew me to the observation that these data do not encompass *worker level* analyses; thus, little is understood about how policy (that constructs worker training and employment conditions, and the socio-

[15] https://www.cihi.ca/en/home-care#_Databases_and_Data

political factors that shape the system) affects PSW-provided care. Given that PSWs provide the majority of personal care, it seemed that study of the care provider population in relation to clients was a key factor. These social, political and organisational analyses benefit from a socio-ecologically-informed approach to account for the situated reality of client and worker interaction (Golden & Earp, 2012). Examination of policy influences through this socio-ecological context allowed me to explore the role of policy and contextualised, person-level impacts (which I describe as 'policy that shapes PSW-provided home care, as this care affects client safety'). I suggest that consideration of the impacts of policy on individuals (workers and clients) may contribute to social sciences investigation in a field often dominated by technocratic definitions designed for purposes such as quality or cost-effectiveness measures and meta-data reporting. I further justify this approach by highlighting where individual experiences are mis-matched to indicators or reported measures and propose that person-centredness at times requires accounting for socio-ecological *(figure 5)* factors including the role of the worker and organisational and policy contexts.

Figure 5: Socio-ecologically-informed assumptions and situated findings



Interpretive Policy Analysis

In keeping with interpretivist traditions, this thesis draws on Interpretive Policy Analysis (IPA) as described by Dvora Yanow (2011). This approach is appropriate for this study because it fosters exploration of the meanings of policy, and the interpretations of the actors involved. This aligns with the study's main objectives: a) to understand how home care PSW work and client safety are addressed in policy, and b) how actors involved in the home care governance and service delivery system perceive policy that affects home care PSW work and client safety.

To incorporate some of the considerable components of IPA, there were two *overlapping* phases within this research. The first phase focused primarily on considering policy and relevant literature to lay the groundwork for understanding policies, and the interpretations of stakeholders. The manuscript that forms the core literature review represents the beginning of

our foray into this area. Familiarity and interpretation of policy and related documents is usually the first phase of IPA (Yanow, 2011, Chpt.2). However, policy and other texts were reviewed, and analysis continued, throughout the study.

Overall, this research explored how actors involved in the home care system perceive policy to impact PSW-provided care and client safety. IPA permitted a broad interpretation of 'policy' and exploration, inclusive of a large and complex system and meanings; and it was able to encompass diverse policy that may be broad or specific, with different intent but all pertaining to the problem at the heart of this work. The IPA approach also promoted systematic analysis of who, as policy actors, would be relevant to approach as potential participants, and incorporated the experiences and views of key informants.

The focus of this thesis – exploring Ontario's home care system policies that shape the work of PSWs as far as it pertains to risk of harm (especially abuse) for home care clients – requires such an approach, to encompass not only the various forms and content of data, but also and especially, the meanings interpreted by the parties involved in and around PSW-provided home care. Another factor contributing to the importance of working with a methodology that could adapt to circumstances were two major events: first, this research took place during the global Coronavirus pandemic, which put extra strain on health systems and service delivery, and disrupted the health care workforce; and second, the passage of the Connecting People to Home and Community Care Act in July 2020 created uncertainty about the model of care and pending changes.

Yanow's (2011) approach to IPA is described in the book, "Conducting Interpretive Policy Analysis". For the purposes of this thesis, the book provided several methodological guideposts. For instance, *Chapter 1: Underlying Assumptions of an Interpretive Approach*, guided the philosophical approach to this study. As described in detail above, this thesis is

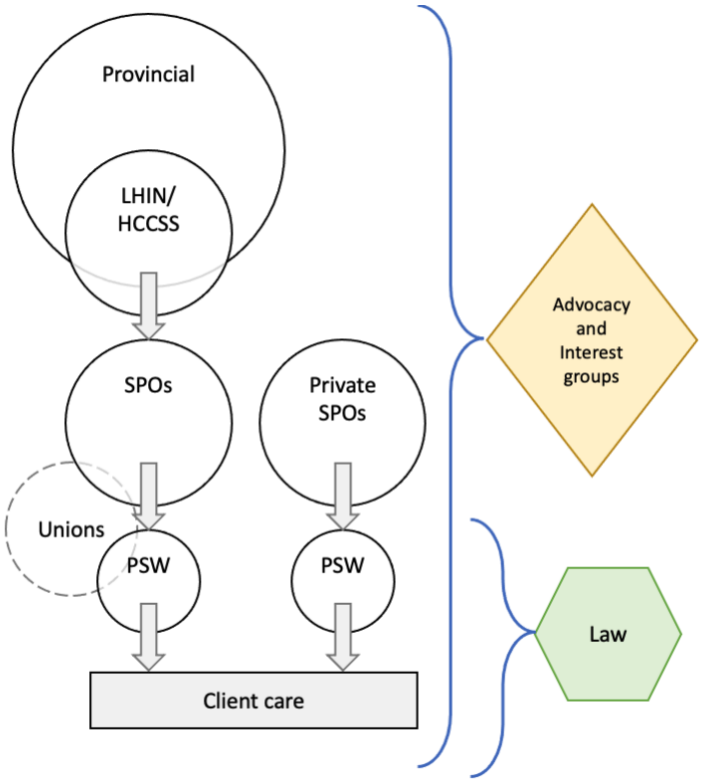
underpinned by a constructivist philosophy, holding that there is no objective 'policy-reality' where meaning is straightforward and neutral, and that policy is created, enacted, and understood through actors' interpretations, and the researcher's own understanding of policy is also recognized as interpretive and not a singular hard-and-fast 'truth' (Yanow, 2011, Chpt 2., p.5). Yanow also emphasizes the importance of accessing local knowledge and policy 'artifacts'. In this analysis, acquisition of local knowledge was preceded by the researcher's a priori knowledge of the home and community care sector (employment in this sector) and some of the sub-communities within and related to this area. Artifacts were predominantly texts, as was necessitated by the limitations of research during the Coronavirus pandemic. However, artifacts also included grey literature such as reports, news articles, parliamentary proceedings such as debate transcripts, and stakeholder submissions to government or presentations in committee hearings. Immersion in local knowledge about the home care system as the site of policy and origin of care delivery included in-depth exploration of 'artifacts' and in-depth interviews with KIs.

Symbolic objects are also used to communicate meaning (Yanow, Chpt. 4). Home care is strewn with symbolic language: notably, nursing profession values, and clinical discourse shapes how many aspects of home care are communicated, such as assessing client needs and terms such as 'Activities of Daily Living' and 'charting'. Professional standards were important symbols, contributing to how the PSW occupation was described, with regulation and registration widely interpreted as means to elevate the social value associated with PSW work. A related artifact was the PSW Program Standard, which emerged as a sort of 'lip-service' symbol without substantial weight or value attached by participants. Among the many other symbolic objects of importance were contracts, organisation names, home as the site of care, legal terms and political processes.

Key Informants

According to Yanow's (2011) description, actors include any parties involved in policy or policy-related processes. In the context of this study, actors thus include politicians and government legislators, home care industry-related organisations or stakeholders that may support or oppose policy, executives, boards, managers, or other staff involved in agencies enacting policy, PSWs and care recipients. Yanow (2011) also discusses identifying sources of knowledge based on news media, agency documents and reports, and government documents including testimony and hearings (Yanow, 2011, Chpt. 2., p.10). For the purposes of this thesis, potential participants were purposively selected based on position within the home care sector. Occupation-specific expertise (e.g., nursing), job role (e.g., policy making), and organisational location (e.g., service provision) all contributed to assessing sources of relevant knowledge. In keeping with the concept of tapping into "local knowledge" sources (Yanow, 2011) I mapped a path of the effects of home care system policy from governance to the point of PSW-home care service delivery, including key actors *(figure 6)*. This map also guided selection of policy documents (*Appendix 4*) with consideration of the relevance to the path of policy effects and the actors in the system.

Figure 6: Map of home care system and stakeholders



Purposive sample

Purposive sampling was used to ensure we obtained KIs with the appropriate expertise to answer the targeted research question (Patton, 2002). We sought KIs who could offer in-depth, rich insight (Patton, 2002). The purposive selection of these participants occurred in four clusters: Government managers, Advocacy/Interest groups, Service Provider Managers, and Service Provider parties.

For this master's-level research which also involved researching policy data, interviewing three participants per category (total 12) was initially proposed. However, as new questions and information came to light, an additional participant was added in each category, leading to a larger sample size of 16. Thus, in some instances, an iterative process throughout the study led to inclusion of a particular key informant type. For example, the importance of police record checks

arose from data regarding PSW background and hiring practices: one participant said the accredited SPOs they were familiar with had exemplary HR practises, including record checks, while a SPO manager also spoke of the importance of background checks. As a result, we recruited a police chief who had multiple years of experience with crimes against vulnerable populations. Therefore, key informant knowledge was sometimes broad or could be highly specific as in this case. This sample size was appropriate based on the quality of knowledge and in-depth information provided, in balance with the practical considerations of this research (Patton, 2002).

Recruitment

Recruitment strategies differed for some types of participants. Cold calling and email recruitment were the primary methods used to reach out to all participant types. This recruitment strategy was successful for obtaining Government, union, law and interest group participants; however, it was not effective for recruiting representation from two demographics: LHIN care coordinators, or Service Provider Organization managers or supervisors. Given the environmental conditions of the COVID-19 pandemic and the restructuring of health care in Ontario we had anticipated these key informants could be challenging to recruit. Therefore, we included snowball recruitment in the research protocol.

Snowball recruitment

To include coverage of expert knowledge relevant for this study, we occasionally used chain recruitment strategies, contacting individuals in professional networks who were well-placed to share study information inviting appropriate individuals to participate. In some instances, we asked individuals to refer us to the most appropriate person in their area based on our recruitment criteria (individuals with expert knowledge of PSW-provided home care and policy ensuring client safety). Based on email threads showing contact from referral sources to potential

participants, this chain referral process occurred in recruitment for particular occupation/roles, and fanned out to people in established professional networks or referees' personal contacts with relevant knowledge.

i. Government

Individual government employees were sent an information letter and an invitation to participate. In some instances, individuals passed study information to other potential participants. Four individuals with study-related experience in government participated.

ii. Service Provider Organisations

We reached out to multiple home care providers of various sizes, and asked two participants with industry contacts to pass on snowball referrals. During September – December 2020, no SPO managers or supervisors were successfully recruited. In January 2021, one SPO was recruited by cold call while chain referrals led to the inclusion of three SPO participants. Two of the key informants had experience with LHIN-contracted services while two worked for SPOs providing private home care services.

iii. Interest Groups

Of the organisations assessed as stakeholders, four organisations' CEOs agreed to participate. These individuals make up our advocacy and interest group category.

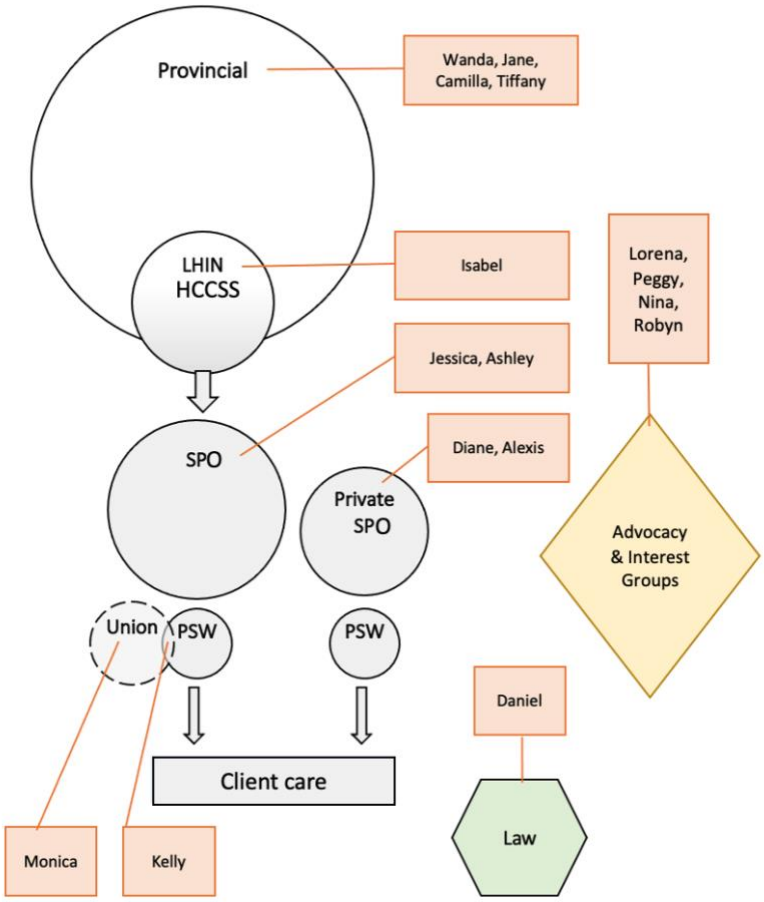
iv. Care Coordinators and other actors

Home and Community Care Support Services (HCCSS, known as Local Health Integration Networks or LHINs prior to April 1, 2021) are Crown agencies which provide care coordination and manage funding for, and contracts with home care SPOs. We did not receive responses from the LHINs we contacted directly. We also did not have any responses from the student researcher's professional network or asking a provincial nursing organization to send recruitment letters to any members who were care

coordinators. With snowball/chain recruitment, one care coordinator agreed to participate. The minimal representation of this demographic is a limitation of this research (see Chapter 5, section 5.3., Strengths and Limitations). Given recent and ongoing restructuring of Ontario's health care system and the home care sector, system reform may have contributed to a lack of willing and available participants. Additionally, as recruitment occurred during the COVID-19 pandemic, these professionals are likely to be working overtime hours in very challenging conditions while attempting to provide services. Other actors included in this category include those involved with unions and law enforcement.

Overall, the KI sample was selected with consideration of key actors in the system. Note that, while law would apply to the entire map, the Law KI (Daniel) spoke about client and PSW issues; thus, we have located him parallel to the level of care provision. Interest groups were those concerned with health care advocacy very broadly, and/or some facet of the home care industry, clients or workers. The private SPO KI managers (Diane and Alexis) are not engaged in the provincially-funded path of service provision and so fall outside of the realm of HCCSS/LHIN contractual relationships. Each KIs positionality in the system is indicated below (*figure 7).*

Figure 7: KI position relative to home care system



Interviews and Analysis

Semi-structured, in-depth interviews were conducted with 16 Key Informants. A foundational set of questions (*Appendix 1*) focused on each KI's expertise as it related to policy affecting client safety in PSW-provided care. The interviews ranged from 20 minutes to just over two hours, with most ranging from thirty to sixty minutes. Follow-up questions based on KI responses were used to expand on participants' expertise . The majority of interviews took place by phone, although some participants agreed to video interviews on Microsoft Teams. All interviews were recorded and transcribed verbatim. Memos and fieldnotes were made throughout to aid in data interpretation and analysis. The student researcher transcribed recorded interviews and de-

identified transcripts before they were uploaded to NVivo-12 (NVivo, 2018). This process was done within one to five days of each interview.

After the first four interviews, those transcripts were read through repeatedly by the student researcher. Each unit meaningful for analysis (e.g., line, sentence) was given an initial descriptive code and these were analysed based on similarities with other topics. The resultant 47 topics were further reviewed and folded into larger categories which led to an early set of codes. These codes were reviewed with the supervisor. After applying these to the first four transcripts (NVivo, 2018), the codes were slightly revised. The final code book (*Appendix 2*) included 27 codes; however, some of these were reviewed and found to belong with a broader category (e.g., Policy included Law, regulation, process, and legacy policy to denote historical or defunct policy). These data were folded together for in-depth analysis.

The data demarcated with each code was pulled from across all KI transcripts (NVivo, 2018). These data were analysed code-by-code with ongoing consideration of KIs' positions, interpretations, and attention to the symbolic language. Each code and in-depth analysis was discussed with the supervisor. Findings from this study presented in Chapter 4 are based on the Policy and COVID codes.

Ethics

This study was reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB 42390). All participants were provided with a description of the study and informed of their rights and the ability to withdraw without penalty up until the publication of any data. Participants were also provided with a consent form: nine participants signed the consent forms and the remainder were read a pre-approved verbal consent script and answered questions confirming their consent. Verbal consent was audio-recorded at the beginning of each interview.

Participants' identity is masked through the use of pseudonyms and any information which could be used to identify them has been removed from quotes. Their occupations and workplaces are described at a level to protect participants' identity. Each of the first three clusters – Government, Service Provider Organisation managers, and Service Provider parties – are sufficiently broad or generically described to protect participants' identity; however, to maintain anonymity of individuals within the Interest Groups cluster, further description is minimal. As examples, interest groups might be organisations such as Unions, or industry or political advocacy groups.

Chapter 4: Policy, COVID-19 and unregulated home care workers in Ontario Canada: Implications for client risk

Status: *(Preparing for submission) The International Journal of Health Planning and Management*

Planned Authors: Hopwood, P., MacEachen, E., McAiney, C., and Tong, C.

Introduction

Growing numbers of older people are requiring more complex care at the same time that policies involve shifting care away from long-term care (LTC) homes and hospitals. This has increased pressure on home care workers in Canada and internationally (Andersen & Westgaard, 2013; Ganann et al., 2019; Grønoset Grasmo et al., 2021; Sayin et al., 2019; Strandell, 2020). Home care workers provide the majority of direct home care, and have experienced increased intensity and responsibility in their work (Barken et al., 2020; Denton et al., 2015; Sayin et al., 2019). Home care occurs in usually-unsupervised private home environments, with workers often providing intimate personal care for clients who tend to be vulnerable (e.g., dependent on others, cognitively impaired) (Saari et al., 2018; Saks & Allsop, 2020; Sayin et al., 2019). In Canada, home care is organized and delivered at the provincial- and territorial-level; in essence, there are at least ten distinct models of home care delivery, with virtually no federal oversight or national-level coordination (Martin-Matthews et al., 2012).

The policy landscape in the province of Ontario provides a useful example for the study of the home care worker policy situation, and gaps that may elevate client risk. Ontario health care is undergoing significant reform, particularly since the 2019 Connecting Care Act (S.O. 2019, c.5, s.1) started laying out a framework for system-wide restructuring. In June 2021, Ontario passed legislation outlining a plan for regulating PSWs, although registration will not be mandatory and this law (Health and Supportive Care Providers Oversight Authority Act, S.O. 2021, C.27, S.2) was not yet in force at the time of writing (June 2021).

The unregulated status of Personal Support Workers[16] (PSWs) contributes to policy considerations for oversight of this important workforce. PSWs are currently not covered by Ontario's Regulated Health Professions Act (1991) and have no legally-mandated minimum education or certification, licensing or registration, or scope of practice (Afzal et al., 2018; Saari et al., 2018). Complex care tasks outside the skill set of unregulated workers, such as administering medication, are also a safety consideration (Blay & Roche, 2020; Gransjön Craftman et al., 2015; Ree & Wiig, 2019; Saari et al., 2018; World Health Organization, 2008). Ontario PSWs routinely provide support in activities such as washing and bathing, mouth care, hair and skin care, toileting, and dressing. However, in addition to routine personal care-related activities, home care PSWs are regularly assigned complex clinical tasks requiring skills beyond their training, such as: transferring clients using equipment, assisting with medication administration, gastrostomy feeding (G-tube), catheter care, and applying ointments and eye drops (Denton et al., 2018; Saari et al., 2018; Zeytinoglu et al., 2014). A study of the clients for whom PSWs have been assigned additional tasks found that they are older, less independent with functional tasks, and have greater cognitive impairment than other home care clients (Saari et al., 2018). While researchers have noted benefits of task shifting, such as decreasing the number of people coming and going while increasing continuity of home care workers (Denton et al., 2015), concerns around education adequacy, skills and ongoing supervision of unregulated staff have also been raised (Blay & Roche, 2020; Estabrooks et al., 2015; Saari et al., 2018). Not only does task-shifting increase client risk, is also increases the potential risks for PSWs, who experience high rates of injury, burnout and turnover (Barken et al., 2018; Denton et al., 2006;

[16] For the purposes of this paper we do not distinguish between the two unregulated home care workers in Ontario (PSWs vs. the broader term Home Support Workers). In other jurisdictions, home care workers are also called by other terms (e.g., Home care aides).

Lee & Jang, 2016; Sayin et al., 2019; Zeytinoglu et al., 2009; Zeytinoglu et al., 2014). Ontario has experienced alarming rates of turnover in the PSW workforce (Barken et al., 2018; Sayin et al., 2019; Zeytinoglu et al., 2014) with an estimated 60% of home care PSWs leaving their job each year (Ministry of Health and Long-Term Care, 2014).

Gaps in data also raise questions about policy governing PSWs in home care. Unsystematic job categorization and the fragmented structure of Ontario's health care system have contributed to limited availability of statistical information about this workforce. Despite incomplete workforce data, studies have clearly shown Canadian home care workers experience precarious employment circumstances, increased responsibility, and poor occupational health conditions including workers' elevated risk of injury, abuse, and violence (Craven et al., 2012; Denton et al., 2002; Denton et al., 2018; Gruben & Bélanger-Hardy, 2020; Martin-Matthews et al., 2012; Tong et al., 2016; Zagrodney & Saks, 2017; Zeytinoglu & Denton, 2006; Zeytinoglu et al., 2009; Zeytinoglu et al., 2017). Policy, PSW worker safety, and client risk and abuse, are often each explored in separate literature, although worker safety has been found to directly impact client safety (Shaw et al., 2020). Examination of the relationship between specific types of home care workers and client risk, and the specifics of these relationships are considered together in fewer papers (Lang & Edwards, 2006; Lang et al., 2014; Tong et al., 2016).

Policy influences care setting and employment context, including education, hiring and supervising unregulated PSWs, and task shifting. This paper also considers that policy gaps may create circumstances that increase client risk. Client risk as is based on a risk-assessment framing similar to the approach used by the UK Professional Standards Authority in a review of regulation and the PSW occupation in Ontario - a review that considers "right-touch" (proportionate) regulatory responses after evaluating "…where the risk of harm may lie in a

particular occupation" (Professional Standards Authority, 2016, pp.36-37). In contrast to risk is client safety, defined broadly throughout this paper with inclusion of safety in care relationships and safety from abuse. For this paper we use the Centers for Disease Control and Prevention's definition of abuse: "…an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that *causes or creates a risk of harm to an older adult.*"[17]

Given the risk-assessment framing (Professional Standards Authority, 2016) that being safe from abuse is one part of the broader client safety umbrella, we explored client abuse literature. A marked gap exists within the study of abuse of older people: this research seldom considers the relationships of victims and abuse perpetrators, and other factors at "eco-systemic levels" (Burnes et al., 2020, p.6) such as social systems and home environments, that are critical for understanding risk and for developing safety interventions (Burnes et al., 2020). Particularly, research on the abuse of older people infrequently investigates specific types of care workers as perpetrators. For instance, a pan-Canadian abuse prevalence study does not distinguish unregulated care workers from within a broader category of "paid caregiver", which can include anyone from nurses to client therapists (McDonald, 2018). This prevalence study found that "paid caregivers" were responsible for 1% of the 173 reported incidents of physical abuse in the previous 12 months, but 9% of the 99 reported neglect instances (McDonald, 2018). A challenge with applying the results of this study to the home care client population is that the study participants were excluded if they did not pass cognitive screening; thus, those who may be more vulnerable on the basis of their cognitive ability (DeLiema et al., 2017; Yon et al., 2017) were not included.

[17] https://www.cdc.gov/violenceprevention/elderabuse/index.html

Despite a scarcity of studies focused on client abuse by unregulated care providers, there is *some* evidence of client abuse by Ontario PSWs in media coverage, which provided examples of PSWs missing visits, screaming at a client, and sexual abuse (Baxter, 2018; Rinaldo, Sandie, 2018). We also note that in their review of the PSW occupation, Ontario's Health Professions Regulatory Advisory Council (HPRAC) found that abuse and misconduct occur, although prevalence is unknown and incidents are likely underreported (Health Professions Regulatory Advisory Council, 2006) Instances of psychological, physical, sexual and financial abuse were among issues reported to the advisory council, although they were unable to assess the extent of abuse due to a lack of data:

> "It was impossible for HPRAC to document the frequency of such abuse, but patients, clients and employers all spoke of these matters, and there is a record of police intervention and jurisprudence associated with such abuse." (Health Professions Regulatory Advisory Council, 2006)

The Health Professions Regulatory Advisory Council also found that employers lacked adequate means of verifying PSW credentials and their work history (Health Professions Regulatory Advisory Council, 2006).

Overall, we know little about abuse of older persons by workers in the home care setting – a topic which may be further limited by hard-to-detect home care provider misconduct. It is vital to understand that while the focus of this study is policy related to PSW-provided care and how this may affect client safety, a lack of data prevents assessment of the frequency, type and context of abuse. Accordingly, our focus is *the policy and lack thereof,* and *not* the individual conduct of PSWs providing care . Furthermore, it is essential to acknowledge these workers are a critical part of the home system and have key roles in care provision. PSWs are often client advocates and in many instances, they report suspected abuse by others. They work in low-paid and often insecure conditions, in a system that fails to provide employment circumstances to

support this gendered, racialised workforce (Dent, 2020; Saks & Allsop, 2020; Zagrodney & Saks, 2017).

Long before COVID-19 highlighted issues such as home care PSWs working without masks and having to work in multiple jobs to earn a living (Rinaldo, Sandy & Jones, 2020; Rowe et al., 2020), PSWs faced challenging work conditions. The nature of the home care setting introduces complexities to the concept of 'workplace' and introduce elements of danger (including physical and psychological abuse from clients and others in the home) for PSWs who are primarily lone workers (Barken et al., 2020; Craven et al., 2012; Denton et al., 2018; Martin-Matthews, 2007; Workplace Safety and Insurance Board, 2019.). These workers sometimes perceive a need to operate outside their defined roles in order to provide client care; however, not only are they responsible for their clients' safety, but they are also made responsible for their own safety (Barken et al., 2015; Barken et al., 2020). A lack of policy – including professional regulation – has increased responsibility and risk for workers, as well as contributed to client risk (Armstrong & Cohen, 2020; Saks & Allsop, 2020). Dent describes governance models and responsibilisation of home care workers as being expected to uphold standards similar to colleagues with professional status:

> This means in turn that support workers, in so far as they follow the guidelines in a committed way, exhibit a form of 'proto- professionalism', in which their actions and talk emulate the work of their professional colleagues, but are not grounded in the training, socialisation or responsibility associated with full professionalism (Dent, 2020, p.72)

Many PSWs enact this 'proto-professionalism' in their day-to-day work despite being undervalued and paid far less than regulated professions (Barken et al., 2020; Dent, 2020).

The purpose of this study is to explore policy and identify gaps that create potential risk for clients in the context of PSW-provided homecare. Our study focuses on the case of Ontario, Canada and policy guiding home care PSW work, through a client risk lens, and highlights the

role of policy developments during the COVID-19 pandemic in relation to pre-existing policies and circumstances. In the rapidly-evolving COVID-19 policy environment we consider how policies affecting home care work may inadvertently increase client risk in the PSW-client relationship. We acknowledge that clients and workers are affected in other ways beyond the scope of this paper.

For the purposes of this paper, we describe the entities which have traditionally coordinated client services as LHINs/HCCSS. In Ontario, home care has undergone multiple rounds of re-organisation in administration, with home care coordination falling under Local Health Integration Networks (LHINs) from 2017 to April 1, 2021 and Community Care Access Centres (CCACs) prior to 2017. The LHINs were re-named Home and Community Care Support Services (HCCSS) on April 1, 2021 (Ontario Ministry of Health, 2021); thus, we use LHIN/HCCSS to cover the time period of the study.

Methods

Qualitative research is useful for answering our research question as it permits in-depth exploration of policy in the context of a complex home care system and in relation to perceived client risk (Yanow, 2000; Yanow, 2007). It also allows investigation of the nuanced organisational factors that shape key informant (KI) positions and their framing and interpretations. Specific methods were derived from Interpretive Policy Analysis (IPA) which provides the opportunity to explore a variety of data including interviews and policy texts, with the central tenet that meanings within, and understandings of, policy are interpretations reflective of human understandings (Yanow, 2000) This method is appropriate for exploring standpoints of the multiple actors involved in home care and their situated perspectives of policy related to PSWs and the implications for client risk. It involves a focus on local knowledge, including in-

depth understanding of the actors and circumstances surrounding policy as well as the practical consequences of policies (Yanow, 2000).

Data collection coincided with Ontario's second and third waves of COVID-19. From September 2020 to January 2021, we gathered data for this study consisting of in-depth, semi-structured interviews with 16 KIs (Table 1) and Ontario-focused policy documents. In-depth research of applicable law and government documents was undertaken in keeping with the importance of obtaining "local knowledge" in IPA (Yanow, 2000). Potential key informants were identified by mapping a path of home care system policy beginning with policy-making through to the point of service delivery, constructed by drawing on ministry organizational directories, submissions to governments, organisational reports, and lists of home care service providers. This allowed for purposeful sampling of well-positioned individuals from organisations and government. For inclusion, KIs were required to have close knowledge of home care policy, the PSW occupation and/or client safety. Ethics approval for this study was provided by a University of Waterloo Research Ethics Board (REB #42390) and included informed consent, anonymity and confidentiality.

In-depth interviews conducted by a graduate-level researcher focused on KIs' perspectives of policy affecting client risk in PSW-provided care, including how this policy worked and any gaps. Follow-up questions and probes targeted participants' expertise, often informed by their occupational knowledge base or their role in the organisation (Yanow, 2000). All interviews were recorded and transcribed verbatim. Memos jotted during interviews and detailed fieldnotes were also used to inform interpretations (Yanow, 2007). Final transcripts were uploaded to NVivo-12 (NVivo, 2018) as interviews and transcribing were completed.

Initial analysis involved organising the data into coded segments. First, four interview transcripts were read for meaningful units and inductive codes were created and applied. Following coding, each set of code excerpts was extracted from NVivo-12 and read and re-read by the first author and in-depth analyses of each code were discussed with the second author (Silverman, 2015).

This study investigates client risk in the context of PSW-provided homecare. While we acknowledge the careful and compassionate care provided by many PSWs, our focus is on system policy and not individuals. That is, we are concerned with the parameters of the home care system that set the stage for client risk (i.e., possible client harm).

KIs in this study were classified as one of four types: Service provider managers, government ministry of health (position based on National Occupation Code description to protect participant identify), provincial advocacy or interest organisation CEOs, and a fourth category of individuals with other context-specific knowledge. Four KIs had 2 – 10 years experience and 12 had more than 10 years experience. These KIs were well-positioned to provide up-to-date information about policy in a time of COVID-19. They were also suited to responding to questions of client risk and abuse, whereas finding workers or client populations with this knowledge is unlikely.

Table 1: Key Informants

Pseudonym†	*Organisation*	*Position/role*	*Identifier*	*Experience*
Jessica	Service provider organisation	Nurse, Service Provider (SP) Organisation management with government contract	SPO	> 25
Ashley	Service provider organisation	Nurse, Service Provider (SP) Organisation management with government contract	SPO	2 – 5
Diane	Service provider organisation	Nurse, Service Provider (SP) Organisation management; private care	SPO	> 25

Alexis	Service provider organisation	PSW, Owner/operator of Service Provider (SP) Organisation; private care	PSW/SPO	2 – 5
Camilla	Ministry of Health	Senior government manager or official‡	GOV	10 -15
Wanda	Ministry of Health	Senior government manager or official‡	GOV	> 25
Jane	Ministry of Health	Policy specialist	GOV	5 – 10
Tiffany	Ministry of Health	Senior government managers or official‡	GOV	2 – 5
Peggy	Provincial advocacy/ interest organisation§	CEO	ORG-CEO	> 25
Nina	Provincial advocacy/ interest organisation§	CEO	ORG CEO	> 25
Robyn	Provincial advocacy/ interest organisation§	CEO	ORG CEO	15 – 25
Lorena	Provincial advocacy/ interest organisation§	CEO	ORG CEO	15 – 25
Isabel	LHIN/HCCSS	Nurse, Care coordinator	LHIN/HCCSS	10 – 15
Kelly	Service provider organisation, Union	PSW, Union representative	PSW/Union	15 – 25
Monika	Union	Health & Safety Officer	Union	10 – 15
Daniel	Law and enforcement	Chief of Police	Chief of Police	> 25

† The lack of diversity in pseudonyms is reflective of participants' actual names. Internet name databases were used to derive pseudonyms based on name origins and common names in participant age category.
§ Broad categories are used to describe organisations and roles in order to protect the identity of the KIs.
‡ Based on National Occupation Code description to protect participant identify

Study findings

In our findings, we report on three themes that emerged. Each is considered in the context of policy gaps that have potential to exacerbate client risk. First, we consider PSWs' unregulated status in relation to concerns with education and background checking. The second theme addresses supervision and skills, which participants linked to poor practises, including a lack of in-person supervision and advanced skills assigned to PSWs. Third, we describe worker

shortages and particularly how this problem escalated during the pandemic, driving the development of policies such as more rapid recruitment, education and hiring.

1. PSW education, regulation, background

KIs frequently discussed education as an important PSW-factor related to client safety. There appeared to be wide variation in education programs, running from as long as a year or as little as "[...] a two-week crash course" (Jane, GOV). The skills taught in programs also varied, according to KIs. This led to some concern with the adequacy of education. For instance, Jessica discussed the importance of considering the effectiveness of education, not just the length of time:

> We now have these fast-track PSW programs which are great to get PSWs out in the field, but how fast can we educate and train them sufficiently and properly so that they have those skills and knowledge to take with them, to provide the support? (Jessica, SPO).

A few KIs spoke about a lack of professional regulation and hiring practices, such as a lack of reference checks, as failing to protect clients. Risk was also seen as inherent in a system that did not have a mechanism (e.g., registry) for confirming a worker's education and employment history outside of self-provided references. One KI noted that nurses' professional standing and history could be verified through their professional college, and that a similar service for PSWs could be beneficial.

Tiffany spoke about regulated or unregulated workers moving to new jobs and the importance of employers' due diligence for verifying workers' employment history:

> […] I think that happens with PSWs […] you keep getting hired and moved on because the shortage means that people aren't maybe taking the time to do all the background checking or perhaps it's kind of out of sight, out of mind […] (Tiffany, GOV).

Other participants also identified some aspect of unregulated care provision as having potential safety concerns, and a few thought a registry may provide some client protection. Peggy drew attention to two separate jurisdictions and the differing purposes a registry may serve:

> […] in Nova Scotia they have … a registry of sorts. But that registry really just looks at credentials […] In BC, they have a registry, but that registry is really around patient safety. So if you if you abuse a patient or whatever, you end up in there. So … the overall sort of quality, the standards, the scope of practise, all those kinds of things, there isn't a single jurisdiction, to the best of my knowledge, that has actually done that (Peggy, ORG-CEO).

A Chief of Police who had multiple years of experience in crimes against vulnerable persons described the typical types of crimes involving providers. He spoke about common allegations of crimes such as theft and fraud (e.g., stolen cheques), as well as abuse and neglect. He also said investigations should consider that complaints of rough or abusive treatment may be part of a larger pattern.

Reference checks were considered one means of vetting workers, and police record checks were also viewed as important. Diane described her company thoroughly reading resumes and checking references: "[…] and I mean THOROUGHLY, check at least two professional references" (Diane, SPO).

SPO managers, advocacy/interest organisation CEOs, and both PSW KIs also identified that SPOs require clean police record checks. Although police record checks were mentioned as means of ensuring client safety, this measure is also imperfect. KI Daniel, a Police Chief, described the criminal record checks and vulnerable sector record checks often used for workers applying to work with children or people who are older as ineffective:

> In my opinion, they are not effective. They show criminal convictions. Vulnerable sector checks show criminal convictions, they show current charges and they show pardons for sex offenders. What they don't tell you, they don't flag any serious mental health concerns. […]They also don't track withdrawn criminal charges that were dealt with

> through alternative measures in the court system – that we're seeing much more, especially during COVID, to clear up the backlog. […] they reach that time period to say you've been good for X number of years, so remove it from your record. Well, they also don't show associations. We link a number of people and organised crime groups. […] Those are my worries about it, is it thorough enough? (Daniel, Chief of Police)

Another KI also pointed out further concerns regarding worker background screening:

> One of the biggest issues in home care that I found was there really is no oversight, like, AT ALL, number one. Number two, there's no guarantee that that's a PSW walking in your door to take care of you because they could hire people that are home support workers, they can hire basically anybody […] We call home care the Wild West. It literally is. I mean, we think long term care is bad? Welcome to homecare. (Robyn, ORG-CEO)

We also found instances suggesting some benefits to regulation, and that some PSWs would welcome regulation *(Table 2).*

Table 1: PSW perspectives of regulation

KI	Role	Quote	Perceived benefits
Kelly	PSW/Union	"I would love to be regulated, but I think it should come from the federal level […] They can base it- if you're at the federal level, I could be a PSW here. I know you should be able to transfer all of your knowledge from province to province, but if you're federal and you've done all of these certificates, like the GPA, you've done health, health and safety, you've done ANY course that you've taken where you are, should be able to go with you wherever you go. And you shouldn't have to be retrained in that. It should be set up that 'she was trained here. She just needs a refresher […] It would also regulate our pays. Across the board."	• Mobile qualifications • Reduce training • Regulate pay
Alexis	PSW/SPO	Well, just more stability in our profession, right? The scope. There's no consistency or scope. There's no consistency to the schooling. I mean, you go to a private school, you can go to a continuing education, […], you can go anywhere and become a PSW. They actually offer it online right now. […] No practicum. You just show up once you're done your	• Stability • Scope of practice • Consistent education

		certificate online and you're just supposed to work. I'm like, oh, my goodness"	
Alexis	PSW/SPO	"See, there needs to be more respect in the health care industry, as you probably know as PSWs, we're at the bottom of the totem pole. So when it came time to PPE and stuff like that, it was the PSWs, the first wave that were dying. There was eight that died. WHY? Because I bet you it was the doctors and the nurses who got the PPE first and then the PSW got it last. So that's what I think regulation would really help with. I think it would just give us more respect in the health care profession and it would give us more consistency as well"	• Increase professional value/respect • Consistency
Jessica	SPO	"[…] some PSWs could be a little more risk taking, knowing that there's maybe less -- that they may be responsible for; that they have less to lose they may feel, where nursing have licenses to lose, things like that. So it would be great if the PSWs could become a regulatory body where they feel that they are an actual profession now and they have this responsibility and someone that they need to speak to. If there's something that they do that maybe they weren't supposed to be doing. […] and we know that there are some people who are on the side of caution and then there's those risk takers. I think the individuals who maybe err on the side of caution would welcome the regulatory bodies so that they KNOW they're being safe, they're doing things properly. There is someone that they're overseeing them"	• Increased accountability • Confirmation of safe practices • Affirmation through oversight
Camilla	GOV	"[…] advocating for making this a profession and all the terms that must come to be qualified as a profession, are, I think in many ways- are motivated to do that in order to gain some level of respect, in terms of financial and work employment conditions. So it's one I think that would that would work would attract people to the sector. So there you know, in the long game, that may be the answer to the people shortage as well. […] one of my colleagues [..] she said, you know, in Denmark they really did. They really went that route of like it's— it's very valued and didn't used to	• Respect • Improved pay • Benefit • Improved work conditions • Attract people to sector • Higher credentialing leading to improved value of profession • Address shortage

be. And they— she said they went that route of highly credentialling and sort of raising the level of work the PSWs do and paying and you know, benefits. All the rest of it. And that they DON'T have a shortage there now. And they did before. So I don't know. Something to do for whoever is interested in that policy topic?"

2.Supervision and skills

The perspectives of KIs demonstrate that policy and scope of PSW activity in home and community care settings may not be followed, or interpreted, in the same way by all parties. For example, Kelly emphasised that not all PSWs completed mandatory documenting:

> That's another thing that I absolute— is a craw in my side right now. And I'm all over our supervisors because I've been into a home […] since COVID started, and I'm the only one who charts every time I'm there […] So I don't know if the person before me actually gave so-and-so a bath. They [client] said they had a bath. They don't know frickin' know if they had a bath. […] So it could be a week and a half before this person has a bath because they keep saying, yup, I had a bath. But it's not charted (Kelly, PSW/Union).

Kelly noted that she had reported this issue to supervisors; however, it was otherwise unnoticed.

The checks or balances described occur at the level of the employer/SPO level, with SPOs mandated to report incidents to the next administrative level (LHINS/HCCSS). LHIN/HCCSS case manager Isabel described that she receives and approves provider reports but they are primarily used for billing. She indicated that it is not within the purview of her role to manage home care workers, although she does try to ensure clients' care needs are met:

> "[…] policy-wise, care coordination or— care coordinators have to check in with our patients at specific intervals throughout their stay with us. And we do check in on how their satisfaction is- satisfaction level while they're receiving the care. So it's sort of like […] like outstretched policy, but it's not specifically managing that […] I do encourage them [clients] if you're feeling like your service is not up to snuff, please do call me. So I kind of have to trust that those people are doing their job well and – not that I manage that, that much (Isabel, LHIN/HCCSS).

Another concerning issue with supervision is *ongoing* oversight. In terms of supervision, Tiffany described that ensuring quality of care for clients was not part of government measurements: "[The Government's] role is sort of to measure the quality of the health system and their [SPOs] organizations, [the government is] […] not necessarily there to measure the care of individual patients" (Tiffany, GOV). She suggested that clinical supervision by SPOs could provide more information about the quality of care provided by PSWs:

> […] Other than I imagine it would be useful to have some kind of clinical supervision aspect so that those supervisors would know about the quality of the work that people are doing. It's kind of at *THAT* level that I would think you would have more understanding of individual care […] is that supervision just, 'did you get on time, and did you finish the visit in the 15 minutes you're supposed to' or is it about clinical supervision? (Tiffany, GOV).

Supervision is particularly important considering the complexity of tasks PSWs perform, as well as the fact home care PSWs usually work alone.

Alexis (PSW/SPO) and Kelly (PSW/Union) both described how PSWs may encounter challenging circumstances when dealing with assigned tasks. Alexis described she had encountered situations where other home care PSWs had failed to appropriately address problems (e.g., report to a supervisor) or engaged in tasks beyond their training:

> […] when you have a client that is bedridden and all of a sudden they've had a bowel movement and now their dressing is covered in feces. I mean, you shouldn't- as a PSW you should not leave that dressing on. I've seen PSWs leave it on. I've seen PSWs pull the dressing off and leave it off completely. And then the client has another B.M. and now there's feces all in the wound" (Alexis, PSW/SPO)

A high-ranking government manager, Wanda, explained how the care setting is an important contextualising factor in considering supervision, noting less concern with PSW regulation in LTC, where there are regulated staff supervisors on site:

> And again, PSWs impact, obviously, to support clients, residents, patients, whatever you want to […], call your population, but they impact the workforce of

> regulated. So, for example, nurses actually need to supervise and help support in that interprofessional team. So, again, you know, depending on what sector they're in- […] in long term care, PSWs do *MOST* of the hands on direct care, just like they do in home and community care. But in home and community care, they're on their own with the patient. In long term care, they're in a little bit more circle of care, […]. It's interesting - different sectors in value, isn't it? […]So they [LTC] don't worry about it as much – regulation. […] Because there's the Long Term Care Act, right. There's compliance issues. It's not just based on a PSW, it's based on, like the model of care and making sure everything's done. And there's some checks and balances at least. (Wanda, GOV).

3. Shortages

Many KIs commented on worker shortages as common and a challenge for quality of client care and becoming increasingly problematic across health sectors during the COVID-19 pandemic. KIs often linked shortages to job dissatisfaction. However, Camilla identified that PSW qualifications were a relatively minor consideration next to adequate staffing:

> And I think one thing that is a limiting factor on all those things, is that there's every- you know, we're always in a chronic shortage of resources. […] my perspective of it- is that there's a drive to, you know*, enhance the profession's visibility and the qualifications and the role*. And that that's not always marching at the same step as – we just need people. We need people. We're desperate for people. […] I feel like the, *'we need people' may be the stronger urge right now* (Camilla, GOV).

During COVID-19, the provincial government in Ontario created a regulation that LTC workers should perform work exclusively with a single LTC or home care employer to minimise opportunity for disease transmission.(Limiting work to a single long-term care home, 2020) PSWs who were employed within home and community care, in addition to LTC, often elected to stay with LTC employers because they tended to provide them with higher wages and/or more scheduled hours. KIs also reported absences or loss of workers due to family care and income needs related to COVID-19. For example, Peggy noted a drop in staff:

> "Overall, during the height of wave one, we probably lost a good 20 to 30 percent of our staff. Not only just to better paying jobs, but to government subsidies" (Peggy, ORG-CEO).

Widespread labour shortages were also seen as adding to potential client risk. The interplay between shortages and hiring was described by Nina:

> "…really there is such a shortage that I mean, even if a worker was to lose their job for, you know, poor practise, they would just get a job somewhere else immediately" (Nina, ORG-CEO).

3.1. Recruitment

The Province of Ontario made consistent efforts, prior to, and over the course of the pandemic, to support recruitment and retention of PSWs. This included providing SPOs with funding for temporary wage increases for their workers. The government also provided free or subsidized education to aspiring PSWs, and "Return of Service" bonuses of $5,000.00 for newly graduated PSWs who complete six months work for employers enrolled in the program. With many SPOs seeking to hire new workers, some organisations offered wages above the minimum standards. Some SPO managers saw this wage increase as amplifying competition for hiring PSWs. PSW wage increases would not affect the quality of care for clients receiving publicly-funded care, but one KI suggested that clients who must pay for private care may be affected. Diane predicted that wage increases to attract PSWs could increase the fees for clients:

> We've got shortages right now for sure. And it's something that we've grappled with for a number of years. […] for us to be able to pay the caregivers even equivalent to what the [LHIN/HCCSS] pays, we have to charge the client more. If we charge the client more, we price it right out of the range and then then NOBODY is happy (Diane, SPO)

Alexis conveyed that low wages, as well as scheduling, may make home care-based PSW work unattractive. She described turning down an offer of employment from a large SPO due to the low wages and limited hours, and pointed out that, with the majority of home care visits being only an hour long but with travel time in between care visits, it can be challenging to achieve anything resembling full-time paid work hours:

> "[…]a lot of their visits are an hour. So you go in for an hour and then you leave and then you're traveling to another client and then you're there for an hour […] In order to get an eight hour shift in, you're at least working a minimum of 10 hours. […] They're sitting here and they're making it seem like this is such a great thing to be a part of as PSWs. But PSWs don't have money. A lot of PSWs live in poverty because of the wages they make (Alexis, PSW/SPO).

Isabel noted that it was important that recruitment be truthful and that potential PSWs should be informed:

> "You need to know that these people actually know what they're getting into, because if they don't understand, like what you're doing, they're not going to stay (Isabel, LHIN/HCCSS).

In Ontario, tuition-free college education has been offered to people interested in PSW work. However, some KIs, such as Alexis, saw this as drawing in people who might be attracted to free schooling but unsuited to the PSW profession:

> "That attracted so many WRONG people to our profession. Being a PSW, you can't just be anybody. You need to be caring. You need to be compassionate" (Alexis, PSW/SPO).

Low wage-related issues spill over and beyond making the home care PSW occupation less attractive, as they also create competition between health sectors and among service providers. A lack of wage parity between LTC and home and community care, and incentives offered by SPOs, may lead to increased competition between care sectors for PSWs. Ashley discussed an increased focus on recruitment, saying "…we constantly are needing individuals. It's difficult when you're competing with the long-term care homes and retirement homes" (Ashley, SPO). She further described the constraining role of wages:

> "So, because every company essentially set up their own their own pricing for their workers …. It doesn't matter if we had full time hours to give them, but we were, you know, like a dollar shorter. You know, chances are they were going to go with another company or someone that was hiring them at an INFLATED price because a lot of companies were doing that" (Ashley, SPO).

In a similar vein, Jessica said:

> "[…] multiple PSWs have multiple jobs. […] And then next thing you know, they're calling and canceling their shifts because maybe the shifts that we had for them that they originally accepted might have been those shorter ones. But the other company now offered them those longer ones. So now they're canceling on us and leaving the team to scramble to fill (Jessica, SPO).

3.2. Shortages and home care services

Government managers Camilla, Wanda, and Tiffany, and LHIN/HCCSS coordinator Isabel all spoke about how PSW shortages interact with the home care system more broadly. Camilla spoke about how PSW occupational factors intersect with shortages:

> […] we're going to need to have better conditions, probably. Otherwise, we're just going to not have the people. And talking about increasing investment in home care is one thing, but to do it without putting money into the PSW side is going to be a real challenge because how do you keep up? I know some [LHIN/HCCSSS]s are like, we can't spend the money you give us because we CANNOT find people to deliver it […] (Camilla, GOV).

Another aspect of this issue is the impact on workers when SPOs attempt to provide services for clients, but are insufficiently resourced to do so. Monika, a Health and Safety Officer with a union, shed light on this from the workers' perspective:

> And the other thing we hear a lot from workers is that agencies are taking on patients and clients that they don't have the capacity to service, but they're taking them, just to get the money. Well, just to get the funds attached (Monika, Union).

Tiffany described that with a PSW shortage and not having an adequate supply of workers to provide care, there is potential for care quality to be sacrificed and quick hiring to be prioritised:

> "The fact that some care is better than no care, I think maybe has driven a lot of the decision making" (Tiffany, GOV).

Government KIs overall described health care challenges as existing across health care sectors, with some synergistic consequences. LHIN/HCCSS coordinator Isabel noted shifting client needs also made adequate staffing for home care challenging. As clients were moved from hospitals to LTC in order to create hospital space during the pandemic, the number of home and

community care clients waiting for LTC grew from an estimate of almost 35,000 before the pandemic, to more than 39,000 people as of January, 2021 (Stall et al., 2021). Isabel described a dire staffing situation:

> So trying to find a PSW […] is tough because a lot of the crunch right now for long-term-care facilities is crisis from hospital, because they're trying to clear out hospitals right. So that's an interesting consideration for the work life of PSWs and the demand for them, because this is a very interesting twist of events. So there's a lot of patients that should be in an institution but aren't. […] Like high service needs, I don't even know if we can staff them in the [municipal] area, to be honest (Isabel, LHIN/HCCSS).

Discussion

This study considered policy gaps related to PSW work in Ontario, and how these gaps affect the circumstances of home care PSW work, with a focus on potential risks for clients (including worker to client abuse). Drawing on IPA, our findings highlight elevated client risk in connection with a lack of adequate policy mechanisms, such as insufficient mechanisms for performing thorough background checks. Absent or minimal supervision and transferring skills (e.g., task shifting) are also discussed as areas that create opportunity for increased client risk. A major finding was that worker shortages, which increased during the COVID-19 pandemic, in confluence with policy mechanisms, created increased risk for clients.

Although many of our findings reflect other findings within PSW literature, key contributions of this study are our focus on PSW-provided home care specifically and our description of how policy in this area affects client safety. Analysis of a specific occupation allowed us to consider policy related to training, supervision and employment conditions for the large and important PSW workforce. As with previous literature pertaining to unregulated workers' education, our KIs noted that a PSW certificate is not a legal requirement for Ontario home care workers. Our study unfolds the unique implications of training policy for client safety in PSW-provided home care, adding to prior literature which has described the types of PSW-

education and efforts to create a provincial standard (Kelly & Bourgeault, 2015; Kelly & Bourgeault, 2015).

Our findings about types of information that is not captured in background screening or police record checks - and the resultant gaps allowing employment of individuals who may not be suitable to enter PSW work – are an important contribution to PSW literature. To the best of our knowledge, few previous studies have considered reference and police record checks. One U.S. report explored development of policy for ensuring criminal background checks and screening (Galantowicz et al., 2010). Within other publications about health provider background screening, we found a report that provinces in Canada did NOT regulate required police background checks for medical doctors, despite an international jurisdictions finding that "[…] criminal background checks are a necessary tool for weeding out disreputable physicians."(Vogel, 2012). This suggests that there is room for improved practices for background screening in Canada - something which may extend in relevance to managing the PSW workforce and other workers who work with vulnerable populations. Furthermore, the limited information about healthcare provider background and limited knowledge about home care client abuse (Baxter, 2018; Galantowicz et al., 2010; Rinaldo, 2018; Vogel, 2012) together with our findings regarding background checks police checks and KIs' references, illustrates that it is important to ensure background checks are effective. Exploring if background checks are effective may be a relevant concern beyond the PSW occupation.

We found that Ontario home care policy, especially service contracts, place SPOs as responsible for supervising workers, although home care PSWs are rarely supervised in-person. Our findings are congruent with other research, that highlights increased responsibility for health and safety is placed on workers (Barken et al., 2020). Our KIs described circumstances that

highlight where a lack of supervision may be problematic. For instance, one KI discussed client care not being charted by other workers and having to report this to supervisors who would otherwise not know about this missing medico-legal piece. Lack of documentation is a concern noted elsewhere (Saari et al., 2017). Where clients' safety was jeopardized by PSW action or inaction (such as a lack of charting and emergency wound care), poor practises could go on unchecked in the absence of supervision. Another component of this is that PSWs may be put in positions of surveillants over the work of colleagues, especially when supervision does not occur in the field. Though we had only two KIs who were PSW, both discussed issues with other workers' performance at length, highlighting that PSWs may have to deal with fallout from colleagues work. This relates to the notion of individually responsibilising workers discussed in previous literature (Barken et al., 2020, England et al., 2007). If PSW observe harms caused by colleagues, and may have to compensate for, or police poor practices, this may contribute to their desire for regulation. It may also underlie the logic that respect for PSW work can be improved by demanding a higher level of performance from PSWs.

Although Ontario government contracts with SPOs state the service providers are responsible for safety and must have at least one registered nurse in a supervisory role (Ontario Ministry of Health, 2014), these contracts fail to specify regularity or other parameters of supervision (Steele Gray et al., 2014). SPO managers and LHIN/HCCSS care coordinators may only encounter adverse PSW-related information if clients or others complain, or if they stumble across issues during client reassessments. As stated in the introduction to this paper, considering policy related to this single occupation (PSW) is not intended to problematise the work of individual PSWs, but to identify policy gaps at the system level and how these influence client safety.

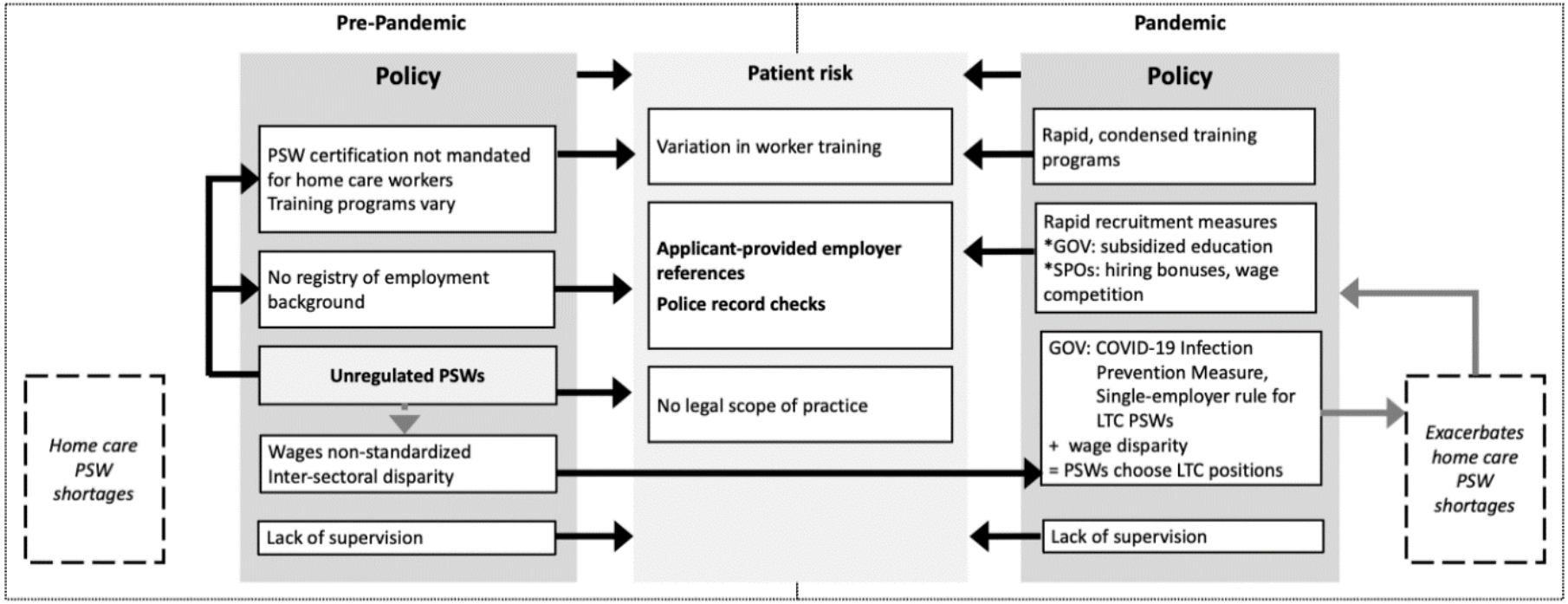
Other concerns identified by our participants are also consistent with previous studies, including PSWs performing nursing tasks or 'task-shifting' (Afzal et al., 2018; Barken et al., 2015; Denton et al., 2015; Saari et al., 2018; Zeytinoglu et al., 2014). For example, our KIs identified potential safety issues related to task shifting in the same areas that Denton et al. (2015) noted, including: "insufficient training, inadequate delegation or supervision, and scheduling and time constraints" (Denton et al., 2015, p.489). This study adds to what is known about how task-shifting policy is understood by different parties within the home care system. Symbolic language is a key component of KI interpretations of task shifting, with PSWs, some SPO managers, and one CEO describing delegation or being assigned tasks to PSWs as outside PSWs' 'scope of practice'. Indeed, KIs regularly referenced a 'scope of practice', conveying their belief in the pervasive myth that PSWs actually have a scope of practice, although there is no legal scope of practice for this occupation.

The dire circumstances of the COVID-19 pandemic have exacerbated PSW shortages to the point that education requirements have been reduced and recruitment has become an increasing focus. However, policy measures to address shortages disproportionately affected home care, where shortages escalated in part *due to* infection-prevention policy measures limiting LTC PSWs to one employer. Requiring PSWs to work for one employer magnified issues of pay disparity between LTC and home and community care, with PSWs often choosing better-paying LTC jobs when required to limit working to one employer. That this was identified by multiple parties speaks to a strength of the study in that our sample represented stakeholders across the home care system. That this diverse sample also consistently identified worker shortages as problematic also speaks to the scale of this pervasive problem.

KIs' positions in multiple parties involved in home care policy and the point-of-delivery also highlighted how worker shortages may be interpreted by different stakeholders. These perspectives – such as SPOs describing not having enough staff *to meet client needs*, versus the narrative of SPOs focusing on having difficulty finding workers *to cover shifts* -- contain nuanced divergences that speak to the tension between a client-oriented approach to meeting client need and a business-minded goal of fulfilling service demand in order to receive payment. How client need (e.g., "person-centred care") will be balanced in the face of cost-constrained and fee-for-service models is a critical challenge with broad relevance for home care systems in Canada and internationally.

Dire worker shortages and infection-prevention control measures led to policy-development that some KIs suggested may further undermine client safety. This included subsidizing education, paying student-PSWs for practicums, and the hurried development of rapid education programs. An interpretation of these findings of the interrelatedness of pre-pandemic and pandemic policy and PSW shortages is depicted below *(figure 8*).

Figure 8: Policy effects on client risk



Although previous literature has identified home care PSW shortages and critically examined reasons for poor retention, to our awareness this is the first study to explore this in the context of the pandemic. Similar to previous research, multiple factors were identified as being at play in obtaining and retaining workers. Lack of respect for PSW was mentioned by several KIs, and low PSW wages were discussed by most KIs. These findings echo those of studies exploring precarious PSW work (Martin-Matthews et al., 2012; Panagiotoglou et al., 2017; Zeytinoglu & Denton, 2006). That wage-competition between service providers and between LTC and home care sectors may increase client risk by contributing to workforce instability is also worthy of exploring further.

Client risk due to lack of supervision, and other studies' findings such as PSWs' increased responsibility (Barken et al., 2020), point to system organisation and structural problems. The hands-off stewardship approach to governance allows policy gaps that jeopardise client safety. Differing PSW employment conditions, such as lower wage levels for home care workers contributed to shortages. Occupational safety is an important factor linked to PSW shortages, as workers frequently face challenging circumstances, including unsafe environments and abuse from clients and others in the home setting (Allison et al., 2020; Barling et al., 2001; Craven et al., 2012; Geiger-Brown et al., 2007; Grønoset Grasmo et al., 2021; Hanson et al., 2015).

What we do not yet know about the PSW workforce (Estabrooks et al., 2015) is also concerning given that our knowledge about the safety and risk (including abuse) for older people receiving home care is limited and these issues are under-reported (Matthias & Benjamin, 2003; Mercier et al., 2019; Yon et al., 2017). Abuse of any sort – regardless of frequency – requires

examining how to best develop preventive measures to ensure a strong and safe system is in place to support our increasing older population.

Strengths and limitations

A strength of our study is the diverse sample of experts with knowledge relevant to policy, PSWs and the home care sector. This focus allowed inquiry specific to the case of Ontario home care policy, PSW policy, and the unique circumstances arising from policy developments related to COVID-19 over the course of the research period. Although beyond the scope of this paper, policies such as rapid education, may increase risk for workers as well. Lack of appropriate training may increase likelihood of injury and provide PSWs with insufficient skills to deal with crises (Sims-Gould et al., 2013).

Our study included both publicly-funded and private service providers, which provided additional insight into the policy-development reported by the SPO managers; however, our sample of service provider managers does not contrast the breadth of SPO circumstances that exist (e.g., for profit, not-for-profit). SPO managers all had nursing backgrounds except in one case. This clinical, professional knowledge was key to informing policy development and PSW training and oversight. This nursing expertise also strengthened our study as SPO managers had clinical as well as some policy knowledge. However, the fact remains that there is little legislative guidance for private home care providers.

This study is grounded in KIs' vast body of knowledge and many years of experience. This resulted in rich data targeted to answer our research questions. A key strength of this study is the participant expertise, which spanned relevant occupations and administrative hierarchies within the home care system. In the majority of cases, we obtained consent from our first contact and preferred choice – persons we had selected through purposive sampling, as well-placed in

relation to the home care system and well-versed in matters of policy, PSWs, and/or client safety. Overall, we achieved a strong balance of perspectives from government, service provider management, and sector advocates and interest group.

Conclusion

This study set out to examine policy gaps creating client risk in PSW-provided homecare in the context of COVID-19. Our findings contribute to identification of areas that increase client risk and highlight the importance of governance and strong policy. Understanding policy gaps is critical in order to address client risk that may occur - and continue unchecked - in devolved systems where there is little oversight of organisation-level policies and practises. Our analysis also illuminated how the COVID-19 pandemic escalated risk in some areas of concern, such as PSW shortages, driving the development of more rapid education, and accelerating recruitment and hiring. The potential for worker shortages to prompt less-robust reference-checking or influence hiring practices is concerning for client safety.

Our study is novel in exploring how the COVID-19 pandemic and increased worker shortages undermine pre-existing policy weakness and increase risk for home care clients. Ontario's emergency pandemic policy – to recruit PSWs, reduce education length and subsidise tuition and practicums despite providing only temporary wage increases – illustrates not only a short-term fire-dousing approach, but also how layering policy on top of problematic policy is not without ripple effects.

Chapter 5: Findings summary and contributions

This chapter briefly introduces findings in light of the overall research endeavour. Following that, findings are situated within relevant literature, noting what this work contributes to existing research. Final sections address potential application, future directions, and study strengths and limitations and a conclusion highlighting the value of this work.

Study overview

This examination of policy shaping how PSW-provided home care affects client safety, involved researcher immersion in home care literature, policy (and particularly public policy such as legislation pertaining to the PSW occupation), and related documents like Hansard transcripts from Ontario Legislative Assembly debates and committee hearings. Interviews with 16 key informants provided rich data from a range of positions embedded in the home care policy and service delivery system. KIs positions within the home care system provided opportunity to explore the "interpretive communities" (Yanow, 2011) that share ideology or particular standpoints, and have conflict or tension with other parties. Many parties were embedded in the beliefs and practices attached to their profession (e.g., nurses) or organisational factors.

The use of IPA required researcher familiarity with the "local knowledge" of policy and the contextualising factors. Delving into PSW literature and scanning abuse literature, examining legislative documents, along with key informant interviews, complemented each form of investigation and resulted in overarching interpretations guided by IPA. With a critical interpretive lens, further interpretation transpired to evoke findings rooted in the assortment of data. Synthesis of data from a variety of sources acted as a form of triangulation.

This thesis identifies concerning gaps in data about home care safety and in policy. These are foregrounded by health system structure including government contracting of home care services, and transferring responsibility for safety and quality to service providers.

5.1 PSWs, policy gaps, client safety risk and COVID-19

This study set out to examine policy gaps that are of risk to client safety in PSW-provided homecare. The manuscript in Chapter 4 presents findings framed in the context of PSW shortages. Here, we discuss each of those findings in a broader policy context, to identify policy gaps with implications for client safety. We first discuss key findings in the areas of (5.1.1) policy and the unregulated PSW occupation, including supervision and performing complex tasks. Next, we consider (5.1.2) issues intersecting with the COVID-19 pandemic. We also revisit how conceptual gaps occur when (5.1.3) overlapping contextual factors are overlooked, and explore how these can translate to policy gaps. For instance, occupation-specific research often does not address client risk or particulars of the care setting, while client-oriented studies frequently neglect to identify the safety implications associated with particular types of caregivers. Although previous research has been conducted in many of the *individual* sub-sections identified in this thesis, less has been published that considers the intersecting factors and collective risk that we propose is critical for consideration of client safety. We note that this study begins to identify policy weaknesses that arise in failure to consider context and the overlapping topics of care sector siloes, client-and-worker interconnection, and occupational factors that contribute to safety risk. (5.1.4) Vested interests arising from policy decisions are briefly discussed in light of stakeholder positionality. Finally, (5.2) we discuss how this research may be relevant for other settings and (5.3) strengths of our approach to identifying areas of

client risk with potential for mitigation. We (5.4) look at future research areas and (5.5) conclude by highlighting the importance of contextual research and strong policy.

5.1.1. The PSW occupation: deficits in regulation and supervision

Many of our findings stem from the unregulated status of PSWs. For instance, verifying workers' employment history in the absence of some form of regulation or registry presents challenges for SPOs. Other researchers have conducted occupation-specific studies about home care workers (Barken et al., 2020), PSW precarity (Zagrodney & Saks, 2017), as well as gender and other socio-ecological circumstances of home care work (Aronson & Neysmith, 1996; Martin-Matthews, 2007). Lack of professional regulation of caregivers has also been explored in research (Kelly & Bourgeault, 2015; Saks & Allsop, 2020) although this domain of work does not always consider the granularity of healthcare setting and is, regardless, a slim body of literature. For instance, a recent review of professional regulation in health care completed in the UK (Cardiff University) found 27 articles relating to unregulated health workers– and these included papers about other unregulated health workers such as Physicians' Assistants (Bullock et al., 2020).

A finding of this study is that lack of home care PSW supervision may increase client risk and allow PSW practices that could be unsafe to continue without supervisors' awareness. While home care worker supervision has been the subject of a limited literature, this research seems to be predominantly in the occupational field as opposed to from a client safety perspective. For instance, a 2013 paper entitled *From risky to safer home care: health care assistants striving to overcome a lack of training, supervision, and support* focused on how paid care providers in Sweden tried to compensate and cope with minimal training and supervision (Swedberg et al., 2013).

Our study also found potential risk in the designation or assignation of nursing tasks. In this category of PSW research (sometimes referred to as 'task shifting) our findings aligned very closely with that of other researchers, who have identified PSWs perform more tasks with increasing complexity (Afzal et al., 2018; Barken et al., 2015; Saari et al., 2017; Saari et al., 2018; Zeytinoglu et al., 2014). There was agreement among SPO managers in this study about what policies should guide task shifting to unregulated care providers: the Regulated Health Professions Act (S.O. 1991, c.18[18]) and the College of Nurses' practice guidelines[19] for working with unregulated care providers. These policy documents are recognized in other literature; however, our findings emphasise risk aspects that receive less attention in other literature, such as:

- the lack of policy directive for the regularity of skills supervision (a legal responsibility of the nurse or regulated provider who taught the skill)
- that Controlled Acts (O. Reg. 107/96[20]) taught to unregulated home care providers can legally be supervised indirectly (e.g., dependent on unregulated care providers' reports) despite the fact that these workers may lack the skills to identify new symptoms or complications;
- that an exception applies for anyone (such as privately-hired PSWs as opposed to those who work for publicly-funded SPOs) to legally perform a number of controlled acts when they are part of a clients' regular activities of daily living (Regulated Health Professions Act, S.O. 1991, c. 18., s.27 ss.1, e.)

[18] https://www.ontario.ca/laws/statute/91r18
[19] https://www.cno.org/globalassets/docs/prac/41014_workingucp.pdf
[20] https://www.ontario.ca/laws/regulation/960107

Our contextually-informed perspective – particular to PSW-provided home care – permitted us to identify unique risks inherent to the home care setting and unregulated care providers conjointly.

5.1.2. Home care during pandemic

Understanding policy gaps is critical in order to address client risk that may occur - and continue unchecked - in devolved systems where there is little oversight of organisation-level policies and practises. Our analysis also illuminated how the COVID-19 pandemic escalated understandings of risk in some areas of concern, such as PSW shortages, driving the development of more rapid education, and accelerating recruitment and hiring. The potential for worker shortages to prompt less-robust reference-checking or influence hiring practices is concerning for client safety. Our study is novel in exploring how the COVID-19 pandemic and increased worker shortages undermined pre-existing policy weakness and increased risk for home care clients. Ontario's emergency pandemic policy – to recruit PSWs, reduce education length and subsidise tuition and practicums despite providing only temporary wage increases – illustrates not only a short-term fire-dousing approach, but also how layering policy on top of broken policy is not without ripple effects.

While the devastating toll of COVID-19 has been a glaring issue in LTC, some KIs in this study thought the home care sector was largely buffered from widespread disease transmission – a circumstance they thought to be primarily because home care is *not* a congregate setting. Literature is only beginning to emerge in this area, with data about COVID-19 transmission in home care by a handful of US studies. One larger study found that 238 of the 1,204 home care agencies surveyed (over 36 states) had frontline care workers who were exposed or tested positive for COVID-19 (Rowe et al., 2020). Another US study found 76% of managers reported having home care workers who were symptomatic or tested positive for

COVID-19, and more than 90% said they had workers who missed work due to quarantine protocol (Sama et al., 2021). Other research focused more on preparedness, PPE, and a decline in demand for care. We also heard about a lack of available PPE and a decline in demand for care from our participants, although this was not a focus of the analysis reported in Chapter 4.
A paucity of information on the impact of the care setting may be due to research about more acute COVID-19 problems such as insufficient access to PPE (Allison et al., 2020), the magnitude of crises in LTC (Armstrong & Cohen, 2020; Gruben & Bélanger-Hardy, 2020), and/or the historic tendency to overlook the home care sector and the often-marginalized populations receiving and providing care (Allison et al., 2020; Rossiter & Godderis, 2020; Sama et al., 2021). The challenge of worker-level data collection among organisations in the fragmented home care industry may further contribute to a lack of published information.

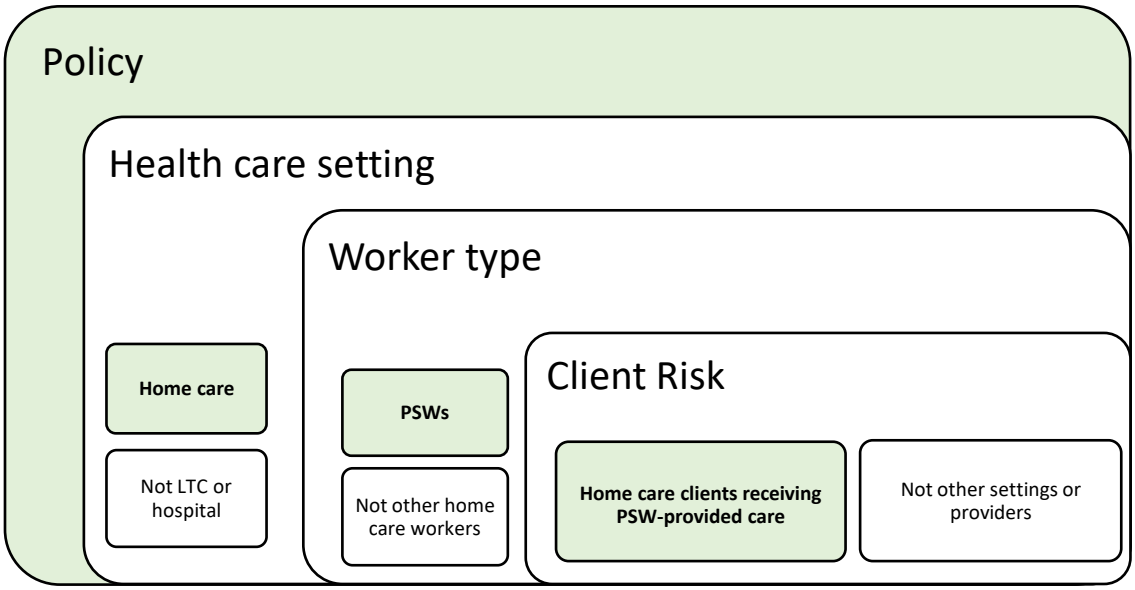
This same individual-level of care may have contributed to lower rates of COVID-19 in home care than in congregate care settings; however, the individual setting also contributes to increased health and safety risks for both clientele and the precarious, racialized and mostly-female workforce. From a socio-ecological stance, the government's devaluation of the home care industry has been constructed *at the expense of the marginalized populations dependent on care or exploited as workers*. Ageism, ableism and racism are evidenced by the policy gaps in this industry, often invisible to the public due to a lack of transparent data.

5.1.3. Focusing in on PSW-provided home care

This thesis offers novel insight into policy weaknesses framing PSW work, the home care setting, and client safety in the context of the COVID-19 pandemic. It also supports previous research linking work conditions and client safety, although this research is unique in identifying policy weakness as contributing to client risk in the specific conditions of home care PSWs. As

demonstrated in each of the subject areas included *(figure 9)*, this contextualised focus enabled identification of specific concerns with potential for pragmatic application and contributing to evidence-informed policy.

Figure 9: Study foci



A recently-introduced law providing a framework for the regulation of PSWs supports the importance of the issues that emerged in this thesis. Many of the safety concerns that arose in this research were also brought up in the introduction of Bill 283 and became the subject of parliamentary debate in the April – June 2021 period. When this law is enforced, this thesis could be a helpful resource to identify areas to compare in pre-regulation and post-regulation evaluation. Among the excellent and substantial work of Canadian home care worker researchers, there have been studies that examine unregulated care providers' work conditions as related to worker and client safety (Barken et al., 2020; Craven et al., 2012; Lang & Edwards, 2006; Macdonald et al., 2013).

Notably, a lack of broad policy regulating the occupation (Saks & Allsop, 2020; Zagrodney & Saks, 2017) [prior to Bill 283] and the terms of care provision, in combination with

the "responsibilising" of PSWs (Barken et al.,2020), inconsistent education, and a paucity of supervision, create opportunity for the employment of unqualified and unsuitable home care workers. Although minimal education requirements might imply there are few barriers to employment in this occupation, a shortage of workers has plagued the health system for years (Ministry of Health and Long-Term Care, 2014). PSW shortages, discussed in Chapter 4, intersect with system-wide policy and facets of the organisational structure of home care. Worker shortages are regularly mentioned in other literature, and shortages are often linked to the home care milieu (Allison et al., 2020); however, a LTC focus has prevailed in literature discussing worker shortages during the pandemic (Sama et al., 2021).

A challenge is that inadequate oversight of home care workers creates risk for home care clientele – and lack of supervision and the care setting mean safety issues (including abuse and neglect) may go undetected. This study did not aim to focus on failings of individual PSWs, but rather *the failure of a system to adequately protect clients through policy governing work conditions*. Despite prominent discussion of the importance of person-centred care – in government policy (Gagliardi et al., 2020), by organisations (such as the Alzheimer's Association[21], hospitals[22], and nursing associations[23]) and in care literature (Santana et al., 2018), — *client risk* as it is tied to home care PSWs' occupational situations, has received less focus. Without adequate government oversight, it is difficult to assess the extent home care providers' quality of care may vary. This disconnect between policy and practice is conceptually similar to the lack of quality care assurance and protections for residents in LTC, where homes range from excellent to deplorable (Armstrong & Cohen, 2020; Gruben & Bélanger-Hardy, 2020). Another

[21] https://www.alz.org/media/greatermissouri/person_centered_care.pdf
[22] https://sunnybrook.ca/content/?page=person-centred-care-videos
[23] https://rnao.ca/bpg/guidelines/person-and-family-centred-care

critical contextualising factor is that work conditions impact PSWs' ability to meet care needs, given they are provided minimal time for visits and are under time constraints in order to travel from home to home (Denton et al., 2006; Barken et al., 2020). Privately purchased care introduces another set of potential risks for clients and workers.

While regulating the PSW workforce is one approach to help reduce client risk, there is a deficit in occupational data about the workers scattered among the dozens of public and private care provider organisations for these publicly-funded services. A lack of information about publicly-funded care provision is contrary to principles of transparency and could also be rectified. Home care worker and client risk could be prioritised together, in policy; and oversight and enforcement could be considered as part of system design. Measures of quality may benefit from revision in order to reflect what affects the people receiving care. That the workers providing care are key to ensuring safe, quality care is also increasingly evidenced, pointing to the importance of fair pay and work conditions.

5.1.4. Vested Interests

Among the key findings of this study are the lasting and unexpected consequences of historical policies that create vested interests. For instance, a modification to contract processes - first awarding contracts through competitive bidding, and then moving to perpetually renewal of those contracts - stabilised the SPOs funding and geographic service delivery areas, but also contributed to entrench the mix of providers. This finding aligns with previous research (Abelson et al., 2004; Denton et al., 2006; England et al., 2007).

KIs pointed out how service providers as employers had developed many of their own policies surrounding PSWs, made organisational decisions (e.g., hiring) based on existing contracts, and had established reputations and relationships with clients and communities; and

SPO managers spoke about having policies developed and approved through accreditation processes. These "vested interests", as a few KIs described, influenced willingness and ability to change.

5.2. Relevance for other sectors and systems

Much of what has been studied in this thesis also exists or is applicable to LTC. For instance, related to worker shortages, if Ontario does not make long-term change to employment conditions, the province is likely to continue to experience problems with recruitment and retention of workers. This affects all sectors, and Ontarians – not only as health service users, but as citizen taxpayers. Despite knowledge that home care is less expensive than hospital or LTC, and the fact that most people want to remain at home as long as possible, Ontario has rationed home care services (Dyck et al., 2005; Gilmour, 2018).

Pulling back from specific findings into a wider frame, it seems that pursuit of short-sighted goals and quick-fix solutions may create uncertainty and even dangerous circumstances in health care contexts. The toll of COVID-19 speaks to problems with policy processes and decision making without fulsome evaluation and consideration of long-term consequences.

5.3. Strengths and Limitations

The principle that worker safety *is* client safety and vice-versa, and that these are inextricable from one another (Lang et al., 2006) underlies this research study from the design stage up to and throughout analysis and writing. Maintaining client and worker safety as interrelated as opposed to siloed issues strengthened this project. A further strength of our study is the dual context-specific foci on the home care sector (versus PSWs in all types of care settings) and the PSW occupation (versus any home care worker). This focus on policy, relevant exclusively to PSWs employed in exclusively home care, was key to maximizing what qualitative research does so

well: incorporate context. The most impactful limitation of this study was the finite resources and time available for a Master's thesis study. This limited analysis and writing for this thesis to a few key findings.

All KIs were purposefully selected with strategic consideration of expertise in order to obtain rich and relevant data. As a result, data is grounded in a deep and broad body of knowledge and many years of experience. Although I was only able to recruit one LHIN/HCCSS KI, the rich data, the wealth of KIs' knowledge, and sampling from positions at higher levels of governance and with managers who interact with both PSWs and clients mitigated the recruitment shortfall of this position.

5.4 Future Research Directions

Findings from in-depth analyses were substantial and require time and resources beyond the time of this thesis to disseminate. Other topics that may be elucidated in future writing based on this study include measures of care quality, structural conditions impacting client care, and facets of employment conditions that arose as concerning for safety overall. A jurisdictional comparison of unregulated workers and home care safety could provide valuable insight in these areas.

5.4.1. Abuse by paid caregivers

Given challenges with under-reporting and fear of reprisal, further research about paid caregiver abuse of older people and people with disabilities might consider appropriate methods for data collection. Due to the sensitive nature of this topic, in-depth qualitative research would be appropriate for data collection about abuse, as well as service quality. This would improve data and help to establish trust and appropriately support clients and other clients who may be victims. The importance of research in this area is crucial for a holistic understanding of client

safety. The approach to investigating this topic through tapping into the experience of KIs is one means of addressing ethical concerns with research of vulnerable populations.

5.4.2. Measures of quality

As Ontario and other jurisdictions increasingly consider person-centred care, whether we are measuring what matters to people receiving care should be considered. Data from this study suggests that the notion of quality is constructed around what *can* be measured quantitatively, data that is convenient, and research questions geared at clinical, system-level, and/or cost-efficiency outcomes. Accountability mechanisms such as Quality Improvement Plans (QIPs) represent little more than year-over-year improvement, with targets self-selected by service provider organisation. One KI said the QIPs did an "excellent job" of bringing about organisational reflection, but did not necessarily address the quality of care provided by workers or ensure clinical supervision. The provincial reporting of 'satisfaction' with home care is another area of concern with a mixed-bag of issues affecting reported satisfaction rates. The construction of this indicator as a "quality" indicator impacts interpretations of home care quality, and may be interpreted as 'evidence' of quality despite being devoid of client experience. To add to previous literature (Steele Gray et al., 2014) this topic may be addressed in future writing based on this research study.

5.5 Conclusion

Ontario PSW workforce training, background checks, previous employment information, and ongoing in-person supervision are important for ensuring the safety of home care clients and hold potential for improving safety for clients in all sectors. Home care in this province has long lacked mechanisms to ensure safety and the actual quality of care individual clients receive, and, critically, fallen far short in transparent data reporting. How Ontario measures quality, success,

and determines funding for the dozens of Ontario Health Teams setting up to operate services in an integrated model, will shape the future of care in this province. The issues raised in this thesis provide important considerations as new population-based care models based on health outcomes emerge.

Despite some shortcomings in safety policy and measures, home care can help provide care according to individuals' needs and preferences, supporting clients to remain in their own homes [where 90% say they want to be (Home Care Ontario, 2020)] and encourage optimal function and independence (Ploeg et al., 2019). How workers are remunerated and supported impacts the quality of care (Armstrong & Cohen, 2020). A structure that supports workers – financially as well as in training and supervision - to deliver this immensely important (and least expensive) form of care is key for the future with inevitably-growing older populations.

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Appendix

Appendix 1: Interview guide

Work experience

1. What is your official job title?
2. How long have you been in this position?
3. How long would you say you have worked in this field?
4. Can you tell me briefly about your role at your workplace?

Nature of expert knowledge

1. What policy related to home care, PSWs, or client safety might you deal with through your work? Can you provide an example?
    i. What was your role with regards to this policy? For instance, were you involved with its development, evaluation or analysis?)

Specific policy knowledge

1. Can you describe for me any policy you are aware of that relates to PSW-provided home care in Ontario? (eg. MOHLTC, MOL, legislation, LHIN, SPO)

    If appropriate for role/expertise:

    i. Do you know how/why that policy was created, or who would have been involved in developing that?

    ii. Who might that policy directly affect?

    iii. Can you tell me how that policy is enforced?

Views of policy

1. In your view, what are key policies that protect clients?
    i. What are policies that work well?
        a. Why?

        If not provided already: Can you give an example?

    ii. What about policies that don't work well?
        a. Why?

        If not provided already: Can you give an example?
2. How do you think current policy influences PSW-provided home care?
    i. What parties might this policy affect? (eg. LHINs, SPOs, PSWs, families)
    ii. *If appropriate:*
        1. What effects could this have on PSWs?
        2. What effects could this have for client safety?

3. In what ways does policy shape home care client safety?
4. What policies do you consider help ensure safety during the interactions of PSWs and home care client safety ?
5. Given that there is no regulatory professional body for PSWs, what are your thoughts about the safety of home care clients?
    a. Is training adequate?
        i. eg. Thoughts about effectiveness of 2014 introduction of standard education
    b. What can you tell me about PSW supervision?
        i. eg. Thoughts about SPOs supervising
    c. (If appropriate for participant's role) A provincial registry effort stopped in 2016, and the Michener Institute 'pilot' project ceased in 2019. My understanding is that most documentation is at the client case level, and the MOHLTC or LHINs do not track complaints about PSWs or other workers. Can you speak to this at all?
        i. Eg. How can we be confident of PSWs performance or track record?
6. What are your perspectives of the adequacy of <<specific policy >> OR <<policy related to home care in general?>>
7. If any new policy could be implemented to improve PSW home care provision as it affects client safety, what would that be?
8. What do you consider as a policy gap, or as concerning or a risk in PSW-provided home care client safety?

COVID-19 and policy

1. How do you think that home care clients' safety has been handled during the COVID-19 pandemic?
        i. During the COVID pandemic, we've seen disproportionate effects for Long Term Care residents. To your awareness, what measures have been taken to protect home care clients?
        If needed, prompt: How do you feel home care client health and safety risk compares with LTC residents?
2. The risk of cross-site transmission of the coronavirus led to calls for health care workers to work in only 1 site. Do you know how this was addressed in the home care sector?
    a. Based on your expertise, were those measures adequate protection?
    b. How do you think this might that have been handled better?

Wrap-up

1. Based on the topic of this research and your expert knowledge, do you have any thoughts about how this study might be improved or additional items I should consider?
2. Is there anything I may have missed, or that you'd like to comment on?

Appendix 2: Code Book

Name	Description
Accountability	How a party is accountable – may include policy, lack of; contracts; government reporting; responsibilities to perform or report
Barriers to change	When stated (not interpreted)
Conditions	Anything re: job conditions such as: scheduling, travel , pay; especially *job*: what is part of PSW job (eg. specific duties, can include 'scope of practice' or assignments. Secondary code to "Safety" (i.e. safety takes precedence when conditions are unsafe)
COVID	Anything COVID -specific. Will overlap with policy, safety. Includes PPE, one employer rule
Effects of System	When stated (not interpreted), what is attributed to or described as caused by system structure
Gaps, critique	Policy gap or criticisms of what is missing
Home Care Pros	Population need for homecare. Includes comparisons with LTC, e.g., Individual settings versus congregate settings
Measuring	Data or lack of data, indicators, lack of measuring; surveys, issues with surveys, bias. Also anything stated as relating to measuring quality
Partp't knowledge	Participant's specific knowledge or misinformation about Home Care PSW work; includes anything that may be untrue
Partp't Role	Their job, experience, role

Policy VS Practice	Practice that differs from policy; divergence from policy acknowledged
Policy, Law	Legislation, enacted law or regulation that is implemented
Policy, Legacy	How past policy influences current conditions - when noted by participants, not interpreted. E.g., past policy created market-bidding, now in "evergreen" renewal; legacy of including private providers, now can't fulfill service requirements w/o.
Policy, Process	Legislation and regulations development; Public hearings, implementing, developing
Policy, Regulation	What is shifted to regulation, pending regulation. Also, comments about not knowing what will be in regulation; e.g., what is *not* in legislation
PSW Registry	Any reference to previous efforts to create registries
PSW Regulation	Anything about Regulating PSW as profession, e.g., "self-regulation" or unregulated care providers.
PSW Shortage	Any description of shortages. *[Noted a lot of overlap with system design, and sometimes safety]*
PSW Training	Comments re: minimum or standard education, inconsistencies, varied education, grandfathering in lower education, mix of educations, etc. Also other training such as Gentle Persuasive Approach, Non-Violent Crisis Intervention
Relationships	Power relations involving any party; includes conflict/controversy between parties/stakeholders etc.
Safety Gap	Interpreted or stated, may be policy, process/practices. Can be for any party

Safety measure	Interpreted or stated, may be policy, process/practices. Can be for any party
Safety, Clients	What is reported as safety concern
Safety, PSWs	What is reported as safety concern. Include COVID & non-COVID, working alone, environment, and other risks identified, right to refuse unsafe work. Hierarchy: Do not also code as "Conditions" *[This code takes precedence when conditions are unsafe]*
Solutions	Suggestions for improvements or solving anything identified as a safety gap or safety concern
SPOs	Anything about Service Providers that is not covered in other codes *or* overlaps with multiple other codes
Supervision	Supervision: includes delegated acts, clinical supervision, observation, etc.

Appendix 3: Tools of Interpretive Policy Analysis

As an example of how the IPA approach informed this study, the table below depicts the steps and tools for IPA. The first column describes each step outlined by Yanow (2001) in the first chapter of the Sage online Research Methods book[24], *Conducting Interpretive Policy Analysis*, and the second column provides a description of how that was followed in this policy analysis.

Chapter 1: Underlying Assumptions of an Interpretive Approach: The Importance of Local Knowledge

From Yanow (2001)	*How this contributed to this thesis*
The analytic acts and the topics that are typically the focus of policy analysis on "…have been conceptually curtailed and directed by the research and analytic methods available in training programs and acceptable to policy analysis scholars" (Yanow, 2001, p.3) Yanow suggest that following methods that have formulaic pre-established expectations, (such as costs-benefits analysis or decision analysis) restrict investigation to particular questions and limit research to question deemed "amenable" to the method of analysis (p.4). She says, policy can be systematically and rigorously studied interpretive methods that acknowledge social context: "…we live in a social world characterized by the possibilities of multiple interpretations. In this world there are no 'brute data' whose meaning is beyond dispute. Dispassionate, rigorous science is possible—but not the neutral, objective science stipulated by traditional analytic methods (as represented by the scientific method)" (p.5)	Many traditional types of policy analysis (e.g., cost benefit, or prescribed step-wise policy-development analysis frameworks) miss the critical social environment that shapes every decision. With IPA, I strive for a sociologically informed, contextualised analysis. This is appropriate for this study because complex social factors underlie and shape the policy context. Particularly, where: • workers face complex and challenging socio-political contexts and with often precarious socio-economic status; and, • poor work conditions disproportionately affect racialised, primarily female workers; and, • work conditions meet few of the criteria for Decent Work as set out the World Health Organisation; and, • clients are often vulnerable; and, • clients, families and unpaid caregivers are not provided with adequate support • neoliberal governance strategically passes risk to other parties; • governments implement cost-restricted care capacity that disproportionately affects older, frail or elderly or disabled populations and especially those who do not have the economic means to purchase private care

[24] DOI: https://dx.doi.org/10.4135/9781412983747

The two initial steps in IPA are to identify the relevant '**interpretive communities**' and the '**artifacts**' that carry meaning for those communities (Yanow, 2001, p.15)	**Interpretive communities:** Workers, worker associations, unions, clients, families and caregivers, other health workforces (e.g., nurse managers), patient advocates and patient safety advocates, elected government officials, political parties (ruling party, official opposition party, etc.), government employees (theoretically non-partisan but highly knowledgeable in practical applications), [n.b. home and community care was not yet merged with Ontario health during data collection period of this research], LHINs/HCCSS, SPOs, industry association and owners of private SPOs, external commentators (e.g., journalists), academics. Due to participant confidentiality, there are limitations to how interpretive communities are described. Broad categories are provided in the participant table (Table 1: Key Informants) and positionality is depicted in *figure 6* and *figure 7*. **Artifacts of meaning:** Initially I planned to explore only Laws and regulations (public policy); however, due to the scant law specifically applicable to PSWs and their interaction with home care clients, this was expanded to explore artifacts of meaning in other areas. The evolving nature of the law during this time further complicated this as new artifacts emerged on a consistent basis throughout the research study. Thus, artifacts included: • Any laws where there was an expectation PSW work might be described (home care, minimum training standards act, occupational health and safety). These primarily demonstrated gaps. • All Hansard Transcripts from the introduction of Bill 185, including readings, debates, and committee hearing transcripts • SPO contracts: As individual policies for the 47 publicly-funded SPOs or the unknown number of private SPOs were not publicly available, standard contracts and templates were used as resources[25] • The transcripts from KI interviews supplemented artifacts for analysis
The 'location' of knowledge is a key component of both interpretive	Local knowledge: In addition to the literature, law and policies, and other stakeholder documents, I created

[25] http://healthcareathome.ca/serviceproviders/en/Procurement/Contract-Templates/Client-Services

communities and artifacts because it positions these in a larger socially-contextualized frame. This 'local' knowledge can be based on a variety of social positions. Yanow suggests, "…within an organizational structure, professional training and membership, sex and gender, and myriad other possible dimensions…" (Yanow, 2001, p.8)	alerts for new publications related to PSWs to inform me when something came out from three Canadian news sources with a history of high-integrity journalism (CBC, Globe and Mail, and The Star), to facilitate keeping up-to-date with 'local knowledge' throughout the study. Additionally, a number of related organisations and hashtags were reviewed on Twitter on a twice weekly basis at minimum
A third stage of analysis is to look at what meaning is embedded in the artifacts or communities.	In executing step three, field notes, memos and spreadsheets to organise data, as well as coding that included consideration of participants' perspectives (e.g. what policy, if any, are you aware of that helps ensure client safety in PSW care). In future papers, policy gaps will be explored further e.g. one KI said, there is a patient rights in Home and Community Act, but "it has made absolutely NO difference" (Nina)
The fourth step is akin to noting disagreement and any conflict (between groups but also within interpretive communities, and between groups and their positions/beliefs/values.	For this particular paper, the fourth step of Yanow's stepwise process is difficult to make explicit as the conceptual and value-based disparity underlies much of the data. One example would be underlying nursing-profession values. Although minimal or not included in this particular paper, references to conceptual conflict between employers and unions were not uncommon. Also not discussed in this paper were references to not-for-profit or for-profit organisations. Public versus private care was another big topic that arose throughout; however, this was also not a large topic of discussion in this paper.
Yanow (2001) describes that a researcher may choose not go beyond step four; however, if they do, she states, a researcher "… might take the next step of showing the policymaker the implications of the different and conflicting meanings for the implementation of the proposed policy" (p. 17)	The findings in this study highlight unintended consequences of some pandemic-era policy that show conflicting meanings of policy such as how some policies meant to improve workforce shortages for some actors were seen by other actors as contributing to competition for scarce workers. Other areas that might provide policymakers with insight into conflicting views of policy effects include perspectives of training, task-shifting, and interpretations of client safety.

Appendix 4: Policy Review Examples

Throughout this study policies were reviewed and tracked in a database. The list below provides a sample of types of documents that were reviewed. (Categories not displayed included: Client focus/impact, link/source, and extensive memos)

Organisation	Title	Law?	Direction for PSW work	How does it apply?	Limitations
ACE [legal aid funded]	Submission of the advocacy centre for the elderly to the standing committee on social policy: February 22, 2016	N	N	Broadly - commentary	n/a
Bayshore Healthcare	Bayshore Partners with Conestoga College to Train Home Care Support Workers	N	N*	Statement - Education related to another form of home care worker	*Potential impact for clients; does not direct PSW activity
Health Standards Organization	GLOBAL STANDARD HSO 42004:2018 - Point-of-Care Testing	N	I*	Standards for *employers/policy-makers to follow.	*Impacts PSWs indirectly. Not mandatory to be accredited
HQO	A Guide to Improving Complaints Processes in the Home and Community Care Sector	N	N	To some extent, focused on public-facing aspects, concerns re: litigation, complaints management/PR	Guide. Query HQO follow up - see Auditor General report
LHINs	LHIN Quality Improvement Plans (QIPs) and Service Provider QIPs Presentation to Service Provider Organizations April 2018	N	N	Guidance	No external accountability or oversight
Ministry of Labour	O. Reg. 67/93: HEALTH CARE AND RESIDENTIAL FACILITIES (Under OHS Act)	Y	Y*	Law	*Not applicable to home care (not a 'facility')
ONA	SUBMISSION To Standing Committee on the Legislative Assembly On Bill 175, Connecting People to Home and Community Care Act, 2020	N	N	Commentary on Law	Perspective of limitations of Bill 175

Glossary

Actors	For Interpretive Policy Analysis, *actors* may be any parties involved in policy or policy-related processes (Yanow, 2011) Some examples of actors relevant for this study include government legislators, home care industry-related organisations or stakeholders that may support or oppose policy, executives, boards, manager, or other staff involved in agencies enacting policy, PSWs and care recipients.
ADL	*Activities of Daily Living:* This terminology is embedded in the description of the type of care provided by Personal Support Workers, and often parallel to Personal Support Workers' "Scope of Practice"
Adverse Event	For the purposes of this thesis, Adverse Events would not be considered as an outcome of interest unless the following conditions are also met: • a PSW has a role as an actor in the system of care and they are (unintentionally or intentionally) involved in a preventable event, • This event occurs in the home care sector, and would not have occurred without a specific policy or policy gap and the role of the PSW • *If policy factors underlie the PSW – client interaction situated in the home setting*
CCAC	*Community Care Access Centre:* Former organisation funded by the Ministry of Health and Long Term Care. See *HCCSS*
Client	Used in this thesis to describe an individual who receives home care services. In Ontario's marketised home care system, the care recipient is referred to as a client. In Ontario's health system's fragmented sectors, patient is usually used to describe individuals in primary care and hospital environments, while resident is preferred in the Long-term Care sector to promote recognition of the location of care as an individual's home, and client is used for recipients of home care services. This thesis adheres to this commonly-used typology to foster knowledge translation given that home care sector managers, stakeholders and health policy makers are considered the intended audience for this research.
Client harm	For the purposes of this thesis, client harm is used to describe harm of any nature – physical or psychological, including neglect and abuse. The cause of harm as intentional or accidental (including iatrogenic) is not differentiated, as analysis sought to include any client *risk tied to policy and PSW-provided home car*e. The concepts of harm (and risk and safety) are thus defined by the contextual aspects of PSW-provided home care. Notably, while client harm can include adverse events, the adverse event must meet context-specific conditions to be considered relevant (See *Adverse Event*)

Client risk	For the purposes of this thesis, client risk describes potential for harm to occur (of any nature) and particularly, potential for harm *stemming from policy governing PSWs in the home setting*. Notably, this concept has been similarly used in risk-assessment for professional regulation (Professional Standards Authority, 2016). In this sense, risk is defined according to linguistic and social meanings and differs from quantitative and epidemiological concepts or measurements.
Client safety	For the purposes of this thesis, client safety is used to refer to the state of being safe from harm. This *conceptual use* differs from terminology commonly used in medical and health service literature which refers to a set of indicators that quantify types of injury (e.g., falls) or other adverse events. In contrast, this thesis' social sciences-informed definition is demarcated by an occupational-specific risk-assessment approach (Professional Standards Authority, 2016).
Controlled Act	An activity of health care provision that has regulations as to who can perform it under what conditions; controlled by the Regulated Health Professions Act, 1991 (1991). https://www.ontario.ca/laws/statute/91r18
Delegated Tasks	*Delegated tasks.* A task assigned by a Regulated Health Professional who, following their college guidelines, delegates a task to another (regulated or unregulated) care provider[26] under specific conditions.
HCCSS	*Home and Community Care Support Services.* As of April 1, 2021 the crown agency responsible for home care coordination [formerly, LHIN, CCAC]
IPA	*Interpretive Policy Analysis* is an approach to policy research (e.g., Yanow, 2001)
LHIN	*Local Health Integration Network.* Former Crown Agency under the Ministry of Health and Long Term Care
Nurse	In this thesis, as with usage found in College of Nurses of Ontario documents, *Nurse* is used to refer to any Registered Practical Nurse (RPN), Registered Nurse (RN) or Nurse Practitioner (NP)
OH	*Ontario Health.* A province wide agency (colloquially, a "Super agency") comprised of many separate parts, aiming to oversee health services of every kind. *Due to rapid change within Ontario's health care system, please check https://www.ontariohealth.ca for current information.*
OHT	*Ontario Health Team(s.* Local teams that will include a variety of care service once established.

[26] The College of Nurses Ontario has specific guidelines for delegating to Unregulated Care Providers: https://www.cno.org/globalassets/docs/prac/41014_workingucp.pdf

PSW	*Personal Support Worker*. Used in this thesis to mean unregulated, paid care workers who provide personal support services of the following nature, as described by the Government of Ontario: *"washing and bathing; mouth care; hair care; preventative skin care; routine hand or foot care; getting in and out of chairs, vehicles or beds; dressing and undressing; eating; toileting; and, taking you to appointments"* [27] PSWs who graduate from an education program that meets the Personal Support Worker Program Standard set out by the Ministry of College and Universities[28] will receive an Ontario College Certificate. PSWs working in LTC are required to have a certificate and meet other standards outlined in the Long-Term Care Homes Act, 2007. There is no equivalent law for home care PSWs.
QIP	*Quality Improvement Plan:* Plans addressing quality indicators and improvement goals. LHINs are required to submit annual QIPs to the province and SPOs are required to submit annual QIPs to LHINs.
RN	Registered Nurse
RPN	Registered Practical Nurse
Scope of Practice	A *Scope of Practice* outlines the activities that professionals are authorized to do and which fall under the terms described by their respective licensing or regulatory body. As unregulated workers, PSWs do not have a fixed, legal scope of practice that consistently applies. Rather, their 'Scope of Practice' is often defined as assisting with Activities of Daily Living (see "PSW"), and refined by what may be delegated to them by a regulated health professional.
SOP	*Standard Operating Procedure*. Not to be confused with *Scope of Practice*.
Unregulated Care Providers	Health care workers who are not regulated by a governing body such as a professional college. In Ontario, unregulated care providers include home care PSWs, who are not covered by the Regulated Health Professions Act (1991). As of July 2021, PSWs are not regulated by law under the Regulated Health Professions Act (1991); however, with the Advancing Oversight and Planning in Ontario's Health System Act, 2021 (2021), the framework for PSW regulation was established. Schedule two, the Health and Supportive Care Providers Oversight Authority Act, 2021 (2021), when it comes into force by proclamation of the Lieutenant Governor, will include regulation of PSWs through repealing and substituting parts of the Regulated Health Professions Act, 1991 (1991) and other affected acts.

[27] As described by the Government of Ontario at https://www.ontario.ca/page/homecare-seniors#section-1
[28] Prior to October 2019, this was the Ministry of Training, College and Universities. Program standard: http://www.tcu.gov.on.ca/pepg/audiences/colleges/progstan/health/41469.pdf