Types and patterns of safety concerns in home care: staff perspectives

CATHERINE CRAVEN1, KERRY BYRNE2, JOANIE Sims-GOULD3 AND ANNE MARTIN-MATTHEWS1

1Department of Sociology, University of British Columbia, Vancouver, Canada, 2Tyze Personal Support Networks, Vancouver, Canada, and 3Centre for Hip Health & Mobility, Vancouver Coastal Health Research Institute, University of British Columbia, Vancouver, Canada

Address reprint requests to: Catherine Craven, Department of Sociology-ANSO Building, University of British Columbia, 6303 N.W. Marine Drive, Vancouver, BC, Canada V6T 1Z1. Tel: + 604-822-6683; Fax: +604-822-9304; E-mail: catherine.craven@ubc.ca

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Abstract

Background. Quality health care in the home is dependent on having a safe environment to provide care. This analysis is based on the data from a larger study aimed at understanding key issues in the delivery and receipt of home support services from the perspectives of home support workers (HSWs), older adult clients and family members. This analysis focuses on HSWs perspectives of safety.

Objective. To explore the types and patterns of safety concerns staff encountered in home care settings.

Design. In-depth, semi-structured interviews were conducted with HSWs. The analysis included topic and analytical coding of workers’ verbatim accounts.

Setting. Interviews were completed in British Columbia, Canada.

Participants. A total of 115 HSWs participated. The average age was 50 years, and the average tenure in this sector was 11.5 years. Fully, 71% of workers had completed at least some college-level education, and 69% of workers were born outside of Canada.

Results. Workers identified four types of safety concerns: physical, spatial, interpersonal and temporal. We developed a conceptual model of HSW safety that demonstrates the: types of safety concerns; the multi-dimensional and intersectional nature of safety concerns and the factors that intensify or mitigate safety concerns.

Conclusions. Our study identifies numerous HSW safety concerns, each requiring tailored interventions and strategies. Where multiple concerns intersect, the complexity and precarious nature of the home care workspace is revealed. The identification of mitigating and intensifying factors points to future interventions.

Keywords: safety, occupational health, home care services, qualitative methods, elderly

Introduction

Home support workers (HSWs), also known as direct care workers and domiciliary care workers, play a vital role in home care by helping older adults with personal care (e.g. bathing, dressing, toileting, etc.) in private homes, thereby allowing these individuals to remain in their own homes rather than accessing facility-based care. HSWs provide the majority of direct care in home care settings [1, 2], having a significant impact on the quality of home care. Their ‘work space’ in clients’ homes is uncontrollable, unregulated and consists of minimal supervision [3]. As a result, HSWs are exposed to a variety of occupational health and safety hazards [4]. The safety concerns of HSWs are important and timely considerations for quality of care for several reasons. First, both clients and families prefer home as the location of care. Second, planning and policy-makers, guided by client preferences and cost containment pressures, are focused on ‘home first’ policies and aging in place initiatives. Quality care in the home is dependent on having a safe environment to receive and provide care, despite the fact that the ‘home space’ of each client is highly variable. A safe work environment in the home cannot be standardized, equipped or regulated in the same manner as a hospital or care facility. Third, although HSWs are the backbone of paid home health care [5], HSWs’ perspectives are missing in existing research about home care safety (for an exception, see 6). Fourth, although there are numerous safety issues encountered by paid care staff in home care settings, most research focuses on a single type of safety concern, such as violence [7–9], musculoskeletal injury [4, 10, 11] or weather-related challenges [12].

In one of the few studies exploring safety of HSWs, Stevenson et al. [6] found that HSWs had an alarming
tolerance for risk. Workers had been in risky situations for such a long time, ‘that it had come to be assumed that such risk acceptance was the norm for both themselves and their clients’ [p. 22] [6]. Finally, researchers have established a link between client and worker safety [3, 6], with an unsafe ‘work’ space meaning an unsafe ‘care’ space and vice versa [13]. Although safety researchers have emphasized the interlinked nature of the worker–client safety agenda, client outcomes and experiences are still the focus of the key research in this area [6, 14–17]. For example, while Lang [3] identified four types of safety in home care (social, functional, emotional and physical), the focus is on patient safety.

Guided by the gaps in home care safety research, including those identified in a recent editorial by Lang [3] in the International Journal for Quality in Health Care, is the need for textual data to capture the multi-dimensional nature of home care safety. To address this, we answer the following question: What are the types and patterns of safety concerns from the perspective of HSWs? We frame our findings using a conceptual framework that demonstrates the types of safety concerns reported by HSWs and the critical patterns reflected in the experiences of HSWs.

Methods

This paper is based on data from a larger mixed-methods study [18–20] aimed at understanding key issues in the delivery and receipt of home support services from the perspectives of HSWs, older adult clients and family members. We collected qualitative and quantitative data through in-depth, face-to-face, semi-structured interviews with workers. The interview guide covered various thematic areas, including basic demographics (as presented in Table 1), experience in the home support sector, training and education, safety concerns and conflicts on the job and their responses, working with clients or family members, ethno-cultural issues, communication with other HSWs and agency staff, and recruitment and retention within the home support sector. Drawing on the qualitative interview data, this paper focuses on the HSWs’ safety concerns.

Setting and participants

Ethics approval was granted from the University of British Columbia Ethics Board and the regional health authority in which our study was conducted. Data were collected from March 2007 to October 2007 in British Columbia, Canada. Eligible participants were employed HSWs who provided care to older adults, and were able to participate in an English language interview. For more information about recruitment, see [18]. Of the 118 HSWs who participated in these in-depth interviews, 115 were asked about their safety concerns on the job. Two participants did not have enough time to complete the full interview guide, and one participant’s transcript was excluded from the analysis due to language and interpretation issues.

### Table 1 Participant characteristics

<table>
<thead>
<tr>
<th>HSW characteristics</th>
<th>Average</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 115)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years as HSW</td>
<td>11.5 years</td>
<td>6 months–29 years</td>
</tr>
<tr>
<td>Ageb</td>
<td>50</td>
<td>27–65</td>
</tr>
<tr>
<td>Hourly rate of pay</td>
<td>$18.61</td>
<td>$10.42–$20.00</td>
</tr>
<tr>
<td>Number of clients per day</td>
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<td>1–9</td>
</tr>
<tr>
<td>Number Percent of total</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>Education</td>
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<tr>
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<td>10</td>
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<tr>
<td>High school</td>
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<td>19</td>
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<tr>
<td>Some college</td>
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<td>10</td>
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<tr>
<td>Completed college</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Some university</td>
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<td>7</td>
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<tr>
<td>Completed university</td>
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<td>24</td>
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<tr>
<td>Registered nurse</td>
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<tr>
<td>Place of birth</td>
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<td>9</td>
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<tr>
<td>Other</td>
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</tr>
<tr>
<td>Employment status</td>
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<tr>
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<td>70</td>
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</tr>
<tr>
<td>Part time</td>
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<td>10</td>
</tr>
<tr>
<td>Casual</td>
<td>34</td>
<td>29</td>
</tr>
</tbody>
</table>

*Of the 118 HSWs interviewed, two workers did not answer the safety questions, and one worker was eliminated from this analysis due to language/interpretation issues.

b114 HSWs reported their age, one participant declined response.

Data collection

Face-to-face in-depth interviews were conducted by trained interviewers. Participants were asked if they had safety concerns on the job; if yes, they were asked about the nature of their concern and the types of responses and strategies that they employ. Interviews were conducted at different locations (primarily in the homes of these workers), and ranged from 60 to 90 min. They were digitally recorded, transcribed verbatim and saved using ID numbers.

Analytical strategies

Our analysis team consisted of post-doctoral fellows, a masters prepared research assistant and the principal investigator of the study, all experienced in qualitative research and analysis. Two team members (the first and second authors) engaged in topic and analytical coding of the transcripts [21]; however, all authors contributed to the analysis through meetings where we shared memos about the codes and the
development of a conceptual model. Thus, coding, themes and the model were developed through a process of collaboration and consensus amongst the authors. Rigour was established through a combination of standard techniques for qualitative research, including team meetings, an audit trail, analytic memoing and peer debriefing [22–24].

**Participant characteristics**

The personal care tasks performed by HSWs most commonly include bathing (98%), dressing (98%), medication reminders (92%), toileting (91%) and lifting and transferring (87%). Most workers (80%) also provide assistance with exercise. Highlighting the physical nature of their work, HSWs provide housekeeping services, including garbage and recycling (90%), laundry (86%), vacuuming (77%), floors (75%) and dusting (70%). See Table 1 for demographic information.

Fully 58% of HSWs had worked in home support for more than 10 years, and just over 10% for over 20 years. Workers had an average caseload of four clients per day (SD = 1.5), ranging from one to nine clients. While 69% of workers were born outside Canada, 78% of these immigrant workers had lived in Canada for more than 10 years. In terms of age, gender, tasks, caseloads and length of tenure in the home support sector, the workers in this study are similar to workers whom we have interviewed in two other Canadian provinces (Ontario and Nova Scotia, see [20]). In this British Columbia study the workers were more likely to be foreign-born and more highly educated. This is largely reflective of migration trends in the urban area where we conducted our study, and the fact that foreign-born workers frequently have overseas credentials in related health care professions (e.g. nursing). For an in-depth analysis of these foreign-born workers, see [19].

**Results**

Based on our analysis of HSWs safety concerns, we developed a conceptual framework (see Fig. 1), which demonstrates the interplay between the following aspects of safety concerns: (i) the types, (ii) the multi-dimensional and intersectional nature and (iii) the intensifying or mitigating factors.

**Types of safety concerns**

In total, 97 (84%) of the workers in our study reported that they had safety concerns. Workers provided accounts of their safety concerns that were both retrospective (a reflection on a previous safety experience that involved them or a co-worker) and prospective (a concern or worry for what ‘might’ or ‘could’ happen). Four types of safety concerns were identified (see Fig. 1 and Table 2).

Workers most frequently identified issues of physical safety, involving lifting and transferring clients, with concerns about potential back injury, followed by spatial concerns referring to the home space in which they worked. The third most cited were temporal concerns, often referring to rushed travel between clients’ homes. The fourth were interpersonal concerns. Typically framed by workers’ interactions within the private spheres of clients’ homes, these involved client and family behaviours, conflicts and specific client conditions. Many of these concerns, notably the temporal and interpersonal, have an enduring, permanent quality: they are ongoing, anticipated safety concerns associated with this type of work. Tables 3 and 4 include additional data.

**Safety concerns: multi-dimensionality and intersectionality**

As demonstrated in Fig. 1, safety concerns were not only multi-dimensional (i.e. more than one type), but also intersectional; it is at these points of intersection that we are better able to understand the patterns of HSW safety. Our analysis identified that the most common intersection occurred with spatial concerns, highlighting the risks presented by each unique home environment. Safety issues are rooted in the fact that care is provided in unregulated, private residences. These residences also regularly undergo change, for example when

![Figure 1](image_url)
family members move furniture, or when a client's ability to care for and clean their home fluctuates. Furthermore, the workers in our study visit, on average, four homes per day. Issues of physical safety especially when associated with inappropriate or insufficient supplies and equipment in the home intersected with spatial concerns. For example, physical/spatial safety issues involved inappropriate beds (e.g. need for a hospital style bed) and the absence of functional lifts. Worker Anita described this relationship between types of safety issues:

Before I have a problem about the bed being low, her bed, because I have to keep turning her...you have a backache because you keep turning...so now they have to raise up the bed...It's been resolved that problem, yeah...They put that [bed on a] block. (Anita, #71)

Gwyneth discussed the absence of appropriate equipment:

...the bathroom is the main safety area, right., which apparently a lot [of] our home support workers have pulled their back out and stuff like that. And, again, it's like, 'Were you wearing the right shoes? Were you bending your back properly;' you know, [but] she's got no equipment in there to grip, you know... (Gwyneth, #83)

In addition, interpersonal concerns with family members intersected with spatial issues about the 'home space'. Uniquely in the home care context, family members often play an important role in setting up and managing the client's living space, which simultaneously serves as the HSWs work space. For example, worker Jane describes her concerns about a family's unwillingness or inability to purchase appropriate lift equipment for the home. In this situation, the worker is expected to compromise her physical safety by doing lifts without mechanized assistance. Here we see the intersection of interpersonal, spatial and physical concerns:

The only safety concern I would have at the moment is...when it involves a person that really wants to stay at home to the day they die and they need a Hoyer lift and they need something, the only concern I have is that the family says, 'Well, we can't afford...
Table 4  HSWs verbatim accounts of temporal and interpersonal concerns

<table>
<thead>
<tr>
<th>Temporal safety concerns</th>
<th>Interpersonal safety concerns</th>
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<tr>
<td>Driving, yeah, driving. Like, you’re in a hurry. I have had co-workers who get into an accident and the office are calling them, you know, so they get into a rush and they get into an accident (#21, Male, HSW, 8 years)</td>
<td>So I went to the kitchen, prepare his food and the medicine and when I went back, he’s already nude... I told him, ‘Okay I’ll just put on your jammies okay?’ But I was a little scared. Because I know he’s still a little bit strong. I didn’t go close to him. I just made a distance... But I was really so scared... I feel uneasy (#74, HSW, 9 years)</td>
</tr>
<tr>
<td>We are allowed to be really cautious when you do things... when we have in-service training, that’s what we discussed there... but you know, when you’re in a hurry sometimes some workers get hurt, yeah (#114, HSW, 16 years)</td>
<td>Ah, I had a client who had severe dementia. And she was living by herself. And they, she had no family or anything... she became incredibly agitated one time, that I thought she was going to hurt me. She had a broom that she was threatening me with and so I just kept backing up and I thought well you know I think I’m just going to leave. So I left (#16, HSW, 15 years)</td>
</tr>
<tr>
<td>Yes, traveling time because ah, they schedule us, they give us ten minutes travel time between clients. So when it’s traffic like this, you know, you need to be to that client at four o’clock... So there’s a tendency that you have to rush and ah, beat the traffic. That’s kind of unsafe for me, too, but you have to be there (#14, HSW, 13 years)</td>
<td>Well, for falls... fall with them to make sure you don’t hurt yourself or them. But if you don’t happen to be close enough to them, you know at the time to catch them, you know, accidents could still happen while you’re there. So I would feel really bad if something like that happened while I was, you know, responsible for them (#35, HSW, for &lt;1 year)</td>
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Mitigating and intensifying factors

While 84% of the workers in our study reported that they had safety concerns, workers’ responses also revealed various factors that mitigated their perceptions of potentially unsafe working conditions (See Fig. 1). Mitigating factors lessened the severity or perceived seriousness of the concern for workers and included positive client and family characteristics and interactions, supportive organizational policies and practices (e.g. responsive, readily available supervisors) and a HSW’s individual capacity to be pro-active in safe-guarding their safety. Indeed, numerous workers reported that their concerns were addressed, and that they were able to speak with their supervisors to assess, prevent or ameliorate a safety concern. This might include removing a worker from a situation perceived as potentially unsafe. Patrick felt that the agency was very responsive to workers’ safety requests: ‘you have the option, like, if you don’t feel physically prepared, then you can say no and you can—it’s valid for them’. Many workers shared examples of pro-active, tailored strategies, which they employed as concerns arose. Tailoring their strategies meant that workers made changes specific to the safety environment of particular households. Examples of tailored strategies included discussing the placement of rugs and furniture with family; changing burnt light bulbs; taping cords out of the way to avoid trips; advocating for better supplies and equipment; carrying flashlights for late night phone calls. Strategies were context-specific, imploring HSWs to make judgment calls and activate appropriate responses as needed. These strategies often involved negotiating with the client. Joyce explained: Sometimes... we talk to our client and we don’t want to upset our clients. Just say, ‘Oh Mr. Smith, is it okay if you can’t smoke?’ I said, ‘Oh we won’t stay here for a long time, can you—’ Sometimes he said, ‘Okay.

HSW Johanna explained her technique for speaking with clients about safety concerns:

Yeah, lots of time I have solved the problem. In fact, sometimes they get so pains in the house, instead of doing anything. So then I’ll take them for a walk and then on the way I’ll talk and then I’ll find out what’s going on.

Conversely, as seen on the left side of Fig. 1, workers identified factors that intensified or exacerbated their safety concerns. Intensifying factors increased the severity, seriousness...
or perceived likelihood that a safety concern could become an incident. These included unresponsive families and clients, and unsupportive organizational practices and policies (e.g. working in isolation, limited preparation or training, fears about insufficient coverage/insurance and inadequate information about clients and families prior to first visits). Ellie, for example, revealed a situation where a client’s highly communicable disease wasn’t communicated to her for nearly a week: ‘I don’t want to transfer it to other clients and my family, too… It’s all about the agency. They have to be responsible, [and] tell us right away’. Workers also discussed their own inability or unwillingness to act on their concerns.

A few workers also identified personal financial risks in reporting safety concerns. In these rare cases, workers felt that they, or co-workers, risked losing clients or much-needed hours of work if they disclosed their concerns. As Elaine reported,

I know out there if there are safety concerns, they don’t really want to talk about it because they want to keep the hours. There’s a lot of pressure to just keep quiet to get work, yeah… Well, you know we’re always told there will be no loss of hours. But the truth of it is, like, we will lose these.

The failure to report a safety concern not only creates future hazards, but also serves as a source of potential stress for the HSW who knowingly accepts risk as a part of the daily work environment.

Specific client conditions, including dementia or mental health conditions heightened the perceived physical risk for workers, including fire hazards, aggression and injury. Insufficient training further exacerbates these situations. For instance, Melissa reported: ‘We are getting more and more extremely demented clients. And I sometimes worry whether or not, you know… we’re not psychologists or psychiatrists or anything. Like it’s really difficult sometimes to handle them’.

Discussion

Our findings highlight HSWs’ perspectives using textual data to better understand the complexity of their safety concerns. While Lang et al. [3, 16, 17] provided broad definitions for the different types of safety issues in home care, we have provided a typology of and definitions that are firmly rooted in the worker experience. This is important because at present, home care agencies and regional health authorities in Canada primarily track physical safety concerns, formally reported through occupational health and safety systems [e.g. 26]. However, our findings suggest that from the HSWs’ perspective, there are also temporal, interpersonal and spatial concerns that are ongoing and persistent and create unsafe work environments. For instance, repeat concerns about the home space and equipment, ongoing interpersonal issues with family members and rushing to and from client homes.

Extending the work of Lang et al. [3, 16, 17], we demonstrate the critical intersectional nature of HSWs’ safety concerns. That is, where multiple concerns intersect, the complexity and precarious nature of the home care workspace is revealed. As represented in our conceptual model, HSWs’ safety concerns continually intersect with the quality of the workspace in individual homes (i.e. the spatial concerns). HSWs identified a number of intensifying factors that point to opportunities for intervention, including more thorough training to work with persons with dementia, more frequent assessments of the ‘home space’ and additional avenues for workers to express and address their concerns. Also, workers discussed a number of ‘proactive’ strategies that they employed; thus, peer-to-peer safety training modules are a potential mode of intervention. We concur with Lang [3], who identified the need for interventions that respond to individual safety concerns, which are different in each home.

Elsewhere, researchers have noted that the patient and HSW safety agendas are interlinked [3, 6, 13, 16]. In our study, workers described situations that presented threats to their work environments; however, there are potential implications for the safety of the clients involved as well. For instance, cluttered or unhygienic homes lacking in proper equipment and supplies, influence the safety of the client who is also exposed to this environment. HSWs’ safety issues reveal hazards not only for the worker and client, but also represent risks for other professionals who enter and work in the home. HSWs provided valuable information about the quality of the home and care space and it is essential that they be consulted about the development of home care safety interventions and approaches. As well, future research should investigate the relationship between client and worker safety concerns so that intervention efforts can be aligned.

There are some limitations to our study. As our data are based on workers’ recollections of safety concerns, there may be recall issues. Future studies should be based on immediate reporting, thereby lessening potential recollection problems. Also, our data rely solely on workers’ verbal descriptions of their safety concerns in the home. Given the intersectional nature of spatial concerns, it is essential that future studies collect observational or visual data (e.g. photos and video) of the home space.

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References


